Public Healthcare Governance in Hong Kong: A Study on the Emergence of Hybrid Physician Managers

FUNG, Ka-wo

PhD

University of York

Social Policy and Social Work

July 2017

Abstract

The emergence of hybrid physician managers in hospital management in western countries under New Public Management has attracted researchers' attention in the past two decades. However, it is under-explored outside the West. As a former colony of Britain, Hong Kong has a legacy of the NHS-style universal public hospital system based on western medicine and a liberal profession of medicine. Similar to the UK, the 1990s and 2000s saw rapid changes in Hong Kong that aimed to modernize the healthcare sector in terms of efficiency and transparency/accountability. The landscape of healthcare governance in Hong Kong is in the same way shaped by the interplay between the state and professional powers.

Although researchers in this field are commonly inspired by the Re-Stratification thesis that sees medicine as being divided into two groups, rank-and-file doctors and medical elites who enrol into the administrative and regulatory posts, only a few empirical studies focus on the identity work of hybrid physician managers as the pivotal players in healthcare reforms. Indeed, it is not only the capacity but also the loyalty of medical elites to their peers that decides whether or not the collective control of medicine on healthcare management can be preserved.

Examining the Hong Kong case, this research aims to have the physician managers' first person narratives on their management role in healthcare, with special attention to their social identification with professional colleagues and organizations. In view of a more sophisticated understanding of physician managers' hybrid identities, a new analytical approach is developed based on previous studies. It is found that physician managers try to satisfice both professional and organizational values, while maintaining respective jurisdictions in policy making and clinical governance, as well as their primary self-identification as rationalizers or protectors of medicine, according to their manager roles as directorial and departmental managers.

List of Contents

List of Tables

List of Tables (continued)

Acknowledgements

I would like to take this chance to express my gratitude to my supervisor Professor Neil Lunt for his guidance in the past three years. Without his support in every aspect of my PhD life, from my settling down in this country to intellectual inspirations, this thesis will not have been completed.

During the past three years, the most difficult thing was my separation from Janice, whom I married only one year before my PhD abroad. As a newly married wife, she placed her husband's pursuits before her legitimate needs - particularly his full commitment to married life. I am deeply indebted to her for my absence from Hong Kong and the subsequent emotional and financial burdens imposed. There is nothing I can compensate Janice for her tolerance and sacrifice.

Finally, I am also grateful to my second supervisor Professor John Hudson for his valuable comments and presence at supervision meetings, my informants Dr Ka-lau Leung and Yun-kowk Wing for their generous help in my data collection, and the last but not the least, all interviewees in this study for their precious time.

Declaration

I declare that this thesis is a presentation of original work and I am the sole author. This work has not previously been presented for an award at this, or any other, University. All sources are acknowledged as Bibliography.

Chapter 1

Background: an overview of the Hong Kong context and case

1.1. Introduction

This study attempts to understand the interrelation between reforms of the Hong Kong healthcare system and its key players, medical professionals, and its implication for the state's capacity in governing welfare provisions. In 1991, a statutory corporate body, the Hospital Authority (HA) was established as a unified system of public health services planning, delivery and financing in Hong Kong. However, it is contentious whether the reforms are a "decentralization" or a "centralization" process - while the healthcare system becomes even more professional-led in terms of the medical professionals' entrenchment in its management (Cheung, 1996) and power to veto policy change (Chiu, Ho and Lui, 2011), the government has successfully rationalized the system with New Public Management (NPM) measures such as performance indicators and businesses-like management system (Cheung, 2002b).

Indeed, public management literature has noted such potential contradictions between NPM ideals of having health care organizations decentralized or centralized (Lindberg, Styhre and Walter, 2012, p. 58). While publicly operated hospitals are reconfigured into a growing variety of independently managed semi-autonomous organizations, in these still publicly owned, publicly capitalized, and publicly accountable organizations, institution-level managers gain control over important operating levers (Saltman and Bankauskaite, 2006, p. 140). It is argued that NPM advocates, on the one hand, to free public service managers from the bureaucratic rule ("let the managers manage"), on the other hand, to fashion systems to performance-manage them from the centre ("make the managers manage") (Askim, Christensen and Lægreid, 2015, p.973). This debate can also be taken in a governance perspective, which is the main theoretical framework of this study: the pluralistic position suggests that NPM is a global reform movement inspired by a broad neo-liberal ideology "hollowing out the state" (Rhodes, 1994); on the contrary, the state-centric position argues that the state's capacity in steering society is actually strengthened by an ever-sophisticated regulation and monitoring system (Fawcett, 2013, p.6). In Chapter 2 we will elaborate governance theory regarding the balance of power between state and societal actors in welfare production.

In the analysis of decentralization/ centralization in health care, it also important to go beyond the organizational level to include the individual as health care practitioners. Professional autonomy is undoubtedly a core aspect of the decentralization/ centralization of healthcare system in terms of devolution in decision making and service delivery (Peckham et al., 2008, p.566). Through the centralizing mechanism of licensing and clinical governance, professional work is standardized and regulated with front-line doctors' labour process being more transparent and measurable. At the same time, this process is often independent from the central government under the banner of collective self-regulation - the medical profession's collective control is preserved by "medical elites" who act as the proxies for the government to run the healthcare system. This widely accepted view, as the Re-Stratification Thesis (Freidson, 1994), singles out managers who are medically qualified (physician managers) as pivotal players in healthcare system negotiating between the state and medicine. With special attention to their dual role representing both managerial and professional interests/agenda, in Chapter 3 we will establish our argument in an alternative position of governance theory, Corporatist theory, seeing the medical profession basically as a partner and sometimes a challenger of the state in healthcare governance. This account may help assimilate the contradictory movements of decentralization and centralization in healthcare as inherent in welfare corporatism.

It is not only the capacity but also the loyalty of medical elites to their peers that decides whether or not the collective control of medicine on healthcare management can be preserved. With the enrolment of medical professionals into healthcare management it could be the state "colonizing" medicine by the co-optation of doctors imposing a tighter self-surveillance regime as "soft bureaucracy" (Flynn, 2004); or conversely, medicine "capturing" the state to preserve their control on daily professional operation as "soft autonomy" (Levay and Waks, 2009) or "loose coupling system" (Doolin, 2001). However, there are rarely empirical studies that focus on the identity work of hybrid physician managers in Hong Kong. This study will then strive to have the physician managers' first person narratives on their management role in healthcare regarding their social identification with professional colleagues and organizations. In Chapter 4 we will develop the method for researching physician managers with reference to literature on relevant conceptual discussions and empirical studies.

In this background chapter we will first outline the Hong Kong setting of healthcare reforms as a "centralized decentralization" (Hoggett, 1991; Watkins, 1993) project. It starts with the overall welfare arrangements followed with the structure of healthcare governance in the territory. As a former colony of Britain, Hong Kong has a legacy of the NHS style universal public hospital system based on western medicine and a liberal profession of medicine. Similar to the U.K., the 1990s and 2000s saw rapid changes in Hong Kong to modernize the healthcare sector in terms of efficiency and transparency/accountability. The landscape of healthcare governance in Hong Kong is in the same way shaped by the interplay between the state and professional powers.

Besides, the very characteristic of the city-state as a "liberal autocracy" (Fareed Zakaria, 1997; liberal economy and freedom without democracy) has constrained it to adopt a non-interventionist and incremental approach to social policy. In view of a small government, cost containment, and the lack of legitimacy of the autocratic polity, Hong Kong Government is left little choice but a decentralization option and steering role in modernizing healthcare. At the same time, in the absence of democracy, welfare provisions serve as its substitute in maintaining legitimacy and social stability; and the executive-led political system enables the state to intervene in social policy when necessary. This also shapes healthcare reform in Hong Kong as another movement of centralizing government control.

1.2. The overall welfare arrangement

1.2.1. The territory's features

At the south-eastern tip of China, Hong Kong was ceded to the UK in 1842. During British rule, she made herself a commercial and financial centre in Asia. Following the restoration of the Chinese sovereignty in 1997, Hong Kong became a Special Administrative Region (SAR) of the People's Republic of China. Under the "one country, two systems" principle, Hong Kong retains as an independent customs territory having her own government and currency.

The vast majority of Hong Kong's population consists of the people of Chinese descent, while foreign nationals comprise 8% (Hong Kong Government, 2016). With a tiny territory of 1,100 km^2, which is only a half of Luxemburg, Hong Kong has a population

of 7.15 million people comparable to Switzerland. This makes her population density one of the highest in the world, 6,620 people per km^2, on par with Singapore. Hong Kong is small but dynamic, managing the world's 9th largest trading economy. Her economy is externally and service oriented, with a trade-to-GDP ratio of 4:1 and a services sector contributing over 90% of GDP (ibid).

Hong Kong is a highly-developed country considering the major comparative indicators. Her Gross National Income (GNI) is $57,650 per capita on Purchasing Power Parity (PPP), ranked 8th in the world, the same as the U.S. and higher than Japan (The World Bank, 2016); her Human Development Index (HDI) is "very high" at 0.91, ranked 12th in the world (The United Nations, 2016). Meanwhile, Hong Kong's Gini Coefficient is among the highest in developed economies, stands at 0.507 (Census and Statistics Department, Hong Kong, 2012b). Given the low tax rates (ceiling of 15% for salary tax and 16.5% for profit tax) and low government spending (less than 20% of GDP), the redistributive function of taxation and transfer programme is not so significant in Hong Kong. Her post-taxation and transfer Gini Coefficient is 0.431 (ibid). In contrast, the UK, whose income inequality is among the highest in OECD countries, is relatively successful in reducing its Gini Coefficient by taxation and transfer, from 0.527 to 0.358 (OECD, 2016a).

As the above listed figures suggest, Hong Kong successfully averts a substantial transfer system along the way she achieves a first-world economy. This may have to pay tribute to the "liberal autocratic" polity in Hong Kong as Fareed Zakaria (1997) depicted. On the one hand, she has a long tradition of constitutional liberalism and the rule of law "protecting its citizens' basic rights and administering a fair court system and bureaucracy" (p.29). On the other hand, her democracy is very limited and the representatives of professional and business elites enjoy veto power in the legislature. Taken together, what Hong Kong has been practising is very close to the ideal of classical liberalism that favours accumulation of wealth but hinders its ability to promote distributive social policy. All these constitutional rights and restrictions have been preserved by the Basic Law (Article 6 for private ownership of property and Articles 27 to 38 for civil liberties), the mini constitution of Hong Kong after she was handed over from Britain to China in 1997 as Hong Kong Special Administrative Region.

Under the Basic Law, the head of HKSAR Government, Chief Executive (CE), is indirectly elected by 1,200 electorates mainly from professional bodies and commercial

chambers. The Legislative Council (LegCo), which is the law-making body of HKSAR, is divided into two groups: half of the seats are from the geographic constituencies and the other half from the functional (occupation-based) constituencies. While every voter in Hong Kong has one vote in respective geographic constituencies, the functional constituencies are again reserved for the powerful few. Considering the small number of 240,000 voters in the election of CE electorates and functional consistencies, against all 3.4 million voters in Hong Kong, the upper-middle class population receives considerable political privileges.

Under the Basic Law, the selection of CE and LegCo Members is to be ultimately by means of universal suffrage. However, in 2014 Beijing proposed a CE election method that allows her to preselect CE candidates through the nomination committee (to be elected by the same method as the current CE electors), insisting that universal suffrage without CE nominators will result in more redistributive social policies that violate the Basic Law's requirements for Hong Kong to maintain its low taxation and capitalist system (Articles 107 and 108). Hong Kong citizens accused Beijing of broking its words and huge street protests, known as Umbrella Movement, took place. As long as political disputes and deadlock between Hong Kong and her new sovereignty China continues, the prospect of democratization is uncertain and the current liberal autocratic polity may survive for a longer time than expected. The principle of liberal economy/ small government and associated non-interventionism in social policy will still govern Hong Kong in the near future.

1.2.2. Modest yet universalist "four pillars"

When discussing the logic governing the Hong Kong welfare state, we should not overlook the influence of liberal ideology as an official doctrine. Hong Kong's long tradition of commitment to free trade and non-interventionist policy makes her the best example of a free market economy for Milton Friedman (Friedman and Friedman, 1980) and an ideal-typical liberal welfare state (McLaughlin, 1993). It has been rated the freest economy in the world by the Heritage Fund for over 20 years since the creation of Economic Freedom Index (The Heritage Fund, 2016).

As characterised by the last Financial Secretary of the colony, Macleod (1995), the Hong Kong capitalism is "a consensus about the need to encourage free enterprise and competition, while promoting equity and assistance for those who need". Specifically,

the government explicitly rejects the idea of promoting social equity by large-scale distribution of wealth through taxation and public welfare on the ground that it would mean interference with the free market and would discourage investment (The Hong Kong Government, 1977). In practice, the Hong Kong Government maintains income and corporate tax-rates around 15% and public expenditure of less than 20% of GDP (for a comparison with other developed economies, see Appendix One). That iron rule was laid down by Sir John Cowperwaite, the Financial Secretary of the colony in the 1960s, and it was preserved by Basic Law of the new Hong Kong Special Administrative Region of China after 1997 (Chiu and Wong, 2005). As Tang (1998, p.71) recorded, the annual growth rates of GDP and government consumption were basically identical (6.83%) throughout the period of the 1960s to 1990s. The cut in social expenditure by the government during the economic downturn from 1998 to 2004 seems to support the preservation of this principle that any increase in public provision could only be realised if it were funded by sustained revenue (Chiu and Wong, 2005).

The capability of the Hong Kong welfare state in wealth redistribution is predominantly restricted by the idea of "small government" (see Appendix Two). While the Hong Kong government are spending 60% of its expenditure in public welfare, the government expenditure itself is lower than 20% of the GDP. As a result, the Hong Kong Government's social expenditure in housing, healthcare, education and social welfare (social security and social services) is comparatively low, standing at less than 10% of GDP throughout all its history compared to 20% to 30% of other developed countries, and the transfer system is extremely minimal with a social assistance programme covers only 7% of its population and spending 1% of its GDP (CSSA allowance for households of 3 persons is approximate to 37% of the median income for the economically active households with the respective size; see Census and Statistics Department, Hong Kong, 2012a; 2012b). The entitlement of welfare as social rights and the de-commodification effects of Hong Kong's public welfare system are actually very modest.

Yet, on top of a modest transfer system, the Hong Kong welfare state actually delivers fairly universal social provisions in public housing, education and healthcare as the four pillars of public welfare. Firstly, public housing in Hong Kong covers a half of the population and is heavily subsidized by the government. It may be seen as a quasi-universal social policy. In 1973, Hong Kong Housing Authority was set up to be responsible for the Ten-year Housing Programme (later extended to a 15-year

programme). By 1987, the Programme had provided 1.5 million people with public rental housing (PRH). The PRH is highly subsidized as the rental is set lower than 10% of the median income level of the tenants. For the social assistance benefits recipients, their PRH rental is covered by their cash assistance. In spite of the means-test, 30% of the population in Hong Kong are living in public rental housing; in the late 1970s, the Home Ownership Scheme (HOS) was introduced to subsidize middle income earners who are ineligible for public rental housing and at the same time incapable of affording private ownership. This Scheme provides accommodation at 30% below market price and with cheap mortgage and generous repayment schedules. Currently, 17% of the population in Hong Kong live in the HOS accommodation. In total, the public housing protects half of the households in the territory. (Hong Kong Housing Authority, 2013; McLaughlin, 1993, pp. 118-119)

Secondary, public primary and secondary education in Hong Kong covers 80% of the school children. In 1978, a nine-year compulsory and free education was introduced for all school children aged 6-15. In the 1980s, the government expanded publicly funded high schools and the high school enrolment rate reached 90% (Mok, 2003). The publicly funded tertiary education rapidly expanded in the 1990s to reach the enrolment rate of 15%. To prevent any students from being denied to university education for economic reasons, tuition fees were set lower than 20% of the cost of provisions and there is a means-tested tuition fee waiver and student loan scheme.

Thirdly, the government has implemented a universal healthcare system directly funded by taxation since 1974 with the underlying principle that "no one should be prevented, through lack of means, from obtaining adequate medical treatment" (Medical Development Advisory Committee, 1974). Nowadays, public hospitals provide over 90% of in-patient services in terms of bed-day occupancy and 20% of public primary and secondary care services in terms of attendance. The Hong Kong Government is responsible for 90% of the public hospitals' income. Medical fees and charges for public hospital services are less than 5% of the cost (Food and Health Bureau, Hong Kong, 2008; See also Appendix Three)

Taken together, the Hong Kong welfare state provides minimal social security as "safety net" while allowing middle income earners access to highly subsidized public education, healthcare and housing (see Appendix Four for a wide range of their coverage in the population and Appendix Five for a fairly equal accessibility among different income

groups). Social provisions in Hong Kong are modest but well accepted by Hong Kong society as universal entitlements considering their accessibility. By the 1990s, as reported by a series of public opinion survey, a sense of entitlement to public welfare among the citizens and their support for collectivist welfare in Hong Kong had been created (Lau and Kuan, 1990; Tam and Yeung, 1994). When China announced the Basic Law of the coming Hong Kong Special Administrative Region in 1991, "rights to social welfare" was accepted as one of the residents' basic rights in Hong Kong that had to be preserved (Article 36), although the Basic Law also provides that public welfare shall not compromise the idea of small government and liberal economy (Articles 107 and 108; Aspalter, 2002, p.101).

As Holliday (2000) argues, the appearance of Hong Kong as a liberal welfare state is somehow misleading. While social rights to public welfare is limited, its production elements (housing, education and healthcare) are expanded on a universal basis for maintaining a productive workforce. The Hong Kong welfare state is not only facilitative (non-interventionist, small government) but also developmental-universalist (pp.709-710). More importantly, as Chiu, Ho and Lui (2009) suggest, "on top of being a central component of the government's developmental project, the socialization of collective consumption has been one of the primary pillars of the legitimacy of the colonial government, and the SAR government has continued to use the provision of various kinds of public services to boost its political ratings" (p.241). Similar to the western democracies, "the welfare state retains considerable legitimacy as a source of social stability and guarantor of basic rights of citizenship" (Pierson, 2001, p.413).

Indeed, the building of Hong Kong welfare state in the 1970s was clearly a plan to expand social rights in the colony as a substitute to democracy that was denied. As the UK's Foreign and Commonwealth Office archives disclose, the efforts to modernize Hong Kong's public welfare were actually a strategy of the British Government. Considering that the lease of Hong Kong to Great Britain was about to expire in 1997, the British Government had to ensure the special status of Hong Kong under Chinese sovereignty by building Hong Kong as a model city and empowering its citizens (Lui, 2010). In Lord Maclehose's (Governor of Hong Kong, 1971-1982) own words, it was to "close the gap" between the colonial state and the Hong Kong society in order to create and foster loyalty of the people to the colony (Carroll, 2007, p.159). While the absence of democracy may help the state uphold the doctrine of small government and incrementalism in social

provisions, it does not make social policy irrelevant. As the primary source of legitimacy, the efficiency and performance in social provisions has become even more carefully watched by the state itself and the society in Hong Kong.

1.2.3. *New Public Management in Hong Kong*

Interestingly, in response to the growing demand for social provisions in Hong Kong, the reluctance of the government to maintain a large squad of public servants for social provisions made the voluntary sector the major agency of social provision delivery. While the Hong Kong welfare state leaves little room for the private market in social provision, it is not always the direct service provider. Non-government organizations (NGOs) play an important role in delivering public welfare and the state rather manages public welfare through mainly its role as sponsor and regulator. Since the 1980s, the New Public Management notions of accountability and efficiency in western countries have been employed by the government to develop an ever-sophisticated system monitoring public funding.

Notable cases of NGOs in Hong Kong are the Tung Wah Group of Hospitals and the Po Leung Kuk. In the nineteenth century, the former gave free medical care and burial service for the deprived labourers while the latter specialized in women protection. Free schools and healthcare services provided by Western missionary bodies were of high importance as well. The important role for a "vigorous voluntary sector" has been recognized by the government (The Hong Kong Government, 1973, p.24). The colonial government found NGOs a readily available partner when it launched the massive investment in public welfare in the 1970s. In White Paper, *Social Welfare in Hong Kong: The Way Ahead*, it is stated that:

> [W]hilst the Government accepts ultimate responsibility for the provision of social welfare services in Hong Kong, experience has shown that if there is a vigorous voluntary sector, with agencies specializing in differing areas, then the Government can make fruitful use of these agencies' services so that together the Government and the voluntary agencies share in the extension of services. In other words, there are areas of service, e.g. children and youth centres, where the Government sees a need and is prepared to meet that need not by the direct provision of services but by providing a financial subvention to an agency, or group of agencies, so that they can provide the service. If the extent of services provided by the voluntary sector were to decline then

the Government would have less choice in deciding how to pioneer new services, or extend into new localities. (ibid)

The heavy use of NGOs reflects the colonial government' reluctance to commit too much in the early period of expansion of social provisions. However, the continuous economic success of Hong Kong in the 1970s supported a regular increase in social spending. From 1975 to 1985, social expenditure in Hong Kong grew 300% in real term (see Tang, 1998, p.72). On the other hand, following the introduction of social assistance of social welfare in 1970s, voluntary agencies transformed from charity dispensing relief to NGOs delivering professional healthcare, education and social services. Injection of public funding, in addition to Hong Kong's democratization, made accountability necessary. Under the name of new public management, government monitoring and regulation regimes have been consolidated over time (Chow, 1995).

By the 1990s, Hong Kong NGOs had delivered 90% of personal social services, such as family counselling, youth work, rehabilitation, elderly care, and community services. The fact that and the government sponsored over 70% of their funding turns them into the state's agents under service contracts. Since the 1970s the government's role in regulating social services spending has been paramount - over policy formulation, policy review, service delivery, coordination, and professional guidance. In particular, the government setup Service Quality Standard to enhance NGO's "management responsibility" (Chan, 2003; Wong, 2008).

In the provision of public education, subsidized schools operated by missionary bodies and voluntary organizations account for over than 80% of primary and secondary schools in Hong Kong, while less than 10% are government-run. The voluntary organizations are responsible for the cost of construction of the school building and assume the management duty. The bulk of the budget, the operating cost and the staffs' salary of subsidized schools, are paid by the government. In return, those schools are under the government's monitor in curriculum design. Other means of control by the government are quality assurance inspections in four major domains: management and organization, learning and teaching, support for pupils and school ethos, and attainment and achievement. Outside the monitoring system, autonomy has been allowed to individual schools with school based-management (Mok, 2003).

In public healthcare, the government expanded the public hospital network by subsidizing not-for-profit hospitals in the 1970s. In the mid-1980s, while 47% of the hospital services in Hong Kong were provided by the government-run hospitals, a considerably high portion of 41% were provided by those publicly funded hospitals operated by NGOs (in terms of hospital beds). Their activities had already been integrated to the public hospital networks, and a number of their key staff was seconded from the government (Scott & Co., 1985). In order to better control the public hospital networks, the government incorporated the publicly funded hospitals, together with those that are government-run, into a statuary organization, the Hospital Authority (HA) in 1991. On the one hand, government-run hospitals were separated from the civil service. On the other hand, the role of voluntary organizations in managing public hospitals was largely reduced to a mere monitor role. They retain presence in Hospital Governing Committees and receive regular management reports from Hospital Chief Executives and monitor operational and financial performance of individual hospitals. By appointing the Board of Directors, the government holds the HA management accountable at arm's length while it devolves responsibilities of managing and delivering public healthcare services. Among others, the HA has developed an ever-excessive managerialism and one well-known example of which is the publication of "Business Plan" couched in management jargon. It sets out key major result areas, initiatives planning and targets to be achieved intending to provide a yardstick whereby performance of the frontline staff can be handily monitored and measured (Cheung 2002, pp.352-353).

The abovementioned setting may explain why New Public Management (NPM) could well settle Hong Kong in the past two decades as a "centralized decentralization" project. On the one hand, the tradition of laissez faire and small government had left the healthcare system, as well as other pillars of public welfare in Hong Kong, prone to a decentralization approach. Under non-interventionism and incrementalism in social policy, charities and NGOs were increasingly subsidized by the government and eventually became the major providers of public services in view of avoiding a big government and cost containment. On the other hand, quality control was stressed for their quasi-public status. Another goal of NPM, accountability, was put at the top of the agenda when the reforms took place in Hong Kong in the 1990s. The institutionalization of those autonomous organizations as public arm-length bodies under NPM therefore has two contradictory goals: first to decentralize the healthcare system from the government, and second to enhance its accountability. The establishment of the HA perhaps is a best

example. In the next section, we will turn to the Hong Kong healthcare system *per se* to depict the basic characteristics of its governance and the historical background of the 1991 reform as a "centralized decentralization" project.

1.3. The overall structure of healthcare system

1.3.1. The Hospital Authority

Established in 1991, the Hospital Authority (HA) is the statutory body responsible for managing Hong Kong's public hospitals and their services to citizens. It is the centrepiece of public healthcare services delivery in Hong Kong and currently manages 42 public hospitals and institutions, 48 Specialist Out-patient Clinics and 73 General Out-patient Clinics, providing annually 1.5 million inpatient and day patient discharges, 2 million Accident and Emergency attendances, 9 million Specialist Outpatient Clinic attendances (clinical and allied health), 6 million primary care attendances and 2 million community outreach visits. It is also the largest public corporation in Hong Kong, hiring 64,000 employees, near to 2% of the working population in Hong Kong. In financial terms, the government allocates 14% of the public general expenditure to the HA. The provision of services in the HA is divided into 7 hospital clusters, each serving 0.5 million to 2 million population of respective geographic districts in Hong Kong. Cluster Managers are responsible for coordinating the services among different hospitals and clinics within the clusters, with a view to create a continuum of care within the same geographical setting throughout patients' episode of illness - from its acute phase through to convalescence and rehabilitation, and community after-care. (Hong Kong Hospital Authority, 2016)

With a budget and manpower which is only one-tenth of that of the HA, the Department of Health (DH, the Medical and Health Department before 1988) is responsible for public and community health, such as education and prevention of infectious decisions. While healthcare includes both "health" (public health) and "medical" (treatment) in a broad sense, our further discussion of healthcare refers to the latter. In contrast to the dominant status of modern scientific (western) medicine, the role of Traditional Chinese Medicine (TMC) is rather a supplement to the private primary healthcare, providing 10% of outpatient services in Hong Kong (Holliday, 2003, p.88). Despite recent efforts of the government to develop some TMC centres for teaching and research, TMC has never

been a formal part of public healthcare services. For instance, the output reported in Annual Reports of HA does not include TMC.

1.3.2. The government's role as sponsor

While the government bureaucracy handed off the provision of healthcare to HA as an arms' length public corporation in 1991, it did not bring any significant changes to the *direct state funding* in public healthcare as the government is still responsible for over 90% of its budget. In Hong Kong, the government's general revenue provides the budget support for the public healthcare and there are no compulsory contributions from health insurance, medical saving or any other health tax. Paying less than 3% of inpatient cost and less than 10% of outpatient cost, Hong Kong citizens enjoy a heavily subsidized public healthcare (see Appendix Three for costs and fees of healthcare service in the HA).

The universal healthcare in Hong Kong is somewhat a "slimmed-down version of Britain's Nation Health Services" (Holliday, 2003, p.76) as the governments' investment in public healthcare has been restricted to the inpatient services from the outset of the mid-1960s. There are no general practitioner contractors of the NHS or their equivalents in Hong Kong. Outpatient services are predominately delivered by private practitioners without government subsidies or public contributory programmes. While public hospitals account for 90% of hospital beds and services workload (in terms of bed days) in Hong Kong, public outpatient clinics have only 20% of the market share mainly serving the elders and low-income populations. Although a means test does not apply to public outpatient services and the service charge is minimal, the younger and better-off populations who are more sensitive to waiting time than price usually exercise choice by using private services (Food and Health Bureau, Hong Kong, 2008, Appendix C).

The limited (universal yet modest) public outpatient services can again be explained by the nature of welfare in Hong Kong as a safety net which targets those who are the neediest: compared to inpatient services, financial risks involved in outpatient services are much more modest for most people, thus the provision and funding of the primary care can be left to market and the hospital care is centralized by the state. As a result, private medical expenditure accounts for half of the total medical expenditure in Hong Kong. This partial patterning of NHS model of direct state provision in secondary but not primary care is also a common phenomenon in other former British colonies where the welfare state is limited, such as Singapore and Malaysia (Ramesh and Holliday, 2001).

In a broad sense, the creation of HA even centralized the *direct state provision*: before that there were half of the hospital services provided by not-for-profit hospitals, which were publicly-funded yet independent (Scott & Co., 1985, Ch. 3); since that, those independent hospitals have been managed under a unified system as well as government hospitals, though considerable autonomy is allowed to HA and the government-run hospitals has been separated from the civil service.

1.3.3. *The government's role as regulator*

Since the establishment of HA in 1991, the role of the government itself in public healthcare has shifted from direct service provider to a pure regulator. The legal framework of the Hospital Authority Ordinance (Ch. 113 of the Laws of Hong Kong) holds the HA accountable the Secretary for Health through its governing body, the Board of Directors at the Head Office (HAHO) as well as the Hospital Governing Committees (HGCs). Their members are appointed by the government and are responsible for guiding and overseeing HA Chief Executive and Hospital Chief Executives in formulating and implementing policy strategy. In order to facilitate the scrutiny of the HA's affairs, "the Ordinance also requires the government to table in the Legislative Council the annual report together with the statement of accounts and the auditor's report on the accounts; the Director of Audit can conduct an examination into the economy and efficiency with which HA has expended its resources in performing its functions and exercising its powers, and to report to the President of the Legislative Council the results of such an examination; the Secretary for the Treasury can give directions to HA to limit its total expenditure in any financial year. Although HA will be provided with a considerable degree of financial autonomy, including the power to borrow money and to invest surplus funds, the exercise of these powers may be subject to direction in certain cases" (Legislative Council Handsard, 2 May 1990). In sum, the government is still responsible for overseeing the HA's overall performance in proving public healthcare services and monitoring its finance.

1.4. The 1991 reform

The 1964 White Paper had marked the Hong Kong Government's interest in developing public healthcare "to provide, directly or indirectly, low cost or free medical and personal

health services to the large section of the community which is unable to seek medical attention from other sources" (The Hong Kong Government, 1964). To actualize the idea, the 1974 White Paper further proposed a ten-year plan to expand public healthcare (Medical Development Advisory Committee, 1974). From 1974 to 1984, the government's healthcare expenditure grew by 119 % in real terms against a population growth of 24%. By the mid-1980s, such a massive investment, as well as socio-economic progress and improvement in the environment of Hong Kong, had brought about a high standard of health which can be measured by an average life expectancy of 74 for men and 79 for women and the low occurrence of major communicable diseases (Scott & Co., 1985, Ch. 3).

However, the overall inefficiency of the system had become obvious confronted with the problem of overcrowding and low staff morale. The fragmentation of the public hospital networks (government-run versus not-for-profit hospitals) and the rigidity of the bureaucratic structure were blamed. Before the reform, public healthcare was directly delivered by the Medical and Health Department in the 1980s. The Department operated government hospitals and supervised publicly-funded not-for-profit hospitals. Those independent hospitals mainly served public patients for they relied heavily on government subsidy and they had been an integral part of public hospitals network for a long time. The entire public hospital network constituted almost 90% of hospital beds in the territory. In 1985, the government-commissioned Australian consultancy firm, WD Scott & Co. Pty Ltd, recommended a single body, outside but accountable to the government, to coordinate the entire public healthcare network and facilitate managerial and structural reform that makes it function like a corporation (Scott & Co., 1985). Under the Hospital Authority Ordinance, all public hospitals, both government-run and publicly-funded not-for-profit hospitals, were incorporated into a unified system.

The government's first three specific references for the Scott consultancy are (Ch. 1A):

1) To review the organizational structure for managing government and publicly-funded hospitals, with the aim of assessing the potential for achieving better integration between these hospitals on a functional basis and to advise whether this aim should be met through the establishment of autonomous authorities for managing government and publicly-funded hospitals;

2) To advise how more effective use might be made of existing resources in order to overcome the problems arising from overcrowded conditions in government and publicly-funded hospitals and to suggest what alternative methods or facilitates should be planned to relieve the load on hospital beds; and

3) To examine the internal administration of government and publicly-funded hospitals with particular regard to roles of the senior medical and nursing staff and of non-medical administrators, and to advise on the changes needed to strengthen hospital administration, including the training required to enhance the administrative skills of senior medical and nursing staff.

1.4.1. Inadequacy of civil servant structure

The most compelling justification for the reform, as the Scott Report put it, was that "the system lacks the flexibility to be able to cope with the range of problems facing it at the present time. Many initiatives to ease the current situation are precluded on the grounds of civil service implications" (Ch. 3.6). The report further lists the potential benefits of locating the authority outside the civil services: 1) a greater measure of freedom for the addressing of those problem peculiar to medical service, without direct comparisons elsewhere in the civil service; 2) the development of new staff terms and conditions appropriate to medical services activities, free from those civil services wide implications which are inappropriate to hospitals; 3) flexibility to develop appropriate relationships, both formal and informal, with the public sector and those outside; 4) the capacity to innovate and develop new services rapidly in response to identified community needs; 5) the opportunity to develop and offer career prospects to non-medical staff without the probability of their being moved elsewhere in the civil services as a matter of course; 7) the ability to use public or private sector facilities, on a contract basis, for the construction, development and maintenance of facilitates and services; 8) an independent and objective approach to the difficult problems associated with staff employment in the new organization; and 9) the authority focussing its attention on its prime objective of using the available resources efficiently in the provision of medical services. (Ch. 5.2.4) It strongly suggested that the rigid civil servant structure had outlived and must be modified in order to rationalize the overall management of public healthcare system, especially the devolution of decision making power to the delivery level.

At the organizational level, structural reform was seen as a solution to the institutional inefficiency. It was believed that the new structure of HA as an independent corporation will facilitate: 1) the establishment of a clear line of accountability, for the management of the extensive resources devoted to the provision of acceptable standards of medical services in all government funded hospitals; 2) a high level of accountability in that senior authority staff can be held responsible for performance, and in the extreme, replaced if results are unacceptable; 3) the identification of inputs and outputs to and from the system for medical delivery, leading to the opportunity for some level of public scrutiny as appropriate; 4) the optimum use of resources throughout, in particular addressing the imbalance between bed occupancy rates in government and not-for-profit hospitals; and 5) wide ranging opportunities for career development for all staff in the system; this will lead to better staff morale and job satisfaction, and thus greater retention of staff and development of medical and other staff skills. (Ch. 5.2.1)

1.4.2. The legislation

The government listed four major objectives of HA when introducing the Ordinance to the Legislative Council in 1990. "First, it will bring the government and subvented hospitals together within an integrated public hospital system, and the Authority will offer common terms of service to its staff. The second benefit is that by being established outside the Civil Service, the Authority will be better placed to demonstrate flexibility and to respond quickly to changing demands. Third, there will be more effective and accountable hospital management, with greater devolution of authority from the central to the operational levels. Finally, community participation in the provision and operation of public hospital services will be enhanced". (Legislative Council Hansard, 2 May 1990)

At first glance, while the first objective tackles the imbalance of resources between government and not-for-profit hospitals, the others are mostly regarding a more decentralized system. At the time, it was believed that the rigidity of the bureaucratic system should be accountable for the institutional inefficiency of the public hospital network. However, the creation of HA was also driven by the need of management reform as the solution to the poor coordination across the entire public hospitals network.

When identifying the problems and needs of public healthcare reform in Hong Kong, the Scott Report states, (my emphasis)

> Throughout, the aim has been to develop a framework within which the system for the delivery of medical services in hospitals can become more effective and efficient…This new framework should have by its very nature, the inbuilt flexibility to respond to the many conflicting pressures which it will have to face, whilst retaining the strength to maintain the overall direction which the government, in its policy properties, and the people of Hong Kong wish it to follow.

> The critical need is to harness all available scarce resources and focus them on the provision and further development of medical services in hospitals. This calls for *the effective integration of the structures at the top* and *the controlled devolution of responsibilities* to the main operating units, the hospitals. (Scott & Co., 1985, p.2)

The emphasis in management measures and control is materialized in the Hospital Authority Ordinance, which sets out the legal functions of HA as to "manage and develop the public hospitals system with the following objectives:

1) to use hospital beds, staff, equipment and other resources efficiently to provide hospital services of the highest possible standard within the resources obtainable;

2) to improve the efficiency of hospital services by developing appropriate management structures, systems and performance measures;

3) to improve the environment in public hospitals to meet the needs of patients;

4) to attract, motivate and retain qualified staff;

5) to encourage public participation in the operation of the public hospitals system; and

6) to ensure accountability to the public for the management and control of the public hospitals system." (Laws of Hong Kong, Ch. 113, Section 4)

Such a choice of reform was based on a narrow scope that the government identified the major problems in the public healthcare system as the rigidity and lack of management. In this connection, "effective integration of the structures at the top" and the "controlled devolution of responsibilities" were emphasized.

As Yip and Hsiao (2003) put it, the decentralization reform of public hospital system in Hong Kong can be characterized as "corporate control by central authority". Firstly, the reform did not touch on the issue of financing. The government still directly funds the

HA with general taxation and money does not follow patients but is allocated by central planning. As purchaser cum supplier, the HA determines both the demand for and supply of hospitals services via a central planning mechanism (The Harvard Team, 1999). Secondly, as a result of the lack of market elements, the performance of the HA Head Office and individual hospitals is measured by the efficiency they achieve in meeting the targets of output predetermined by the central planning. The headquarter holds regular meetings between cluster managers, and hospitals, where hospital chief executives report key results for performance targets agreed in the annual plan and service agreements; then the hospital chief executives and the senior management at the department-level initiate planning adhering to the board product list. In a sense, the HA are acting as the corporation headquarter that relies on a centralized planning mechanism to manage and control individual hospitals. Through the Board of Members which is appointed by the Secretary for Health, the government can easily impose its policy objectives on the HA.

1.4.3. Medical power and the centralized decentralization

In Pollitt's (2007, pp.375-376) terminology, the HA reform is an "administrative" and "non-competition" decentralization: the recipients of the spreading out of authority are managers and administrators but not elected politicians; and the authority is parcelled out on the basis of an allocation rather than or a competition which is more common way of decentralizing decision making in NPM. Such distinction may imply higher public accountability and overall coherence of national policy making. As discussed in the last section, the official claim of reform to strive for a clearer line of accountability and tighter fiscal control of the allegedly irresponsible and irresponsive public service is in line with a vision to enhancing the state's capacity coping with ever-increasing demands for healthcare and its cost containment, efficiency and quality control.

At the same time, the HA reform can also be characterized as "external" and "horizontal" (ibid). Authority is now transferred to a new organization instead of being parcelled out within an existing organization as an internal decentralization. It takes the form of "devolution" of power to entities that are legally separate from the state having their own "legal personality", and are in contractual relationship with the reporting ministry. Compared to "delegation" of power to entities that remain legally indistinguishable from the state but which are given some autonomy and/or independence, this form of external decentralization gives more room for managers to act autonomously from the state

control. More importantly, it is observed that medical professionals took advantage of the reform to entrench themselves in the HA's management structure, replacing the bureaucrats without opening up the system to non-medical general managers (Cheung, 2002b). That means, the reform is not only a vertical decentralization but also a horizontal decentralization in which professional experts have considerable discretion and control on policy process based on networks and partnerships.

For instance, all Hospital Clusters Directors in HA are doctors; as of now, only 4 out of 41 Chief Executives of public hospitals or institutes are not medically qualified (Hong Kong Hospital Authority, 2016); in contrast, doctors comprise only less than 10% of the Regional General Managers and District General Managers in the NHS (Ham, 2009, p.33). In addition, as aforementioned, markets were absent in the HA reform and the role of the HA as the monopolistic supplier and purchaser in public healthcare remained unchanged. So why did the reformers prefer "command and control" under professional dominance over the market which is a common NPM practice to discipline public service providers, if the reform was to favour the medical power?

Alternatively, Cheung (1995; 2002a) offers a public choice explanation seeing the coalition of the colonial government and medicine as the prime driver of the HA reform. First of all, the reform was rather a strategy of the colonial government to "de-politicize performance evaluation of the public sector, hence reducing the pressure for greater political accountability" (p. 248). Under a partial yet rapid democratization of the legislature prior to the handover of sovereignty to China in 1997, the colonial government was facing increasingly turbulent and pluralist social forces in social policy. To help play down political tensions, the reform was presented as a management improvement in order to "managerialise" politically loaded health policy issues. At the same time, Cheung underlines the medical profession as an emerging power in the Department of Health demanding a more balanced power-sharing regime against their administrative officer counterparts in the Health Ministry. Taken together, the creation of the HA was a part of the bureau-shaping strategy to re-delineate the policy secretary (ministry) – department relationship. By the agencification reform, the Health Ministry avoided blame on the failure of healthcare delivery while preserving her policy and resources control through framework agreements with the HA. In return, the reform granted managerial and micro-budget autonomies to departmental officials as executive agents. In this sense, efficiency as a reform theme was just a convenient platform for

reconfiguration of that institutional relationship (see also Yeun, 1994 for a similar public choice explanation for the HA reform).

This interpretation sheds some light to our discussion on NPM reforms in Hong Kong as a centralized decentralization process: the state relies very much on the medical profession as an agent to govern healthcare for its legitimation function to de-politicalize decisions in health policy. At the same time, the decentralization has to be a controlled one safeguarding the state's ultimate control against the "turbulent and pluralist social forces". The decentralization therefore has to be an administrative and non-competitive one to maintain a tight central planning and co-coordination; while the medical profession is the chosen state partner receiving its external and horizontal devolution of power in order to legitimize (de-politicalize) health policy. In Chapter 2 we will further explore this particular arrangement in welfare production as corporatism, and its implications for the power dynamics between the state and sectoral interests of producers (medical professionals) in governing healthcare systems.

The story of the HA reform does not end in the 1990s. As Cheung has also observed (2002b, pp.352-353), the relationship between the management and frontline doctors has intensified since the establishment of the HA in 1991. Among others, the HA has developed ever-excessive managerialism with squeezed planning and targets. Meanwhile, when HA experienced its first budget deficits in 2000, it introduced measures (for instance streamlining services and requesting hospitals to reduce their expenses by "productivity gain" program) aiming at improving efficiency and hired new junior doctors on less attractive terms, which caused deterioration in morale and inequity in pay among staff. As a result, public doctors joined citywide protest against the Government in July 2003 and launched a ten-year long lawsuit against the HA's denial to their overtime pay (Yuen, 2005). The cleavage in the medical sector and public doctors' resistance against their professional peer managers indicate that the HA systems cannot be simply be labelled as doctors' captive. Rather, in a governance perspective, we argue that it is an uneasy balance between the state and the medical profession based on the latter's re-stratification: "medical elites" are an emergent group who act as the proxies for the state control in healthcare while "rank-and-files" are subject to tighter surveillance. With the guide of the Re-Stratification Thesis (Freidson, 1994), in Chapter 3 we will seek a further conceptual crystallization of the medicine elites' role as both the receivers of the decentralization of state power and the agents of centralizing state control.

1.5. Research questions

This chapter has outlined the major background and conceptual issues regarding the Hong Kong Hospital Authority as a typical case of professional-led governance in healthcare. We started at a phenomenal level asking:

1) Who governs healthcare? The state or medicine? To what extent does the HA's governance reflect state control or professional hegemony?

   Why the decentralization of healthcare in Hong Kong is an administrative and non-competitive one to maintain a tight central planning and co-coordination, while the medical profession is the chosen state partner receiving power via both external and horizontal devolution?

   Why do we have a professional-led model that is dubbed "medical hegemony" in local political discourse, while ordinary professionals are feeling alienated from the Hospital Authority in New Public Management reforms?

Chapter 2 will try to put these phenomenal questions into perspective by questioning:

2) What are the relative positions / autonomies of the state and welfare state professionals in welfare production and politics? What are the possible ways of organizing welfare production? To what extent can the HA's governance be defined as a state-centric, society-centric or corporatist models?

   Are policy networks pluralistic or asymmetric in Hong Kong? What are the characteristics of the health policy communities where medicine is co-opted? What are their implications?

Chapter 3 will further apply the welfare governance literature to the healthcare sector. Drawing on the state-centric, society-centric and corporatist models, the discussion will be guided by the following questions:

3) What are the challenges for medicine's dominance and autonomy in healthcare management from the state control and other social actors? How does medicine cope with those challenges? In particular, how do the state and medicine manage to stabilize the health policy community?

What are the characteristics of such a bargain, known as welfare corporatism? What are the implications for the power dynamics between the state and sectoral interests of producers (medical professionals) in governing healthcare systems, as well as the internal changes within medicine, known as "re-stratification"?

Chapter 4 will explore the approach to researching physician managers who are the pivotal players in healthcare governance, situated in the middle stratum of re-stratified medicine and bridging rank-and-file practitioners and the policy/managerial agendas. The guiding questions are:

4) What can we learn from previous studies of physician managers? How can they inform the development of the Re-stratification Thesis? Drawing on them, how can we examine their social identification with or loyalty to the organization or profession?

Chapter 5 will turn to discuss methodological issues facing this study:

5) What are the rationales for this study to adopt a qualitative case study approach using elite interview as the main tool of data collection? How can it address the potential criticisms regarding objectivity and reliability in recruiting interviewees and interpreting their narratives?

Chapter 6 will unpack the empirical findings of the study led by the following questions:

6) To what extent are physician managers developing a manager-self at the expense of their clinician role, or bringing a clinician-self to their manager role? Do their positions as frontline and pure management divide them with two different types of identity work? If so, what do they look like in these different dimensions?

Chapter 7 will attempt to offer a new analytical approach to explore the blurred identity work of physician managers:

7) To what extent is the dichotomy of profession-oriented and organization-oriented identities valid? At the interface of different social forces driving healthcare reforms and the forefront of changes, how do physician managers negotiate between them? What are the implications for our understanding of the power dynamics in healthcare systems and Re-stratification Thesis?

While the corporatist setting in healthcare is a contested arena of professional and managerial powers, how is the equilibrium achieved so both the state and sectoral interests can be represented? Given that they see themselves as rationalizers as well as advocates of medicine, how do they reconcile those conflicting demands?

The remainder of this thesis will be organized around this series of questions set out above.

Chapter 2

Theorising governance and welfare production

2.1. Introduction

This study is set within the wider context of healthcare reform debates in which governance is a core concept. In this chapter, we will first discuss the major theories of governance regarding the balance of power between state and societal actors in welfare production. Their application to healthcare governance will be discussed in the next chapter.

First of all, a clearer definition is needed for the discussion of the widely used term "governance". It has become a part of day-to-day vocabulary for *management* or *leadership*, particularly of a corporate body or organization, for example *good governance*; its traditional use in political science and public administration is not much different from *government*, that is, literally, to rule or control with authority (Bell and Hindmoor, 2009, p.xiii). Landell-Mills and Serageldin (1991) define governance as "how people are ruled, and how the affairs of a state are administered and regulated" (p.304). Similarly, Healey and Robinson (1992) define governance as to "the use of legitimate authority exercised in the application of government power and in the management of public affairs" (p.163). Following this, the World Bank (1992, p.1) adopts a narrow definition of governance as "the manner in which power is exercised in the management of a country's economic and social resources for development".

However, such essentialist definition is rather tautological and provides little clarification and empirical relevance. With regard to the public sector reform in Western countries since the 1980's, Rhodes (1996, pp.652-653) argues that governance signifies "a change in the meaning of government, referring to a new process of governing; or a changed condition of ordered rule; or the new method by which society is governed". In this view, there are at least six uses of governance as a vogue word for reforming the public sector (ibid, 653-659; Rhodes, 2007; see also Hirst, 2000, pp.14-22 for a similar classification) as: 1) "the minimal state" (a strategy to redefine the extent and form of public intervention in social provision, replacing ownership with regulation of [quasi-] markets and networks of public agencies); 2) "corporate governance" (a more commercial style

of management departing from traditional public service ethos, emphasising on accountability and transparency); 3) "good governance" (an efficient public service with accountable administration of public funds as defined by the World Bank to promote liberal democracy); 4) "the new public management" (less government [rowing or service delivery] but more governance [steering by entrepreneurial concern with competition, markets, customers and outcomes]); 5) "a socio-cybernetic system" (a new centre-less pattern of socio-political interactions in social policy backed by shared goals instead of formal authority, for example, self- and co-regulation, public-private partnerships, co-operative management, and joint entrepreneurial ventures, at local and international level); and 6) "self-organizing networks".

In short, social scientists tend to use the term to describe a political phenomenon of transition of public policy "from government to governance" and even of the exercise of "governance without government". It is a thesis that the state has been "hollowed out" or decentred and must work with a range of non-state actors in order to achieve its goals. As Stoker (1998, p.17) suggests, governance "is ultimately concerned with creating the conditions for ordered rule and collective action. The outputs of governance are not therefore different from those of government. It is rather a matter of difference in processes". It may be defined as "a set of institutions and actors that are drawn from but also beyond government" (ibid). In a relatively society-centric account, it may be seen as the state engaging non-actors into public policy process and steering such participation, or "government of governance" (Bell and Hindmoor, 2009, p.xiii; Kjaer, 2004, p.3). With special attention to the field of welfare production, a third perspective, namely Corporatist theory of governance, will be proposed to assimilate the state-centric and society-centric arguments.

2.2. From government to governance: Society-centric Theory

2.2.1. Pluralistic networks

Rhodes (1996) gives special theoretical attention to the use of governance as "self-organizing, inter-organizational networks", which are the permutation of government and the private and voluntary sectors. These networks are made up of organizations that need to exchange resources (i.e. money, information and expertise) to achieve their objectives, to maximize their influence over outcomes, and to avoid becoming dependent

on other players in the game. The network form of governance highlights "reputation, trust, reciprocity and mutual interdependence" (p.659) and therefore is an alternative to markets and hierarchies. As a result, integrated networks resist government steering and develop their own policies and mould their environments.

Integrating those essential elements of governance of public sector reform aforementioned, Rhodes (ibid) refers governance mainly to "self-organizing, inter-organizational networks" of which the characteristics are: "(1) interdependence between organizations. Governance is broader than government, covering non-state actors. Changing the boundaries of the state meant the boundaries between public, private and voluntary sectors became shifting and opaque; (2) continuing interactions between network members, caused by the need to exchange resources and negotiate shared purposes; (3) game-like interactions, rooted in trust and regulated by rules of the game negotiated and agreed by network participants; and (4) a significant degree of autonomy from the state. Networks are not accountable to the state; they are self-organising. Although the state does not occupy a privileged, sovereign position, it can indirectly and imperfectly steer networks" (p.660).

Rhodes further argues, "these networks complement markets and hierarchies as governing structures for authoritatively allocating resources and exercising control and co-ordination" while "interdependence, fragmentation, the limits to central authority, agency autonomy and attenuated accountability are all features of governance as alternative to government" (ibid). Therefore, effective governance requires for "intergovernmental management" (IGM) to bridge that gap. In networks of governance, the effective manager plays a facilitative role with two broad strategies: 1) game management or identifying the conditions which will sustain joint action; and 2) network structuring which involves changing the rules of the game. There are twelve management approaches to IGM, including "grantsmanship" or the several members of the network acquiring grants from several sources for numerous purposes; "process revision", or "smoothing grant management through managerial process changes, such as joint applications"; "bargaining and negotiation"; "problem solving" through "mutual adjustment"; "co-operative management" or management by agreement; and "political games" such as lobbying. (ibid, p.664)

2.2.2. The theory of the state

In this sense, managing policy networks has become the core of public management. In an institutional approach, governance thus be defined as "the setting of rules, the application of rules, and the enforcement of rules" (Kjaer, 2004, p.10), or at its simplest, a "system of rules" (March and Olsen, 1995). "Meta-governance" is a concept developed in the mid-1990s to conceptualize such networked interactions where the state actors confer a degree of input and output legitimacy on policy networks and their activities. While the state plays an important role in managing networks, policy networks are autonomous and decentred and the state's capacity to intervene is restricted (Fawcett, 2013): the use of governance as policy networks is also rooted in pluralist theory seeing the state as a "broker" or even a "weathervane"; the autonomy of the state is circumscribed by the preferences or the interests of most of the strongest groups in society (Levi-Faur, 2012, p.12).

With regard to the theory of the state, this use of governance denotes a thesis of "the retreat of state" from a strong role of rowing and steering in society, losing these roles to other non-state actors. In the first place, the state limits it role to steering and leaves the rowing function to the society as the main body of public services delivery. Subsequently, the state loses some of its steering role to other non-state actors for they have become an integral part of the policy network and developed as forces driven by their own orientations. The state "becomes a collection of inter-organizational networks made up of governmental and societal actors with no sovereign actor able to steer or regulate" (Rhodes, 1997, p.57); the state is also "de-governmentalized since it no longer monopolizes the governing of the general well-being of the population in the way that it used to do. The idea of a sovereign state that governs society top-down through laws, rules and detailed regulations has lost its grip and is being replaced by new ideas about a de-centered governance based on interdependence, negotiation and trust" (Sørsensen and Torfing, 2005, pp.195-196). Therefore, "the growth of governance reduced the ability of the core executive to act effectively, making it less reliant on a command operating code and more reliant on diplomacy" (Rhodes, 2007, p.6).

In short, the idea of governance indicates a transformation of public policy process from "government", which is the formally structured authority of state actors, to "governance", which is a center-less network where non-state actors take part in governing public

services. Power and authority "drift away upwards toward transitional markets and political institutions and downward toward local or regional government, domestic business communities and non-governmental organizations" (Levi-Faur, 2012, p.11). This transformation is best epitomized with the pervasive use of privatization, quasi-markets, NGOs and public organizations as alternative tools to transitional bureaucracy of public services delivery. For example, healthcare reform in the UK transformed the command-and-control mode of bureaucracy of the National Health Service (NHS) into networks of independent organizations - the hospital trusts independent from government as providers and local Health Authorities as commissioners (later Primary Care Trusts [PCTs] and then Clinical Commissioning Groups [CCGs]). Under this network mode of governance, the core executive of the state is rather governing at distance with other semi-autonomous actors in a partnership. Neither hospital providers nor commissioners dominate the policy process as they are functionally differentiated and need to exchange resource with each other. To ensure the delivery of services, framework agreements and quality assurance agencies are used instead of hierarchical orders from the Department of Health. The state also introduces other actors in civil society, such as patients and community representatives, to the boards of hospital trusts and Health Authorities in order to legitimize the input of the policy process. The state actors, healthcare professionals and civil society are now acting in a more pluralistic setting; the policy process can be seen as a result of the interaction of those actors in the network.

2.3. Asymmetries of policy networks in reality: a critique of pluralism

Although Rhodes' idea that contemporary government is a "differentiated polity" or "governance without government" has become "the new orthodoxy" in policy studies (Marsh, 2008, p.735), there are some obvious shortcomings of this model in appreciating 1) the role of the state in governance and 2) the structure of policy networks.

Using the Asymmetric Power model, Marsh, Richard and Smiths (2001, p.234) address some interrelated questions which are core to Rhodes' Differentiated Polity model: has governance replaced government? How important are policy networks in policy-making and who dominates these networks? Is the executive segmented? To what extent are the relations within the core executive and between the core executive and interest groups based upon the exchange of resources and power dependency? To what extent has the state been hollowed out? With his empirical studies on the UK civil service, Marsh,

Richard and Smith (ibid, pp.198-199) argues, while contemporary policy process is characterised by exchange relations, many of them are asymmetric and the government has always been the most important actor. Firstly, the distribution of resources between the government and interest groups is an asymmetric one. The government has the unique authority to make law and control financial resources that non-state actors need. As a result, the government controls, and can always effectively cut off, those groups' access to the policy process. Secondly, there is a pattern of closed networks where the economic and professional groups have privileged access and they, plus the government, dominate. Thirdly, there is a self-perpetuating element that groups privileged in tight policy networks are those who have already possessed resources, and the network membership itself becomes a key resource. Therefore, "networks and plurality do not confirm pluralism. Power seems concentrated in the hands of a limited number of interests" (p.199).

2.3.1. Closed policy communities, insider groups and formal co-option

Such understanding of network governance echoes Jordan's (1981, p.105) definition of the term "policy community" as "a comparatively small circle of participants that civil servants might define as being of relevance for any particular policy". Indeed, Marsh and Rhodes (1992) have distinguished between "policy communities" and "issue networks". While the former are highly integrated networks where relationships are stable and exchange is based on exclusive narrow interests, the latter are unstable networks which are loosely interdependent, less predictable, with a large number of members, usually serving a consultative function which is limited to particular policy issues. In both cases, the state exercises significant control as the constant actor picking its partner in the policy process.

Grant (1995) adds that there are "insider" and "outsider" interest groups in the policy process in respect of how far they are recognized or legitimized by governments. Insider groups are closely involved in testing policy ideas at the early stage of policy formulation and are expected to play by the rules of the game, for example, to regularly sit on a government committee and accept the confidentiality of the discussions. Saward (1990) argues, some insider groups do better out of formal relations with government than others for they may have any of the six resources to contribute to the policy process: "non-positional authority" (skills, expertise and status), "size", "group cohesiveness", "labour

inputs" and control of these, "capital inputs" and "the salience of group values to the wider society". In return, those resourceful groups receive government resources of "positional authority" and "access to government", institutionally incorporated into government decision-making as an adviser, informant or colleague. Based on the mixture of the resources those groups provide to the government, there are three ideal types of formal co-option: "value-based", "expertise-based" and "production-based". He suggests that co-option of health consumers to the government groups is at best a "value-based" one while they rely on a narrow value set and may lack wider support. In contrast, medical professional organizations are high in all these resources, co-opted on an "expertise" and "production" basis and exercising more influence on policy.

Typically, medical associations are frequently consulted or directly involved as producer groups in health policy. In the UK, the Department of Health has also granted insider status to the Association of the British Pharmaceutical Industry (ABPI). In addition to regular meetings between the industry, senior officials, and ministers, civil servants are recruited by ABPI to help it negotiate with government over drug regulation and prices (May, 2008, p.117). On the other hand, patient consumer groups are usually issue-oriented, divided by objectives, interests, size, structure, strategy, tactics and degree of stability. Whether they have aggregated themselves into networks with resources (such as expertise) which policy makers may need and value is contentious (Allsop, Baggott and Jones, 2002, p.61). The fragmented character of health consumer "issue networks" may make those groups the "outsiders" of the health policy community (May, 2008, p.119).

2.3.2. Explaining the asymmetries

In sum, the inclusion of civil society within the policy process is highly structured and biased. Firstly, the state has always been a constituent actor in steering policy networks for its unique functions. Secondly, there are structural advantages for some interest groups among others to exercise control in networks. Such closed networks are not based on the open-access of interest groups, neither is it competitive. Rather, it is a state-sponsored domination. The reality that power relations in policy networks are always asymmetric suggests the pluralist approach of understanding governance is inadequate.

So what exactly is the force forging the asymmetric structure of governance or policy networks? Fawcett (2013) suggests that there are two functional interpretations of the

state in answering this question. The first one is the Weberian approach seeing recent trends in the public sector reform of Western governments as a "strengthened bureaucratic and political control" (p.5) responding to the changing policymaking environment and its increased complexity, particularly "by the role played by central agencies, using tools such as performance management, strategic management, budget and personnel controls, soft law and trust and values" (p.6). The second one is the Critical approach seeing the state's autonomy in governance as circumscribed by "the social political structure that has already existed in society, including the organization of interests" (Kajer, 2011, p.111) and that the state's privileged role in governance is "necessarily redefined as a result of the more general re-articulation of the local, regional, national, and supranational levels of economic and political organization" (Jessop, 2004, p.67). We shall now turn to discuss those explanations in detail.

2.4. "Government of governance": State-centric Theory

2.4.1. The state's institutional capacities and functions

Similar to Marsh, Pierre and Peters (2000) develop a state-centric account of governance seeing it as a process in which "the state plays a leading role, making priorities and defining objectives", increasing "the intervention capacity of the state by bringing non-state actors into the making and implementation of public policy" (p.12). In detail, there are four classic activities that are components of governance for dominant actors (Pierre and Peters, 2005, p.3).

1) "Articulating a common set of priorities for society". Such process must logically include a mediating role exercised by political institutions that are perceived as legitimate in a democratic manner, which is the traditional sense of government.

2) "Coherence". There is a need for those goals to be consistent and coordinated. Networks and markets, as alternative forms of governance are generally not capable of creating coherence, especially coherence across a large range of policy areas.

3) "Steering". There is the need to find ways of achieving those goals and steering the society to attain those goals, that is, the capacity and autonomy of the state

to mix "hierarchy" (direct state provision and regulation, for services that involve basic citizens' rights), "market" (for services that involve some possibilities of pricing and exchange and efficiency goals are paramount) and "network" (for not marketable services and that involve close interactions with clients) as different means of governance.

4) "Accountability". This is to hold those actors delivering governance to the society to be accountable for their actions while it is a particular weakness for the nongovernmental actors, given that markets and networks in particular tend to have little concept of accountability compared to the state. (ibid, pp.3-5)

Pierre and Peters (ibid, p.5) argue that a high degree of "institutional capacity" of the state to perform those four functions is necessary for effective application of governance. First, the "institutional resources" such as staff, financial resources, professionalism expertise and legitimacy. Second, the "institutional integrity" regarding the two fundamental activities of governance – goal setting and creating coherence – that promotes crosscutting interests independent from the captives of sectorial interests. Third, the "institutional ability to provide and process reliable information". Institutions need contact points or channels of information to society in order to know the societal effects of previous decisions and make decisions which are appropriate. As a result, attempts "to eliminate government from governing may not only reduce the coherence of any governing that may be undertaken, but also reduce its democratic content" (ibid); governments must retain a central, if not exclusive, position in governance for those functional imperatives of the state in maintaining legitimacy.

2.4.2. A spectrum from "government" to "governance"

In this connection, Pierre and Peters (2005, pp.10-12) further suggest that the State-centric Model, instead of Rhodes' notion of "governance without government", stands out in a spectrum of five possible models of state-society interaction operating among contemporary democratic systems (from "étatiste" [the state dominates most], "liberal-democratic", "state-centric", "Dutch governance" and "governance without government" [the state plays the least role]). The "institutional capacity" of these models of governance are determined by two variables: first, the *authority* of the state, that is, the capacity of the state "to make and enforce binding decisions on the society…without significant involvement of or competition from societal actors" (p.46); second, the

information gathering and processing capacity of the state. The state must "be in close contact with the society and utilize social information openly and accurately when governing" and "engage in a formal or informal exchange of power over decisions for that information" (p.47). At one end of the spectrum, the "étatiste model" ranks very high on the variable of authority but lacks connection with society, making it a powerful but often blind governor. At the other end, the "governance without government" model ranks high on information but lacks the legitimate authority to make effective decisions, especially those that apply across the range of society. Balancing between the decisional capability and sources of social intelligence, the "state-centric model" has the highest governance capacity.

Here again we see an implicit functional interpretation of the state's role in the asymmetric structure of policy process - the real choice of models of governance in modern societies are rarely at the two ends of the spectrum ("étatiste" or "governance without government") as the functional imperatives of the state is to maintain its capacity in governance by balancing between its authority and connection to society.

2.4.3. *State-centric Relation Approach: governance as the government's tools*

Based on Pierre and Peters' state-centric notion, Bell and Hindmoor (2009) develop the State-centered Relational Approach seeing governance as "the tools, strategies and relationships used by governments to help govern" (p.2). As they conceptualize, the state now has a much broader range of policy instruments at its disposal, including "hard instruments", such as hierarchy, regulation, markets and contracts, but also "soft instruments", such as persuasion, community engagement and network associations. To specify, there are five distinct *modes* of governance as the state's options in forming and implementing public policy (pp.16-18):

1)   "Hierarchy", or top-down governance (direct allocation of resources through taxing and spending, order, rule, regulatory, legal and enforcement measures by governments and state agencies);

2)   "Persuasion" (inculcating modes of self-discipline or compliance in target subjects trying to change their attitudes and behaviour);

3) "Markets and contract" (for example, contracting out services to private firms, encouraging the development of public–private partnerships, privatising state-owned industries, deregulating the markets);

4) "Community engagement" (for example, deliberative polling surveys, public hearings, focus groups); and

5) "Association" (the state works with firms, private associations and interest-groups to develop and implement policy).

Bell and Hindmoor (ibid) argue that, the autonomy of the state in governance should not be overlooked for it can select and mix the "instruments of governance" that it thinks fit, including hierarchical authority among market and networks, if necessary, for particular policy arenas. Therefore, the use of network in governance does not necessarily imply a loss in the state's control on society as long as it is the choice of the state. Instead, the state remains the pivotal player in all forms of partnerships and mixes of the modes of governance as its governance strategies. For Bell and Hindmoor, "[g]overnment and governance are not mutually exclusive alternatives between which societies must choose" (p.12).

Another crucial argument Bell and Hindmoor make here is that, the state has also enhanced its capacity to govern by its closer relations with non-state actors strengthening its own institutional and legal capacities in managing the society. Via "markets and contracts", governments actually enhance or restore their power to achieve their economic and social objectives, while minimising any loss of efficiency, especially when the practice of markets that the state created are managed markets rather than free markets (p.17); via "community engagement", governments seek to enhance their democratic credentials and legitimacy through the devolution of decision-making powers to local citizens and communities (pp.17-18); via "association" as corporatist and private-interest government arrangements, governments offer business associations and other groups influence over the contents of public policy in exchange for public support, access to information, and direct assistance in implementing policy. Bell and Hindmoor refer to this mode of governance as what Rhodes calls "network". They argue that the involvement of non-state actors in the policy process actually has a long history and that now "networks in which public and private sector actors exchange resources" (p.18) have proliferated with a larger scale of interest group involvement and the legitimacy accorded.

2.4.4. The theory of the state

As Fawcett (2013) put it, the state centric-account of governance sees that "the state still remains responsible for securing the conditions necessary for the institutional integration and social cohesion of society" (p.6). The focus of governance is not only on networks, but the "coordination of complexity" by the government between hierarchy, markets and networks, as three different modes of governing. In governance, the state actually gains power by extending its influence into previously uncharted territory, "including a wide range of businesses, voluntary groups and charities as it has recruited, and then regulated, those non-state actors" (ibid). In a Weberian perspective, the rationalization project of modern societies therefore is not retrenched with the decline of the state but ever entrenched with the state's coordination and regulation efforts.

The use of governance as *a spectrum from government to governance* leaves some room for researchers to empirically examine, in a particular country and policy area, the actual combination of different modes of governance (hierarchies, markets and networks) and its impact on the state's authority. The State-centred Relational Approach of Bell and Hindmoor may also enriches our discussion of how the state excises and enhances its autonomy with the five instruments, including networks, in the state-centric model of state-society interaction. However, while Pierre and Peter suggest that the functional imperatives of the state to perform the highest institutional capacity yield an institutionalised relation between the state and society actors in state-centric networks, in reality, governments are not always rational in adopting the most effective mode of governance: it is an empirical question whether the state is performing the highest institutional capacities; in theory, state-society interaction could be state-centric or society-centric. So, in the empirical world, does the use of markets and networks in public policy challenge the authority of the state, and to what extent is the state autonomous in placing its "shadow of hierarchy" on networks and markets (Jessop, 1997; Scharpf, 1994)?

2.5. The synthesis of State- and Society- centric Theories

2.5.1. The Critical approach to understanding governance

Critical Theory is an alternative explanation for the asymmetric structure of policy networks. In this perspective, the traditional governance literature has some shortcomings in bringing political economy to the discussion about governance, especially the autonomy of the state. As Davies (2011, p.144) argues, "the study of networks should be placed squarely in the political economy tradition, examining how they reproduce and embed power asymmetries or generate conflict and resistance". For the critical theorists, governance as a structure or process of policy making does not emerge out of the void but is shaped by the broader power relations in society "within a structurally-inscribed, strategically selective context, which asymmetrically privileges some outcomes over others" (Fawcett, 2013, p.7).

There are two major points of the critical analysis. First, as the state-centric account suggests, the state is autonomous in governance with the "shadow of hierarchy" and its ability to intervene where necessary. As Jessop (2004, p.70) suggests, the state plays an ongoing role in: "judiciously mixing the balance of hierarchy, markets and networks in order to achieve the best outcome from the viewpoint of those engaged in metagovernance". Second, more importantly, the state's autonomy in governance is indeed circumscribed by the social-political structure that has already existed in society, including "the organization of interests, the strength of civil society, and traditions of state-society interaction" (Kajer, 2011, p.111). Jessop (2004, p.6) refers this to the state's privileged role as "the highest instance of bourgeois democratic political accountability".

The politics of cost containment in health policy is a good example. In the critical perspective, public healthcare is no more than "social consumption" and "social investment" that lowers the cost (wages) and improves the productivity of the workforce, reproducing and legitimizing the capitalist order (George and Wilding, 1994). Although policy networks appear to be more pluralistic nowadays, the engagement of citizens and various interest groups hardly undermines the prime agenda of efficiency and budget control in public services. The classic notion of Klein (1990) of "the politics of double bed" in the NHS reveals the "implicit rationing function" (Mechanic, 1978) performed by the medical profession - in the name of clinical judgement, the state buffers social

conflicts set around its unpopular yet necessary decisions in distributing scarce medical resources; at the same time, with the input of expert labour and legitimacy to healthcare services, the medical profession has gained a privileged place as the formal partner of the government in governing the health sector. As Moran (1999) suggests, the wider community interest of maximizing welfare entitlement in health policy is compromised by a state/industrial complex, and the interests of capital is a part of it.

In summary, while the society-centric account of governance as *networks* in a pluralist approach has exaggerated the extent to which the state has been undermined; the state-centric account of governance as *government's device* in the Weberian approach tend to ignore the fact that state authority is exercised in certain social political structure of interests, and basically on behalf of them. The critical approach therefore can be seen as an attempt to clarify the position of the state by suggesting the rule setting or steering functions it plays in policy networks are largely structured by those dynamics of interests. If we return to the discussion of Marsh and colleagues' Asymmetric Power Model earlier in this chapter, we would find that the asymmetric policy networks refer not only to the state's power over society actors but also that of some society actors over others. The corporatist mode of governance in welfare is a typical case of this collusion of special interests and the state in dominating policy networks.

2.5.2. The Corporatist model of governance

Bell and Hindmoor (2009) define "associative governance" or "corporatist arrangement" as "governance through a formal partnership with interest groups" in the formulation and implementation of public policy. With respect to the complex, and usually secret, negotiations between expert producers with public agencies in many of economic and welfare organizations, Corporatist Theory provides an alternative view to Society-centric Theory by questioning whether: (a) there is some rough equivalence of influence among citizens and different interests within society; (b) the leadership of interest associations are ultimately under the control of the members; (c) the state is an essentially democratic or neutral set of institutions; and (d) there are opportunities for participation in interest group politics (Williamson, 1989, p.19). Nevertheless, Corporatist Theory does not see associative governance merely as one of the devices at the government's disposal as Bell and Hindmoor define it in a state-centric account.

Indeed, Corporatist Theory emerged after the Second World War to describe the political economy of interest representation and policy formation in contemporary Western democracies - in contrast to the Classical Corporatism that flourished in the 20th-century Continental Europe as an authoritarian political system, Neo-/ Liberal Corporatism emphasises a regular process of negotiations and collaboration between state agencies and interest groups; while the former is based on functional interests arising from the division of labour in society along a hierarchy of corporate bodies, in the latter policy agreements are implemented through the latter's ability and willingness to secure the compliance of their members. Given an emphasis on the bargaining between governments and producer groups, the essence of Corporatist Theory (as the shorthand of Neo-/Liberal Corporatism in this study) is more indicative of the autonomy and power of producer groups (accurately their peak associations) than the dominance of the state (Wallerstein, 1988, p. 1500).

Corporatist theorists first focused on the tripartite bargaining between government, labour and capital on a national basis (*marco- level*), and extended their study to the phenomenon of the attainment of privileged positions by particularistic interest groups in sector-specific policies at the *meso-* (specific industry sector) and *mirco-* (firm) levels (ibid). For Williamson (1989), welfare production is the most noticeable case of corporatist arrangements at the meso-level, with respect to the power resources held by the professionals as key welfare producers that preclude the state from directly imposing authoritative decisions (p.169). He suggests, in "welfare corporatism", "negotiation is a matter of necessity, not choice…the dependency relationship entailed in production politics means that the state has only *influence*, not *control*, over what changes the intervention might bring about and, therefore, over its direction and success" (p.170).

Williamson (ibid) defines "welfare corporatism" as a system where "the state cannot intervene by means of authoritative regulation and allocations, but because of *dependence* upon others for the successful realization of intervention, has to negotiate with interested parties about the form the intervention will take". He also suggests three reasons for why in many instances of welfare corporatism the state intervention is "largely powerless to achieve any change against the wishes of producers" (ibid): 1) producers can wield a range of sanctions that could adversely affect its effectiveness; 2) producers hold considerable amount of information relevant to its formulation and execution; and 3) producers are responsible for considerable degrees of judgement in the

face of incomplete knowledge and uncertainty. Therefore, "the public authorities cannot very readily hold to account the actions of producers, except on the rather tenuous one of having superior capacity of judgement" (ibid). For Williamson, the professionals in many aspects display the attributes in securing their position in corporatists arrangement: 1) they enjoy a monopoly position based on their right to exercise particular skills of a body of theoretical knowledge; 2) they enjoy the rights to self-regulation; and 3) they enjoy the legitimacy acting in an altruistic or public regarding manner. (p.172) Medicine, as a strong profession, as we will discuss in later this chapter, is closest to this ideal type. For instance, a study of the British Medical Association in the 1960s identifies a corporatist attitude in the NHS that the medical professionals had already have some right to be consulted in the face of the limited authority enjoyed by government (Eckstein, 1960, p.25).

As Williamson (1989) also notices, despite the dependency of the state upon the professionals and their relatively strong position in the policy process according them considerable autonomy, they are not freestanding to the exercise of such autonomy outside the state's authority. Firstly, the bulk of the welfare professionals are state employees that are a part of the state (p.176). The welfare professionals constitute "organized interests within the state system" while the "dominant state interest" (e.g. fiscal discipline), if threatened, will enter into negotiations to secure the necessary form of intervention (e.g. restrictions on the level of spending). In respect of the form of interest representation, "the influence of the professional is not transmitted in conventional competitive pressure group terms" (ibid), but in a less formally organized manner of medical representation or advice by individuals in public institutions. That is "professional representation" in the form of "representation by professionals". More importantly, many of those representative professionals are full-time bureaucrats in the hierarchy of welfare services. Such functional representation bears a legitimatization function in the decision process, especially of rationing, mitigating the needs of outside representative bodies (ibid). Offe (1981) refers to this "attribution of public status" that the professional groups acquire as a "quasi-public status" by which the professional groups become an arm of the state's policy-making and implementation apparatus. In short, the notion of welfare corporatism denotes a highly structured and closed policy network that the welfare professionals exercise control as the state employees and a part of its formal structure.

Secondly, the state sponsors the monopoly status of the professionals in welfare service. As Streeck and Schmitter (1985) suggest, this is "an alternative to direct state intervention and regulation" that the "public use of private organized interests" takes "the form of the establishment, under state licence and assistance, of private interest governments with devolved public responsibilities - of agencies of regulated self-regulation of social groups with special interests that are made subservient to general interests by appropriately designed institutions" (p.128). In other words, the state offers a monopolized place in policy formulation and implementation and rights to self-regulation to welfare professionals in exchange for their discipline and support. The regulated self-regulation or private interest governments are specified with the "guaranteed access, compulsory membership and/or contributions, institutionalized forums of representation, centralized co-ordination, comprehensive scope, jurisdiction and control over member behaviour and delegated tasks of policy implementation" (ibid). To attain this, the contracting interest associations have to ensure their "capability for representing the interests and controlling the behaviour of their members (and where necessary outside mavericks), and an effective monopoly in their status as intermediaries for a given class, sector or profession" (ibid). Meanwhile, such processes "depend crucially on the response of one key interlocutor, namely the state, which must be willing and able to use its key resource: legitimate control over coercion and authoritative distribution of positions, to promote and/or protect such developments" (ibid). Therefore, while devolving public policy functions to private interest associations, the corporatist arrangements are not necessarily linked to direct intervention by the state but with intervention through quasi-public structures.

We can take this account of corporatist arrangements in welfare as "functional state-centric", as it implies the functional imperatives of the state to perform its institutional capacities in order to achieve the highest effectiveness within certain quasi-public structures; while it is somehow "functional society-centric" seeing the state as having no real choice in picking its partners - if the state was to achieve the highest effectiveness, it must work with the most resourceful groups by offering them "public status" and the rights of regulated self-regulation or private interests governments.

2.6. Supporting evidences from organization researches

So, how do the three distinctive governance models, namely Society-centric (Pluralist), State-centric and Corporatist, fit the reality of public governance? Let us first turn to a brief review of relevant debates in organization researches, which are deeply rooted in governance studies.

2.6.1. Society-centric position

The notion of the pluralistic structure of policy networks is confirmed with the tradition in organization studies that present an image of self-organizing policy networks. Knoke's (1993) study on the elite networks of the US suggests that most of the elite power structures are "decentralized bargaining systems, rather than hierarchical systems controlled by a central economic elite" in which "the most important feature of a power structure is its multiple networks of interaction or of influence and domination" (pp.40-41). In this sense, access to other resourceful actors through multiple networks is essential for an actor to increase its ability to influence policy. Extant organization studies have suggested that resources dependence on the state for funding, legitimacy and protection of rights could be offset by the trust, collaboration, influence, shared goals and identities, and institutional and political resources developed by interdependent actors (e.g., Huang, Keith and Provan, 2007; Provan, Huang and Milward, 2009; Saz-Carranza and Ospina, 2011). With a study on the US policy network of Adult Basic Education consisting of services providers and state agencies, Park and Rethemeyer (2012) add that, public service providers, who depend on the state's resources, can exercise "balancing operations" with their monopoly of useful information to counterbalance the fiscal dominance the state actors. Those strategies include "power network extension" (to seek new sources of supply, e.g., private sector funders); "coalition formation" (to work with others in coalitions e.g., through industry and interest associations) and "emergence of status" (collectively "grant status" by elevating a dominant player into a collective role, e.g., the president of an industry association).

This set of organization researches suggests that, although the primary purpose of the hegemonic structure of policy networks is to cope with the state contracts, it is often configured to provide alternatives. It has also been suggested that, networks themselves are able to shape the policy process at the implementation level (for example, the

privatization of water industry and railway in the UK, see Greenway, Salter and Hart, 2007, p.718). In this connection, inter-organizational network researches tend to emphasise that the structure or characteristics of networks, such as density and heterogeneity, affect their resource allocation and mobilization, consequently their ability to influence policy (Provan, Fish and Sydow, 2007; Sandström and Carlsson, 2008).

2.6.2. State-centric positon

Quite differently, some researchers argue that there is still a central role and autonomy of the state in building and guiding policy networks. Provan, Fish and Sydow (2007) suggest that, to create greater social capital and a more co-operative network facilitating co-ordinated and effective policy implementation, the government's direct support for networks through partnerships is essential (see also Provan and Kenis, 2008). In studies of public health policy networks in the UK, Oliver et al. (2013) conclude that the most powerful individuals are policy managers. They identify some strategies that managers use to control policy networks: "controlling decision-making organizations" (designing the governance structures and founding the organizations involved, writing agendas and work programmes for these organizations and using meetings); "controlling policy content" (identifying policy options and knowledge brokerage roles); and "controlling policy makers" (gate-keeping experts, finding champions and persuading other policy individuals).

Researchers also suggest, in reality, without effective co-ordination of the state, loose policy networks could hardly be a stable partner of governance. With evidence from the UK National Health Service (NHS) primary and community care policy networks, Ferlie et al. (2011) suggest that the organizational transition from hierarchical to network forms is only partial in reality. There is only little change in cross-organizational information and communication technologies (ICTs)/databases and inter organizational learning (IOL) which are necessary for effective collaboration of interdependent organizations in policy networks. Holden and Lin (2007) find that the Australian male health policy networks have limited capacity in driving the policy process for their loosely connected structures. With low levels of centralization, their collaboration is hampered, instead of strengthened.

2.6.3. Corporatist position

On the other hand, Marinetto (2003) suggests that "government of governance" could be used to paraphrase a variety of means of the state and societal actors that who would benefit to manipulate the policy agenda and in particular, to disrupt and influence the workings of autonomous policy networks. They include: "direct pressure", "institutional restructuring" and "setting the intellectual framework of the policy discussion".

Greenway, Salter and Hart (2007) also question whether policy networks are operating in a neutral value-free zone: although policy networks may operate in a near-autonomous manner, they are deeply affected by exogenous factors. They reveal that, in the case of the relocation of the Norfolk and Norwich Hospital, negotiation and interactions in policy networks were shaped by powerful vested interests of local medical professionals along with central government actors.

> There appears to be continuity in NHS politics, in that the power relationships in the new networks of Health Service engagement with the private sector are as closed as were those of the traditional arrangement between medicine and the state. Health care consumers are as far removed from the locus of health policy implementation as they have ever been, and Health Service democracy is an irrelevant concept when measured against the reality of this study. Ably facilitated by the skills of a policy entrepreneur, central power was coordinated with the activities of local elites to overcome a series of formidable decision points through the mobilization of novel network dynamics. Sensibly the key local medical interests were recognized and brought onside at a relatively early point in the process in order to negate any potential medical veto of the new build. (Pp.735-736)

They suggest that the public consultation was extremely limited by the elitist implementation networks that control the flows of information in the political arena with the "expert knowledge" (p.729). To make challenges, information or access to the technical specifications were required. However, medical interests effectively excluded health consumer groups and District Councillors from the insider groups of policy networks by denying the information to those actors. Ironically, the complex framework of multi-literal network governance undermined the democratic role of elected members of local authorities and active participation of pressure groups (p.730).

2.7. Closing remarks

The debates set around the theory of the state in this chapter shed some light on the discussion of welfare governance. Firstly, networks have stood out as a pervasive mode of governance alongside traditional hierarchies (bureaucracy) and markets. Secondly, this new form of governance has also called for a transformation in the exercise of power or influence in the policy process, from the traditional top-down authority of the state to a more relational one. Thirdly, the state still exercises considerable steering functions and power in the formation of networks while it loses some of those functions and power to societal actors. Fourthly, Society-centric and State-centric Theories differ in the way they see the autonomy of the state. The former emphasises the self-governing nature of networks and power that the state loses to societal actors in exchange for their resources; the latter stresses the power the state reserves and the autonomy of the state in choosing which part of its power to give up in exchange for a greater control in achieving its goals (the state can decide on the extent of "the shadow of hierarchy" it casts, the mix of modes of governance, its regulatory functions in privately exercised public functions, and most importantly picking the partners it works with in governance). That is a question of how the state exercises authority in a system based on governance as a heterarchical mechanism of coordination.

Given a purposive attention to welfare governance, this review proposes a use of Corporatist Theory of governance to assimilate the state-centric and society centric accounts. It is suggested that the functional imperatives of the state in maintaining institutional capacities have compelled it to adopt a state-centric model of governance subjecting society actors to its policy goals and regulations, and such imperatives have also constrained the state to a highly structured partnership with particular interest groups, the welfare professionals who have got the most power resources to exchange with the state and curtailed its intervention. Sometimes, corporatist system is even captured by welfare professionals. However, it is not a result of the competition among interest groups in policy networks; it is, ironically, an unintended consequence of the state's authority and determination in developing quasi-public structures.

These limited images offered by organizational studies call for more empirical examination of public governance in the real world. So what is the implication of New Public Management in recent decades for the theory of the state regarding governance?

Does the idea of "steering at distance" and "civil engagement" turn governance into pluralistic policy networks with a more society-centric model of state-society interaction? Or with a more sophisticated, mostly targets-driven, monitoring and accountant system for efficiency, governments are creating a more controlled devolution of power that weakens the domination of welfare professionals? To what extent can welfare professionals successfully buffer the impact of reform, maximizing their dominance and interests by maintaining a quasi-public structure that rejects other societal actors and circumscribes the state? The next chapter will attempt to discuss these issues in a more specific arena of healthcare governance.

Chapter 3
Theorising healthcare Governance

3.1. Introduction

In relation to healthcare which is the focus in this thesis, the basic ideas of governance in the last chapter can be summarised as follows: 1) the Society-centric Theory or the notion of "governance without government" is generally rejected on the ground of the asymmetric structure of policy networks as closed communities; 2) while the state's capacities and functions in effective governance upholds the State-centric Theory of "government of governance", they are achieved in a relational approach that focuses on the state's closer partnership with social actors; 3) Corporatist Theory further adds that producer groups, rather than societal actors such as service users, are formally co-opted into the policy community as insiders for they hold key resources and expertise in welfare production.

Corporatist Theory has the strength in assimilating the State-centric and Society-centric Theories, each illuminating an important aspect of the reality - in a liberal or society-centric account, producer groups could be a countervailing power that checks the dominance of state in governance; in a state-centric account, they are the agencies and stable partners of the state conferring the latter necessary resources and legitimacy, preventing the destabilizing effects of other societal actors from the policy community. In this sense, producer groups are the major "partners cum challengers" of the state. Or in negative terms, they could collude with the state in dominating the policy process for their mutual interests (for the capitalist welfare state, cost containment; for medicine, the public-status and associated political and economic interests) at the expense of the larger public interests, and sometimes they could "capture" the system and resist necessary reforms to modernize the system in a self-serving manner.

Through the corporatist lens, this study sees the medical profession as the major "partner cum challenger" of the state in healthcare governance. It goes beyond a simple society-centric position that sees the medical profession as merely a societal actor among others and a simple state-centric position that sees it as merely the tools of the state - the state offers the medical profession a "quasi-public status" in exchange for its support for health

policy, particularly the legitimating function of "implicit rationing" of scarce medical resources in clinical terms.

Before going into detail of corporatist arrangements in healthcare, we shall briefly turn to introduce two other theoretical positions of healthcare governance set against it. The state-centric position holds that medicine is in fact "de-professionalized/ proletarianized" under tighter state control and management. According to the society-centric position, however, a new social movement has taken place to challenge the traditional heath policy community dominated by the medical profession and the state, endorsing new societal actors such as patients and subordinate health professionals to participate in the policy process. Drawing support from the corporatist position, the following theoretical review attempts to argue that the fragmented nature of patient groups has prevented them from becoming a significant challenge to the medical power, since their inclusion into health policy process is only symbolic. Nor have the state's efforts in promoting transparency and accountability by clinical governance, general management and inter-professional networks/ skill mix teams led to a significant decline of the medical power as those efforts largely rely on medicine's authority and expertise to implement.

Indeed, the debate of healthcare governance is set around different assumptions about the mechanism mediating professional power, of which *medical autonomy* is a key dimension. To start with, we will briefly introduce the core ideas of the three theoretical positions of governance in healthcare. Then we will discuss their respective theorizations of medical autonomy. Empirical examples to illustrate those theoretical concepts are mainly drawn from the developments in the UK (generally England) where the NHS originated as an archetype of universal healthcare system funded by direct taxation and transferred to many of her former colonies, including Hong Kong which is the focus of our case study in the later chapters.

3.2. The central issue of medical power

3.2.1. Three positions of healthcare governance

In most modern democratic societies, universal access to healthcare as social rights has required a prominent role of the state in its provisions. Considering the technical complexity of biomedical knowledge, the state often delegates authority to the medical

profession to implement policies on its behalf. It is a political settlement between the state and the medical profession in managing, coordinating and controlling healthcare delivery. Specifically, it is an "implicit concordat" or a "bipartite corporatist arrangement" under which the government does not question clinical decisions, as long as doctors do not challenge the state's authority to set the global budget and ration scarce resources in clinical terms (Klein, 1990; Giaimo, 2002, p.34). The privileged place doctors gained in policy-making and administration often implies more than mere consultation, according them considerable room to determine how to implement policies and to run healthcare systems (Schmitter, 1985); if the state lacks the means to set boundaries to the power of sectorial actors, corporatism is vulnerable to "capture", whereby sectorial actors may come to dominate policymakers and exploit their privileged position in governance to their advantage (Giaimo, 2002, p.11). In this connection, the organized interests of medicine embedded in the original corporatist institutional arrangements have always been able to curtail or take advantage of healthcare reforms.

On the other hand, such corporatist arrangements also permit the state the authority and means to mandate public policy obligations on doctors. Whereas the medical profession gains "public status" to share the state's authority in governance, the state expects the peak associations of medicine to discipline their members with compulsory membership and associated control of licensing (e.g., entry, fitness to practice, examination and education) so that the workforce of medical service providers will adhere to the agreement reached and broader public policy aims (Giaimo, 2002, p.10; Streeck and Schmitter, 1985, pp.125-127). More importantly, we should not overlook that such soft governance practice is backed by the state's ability to impose more direct sectorial administration measures such as decree and laws, or to threaten such interventions (pp.131-135). In addition to those direct (traditional hierarchies) and indirect (professional self-governing networks) approaches of state control, a hybrid form of "neo-bureaucracy" (Harrison and Smith, 2003) or "soft bureaucracy" (Flynn, 2004) has been identified - under New Public Management, the state actors exercise strong centralized control in healthcare by targets and indicators via regulatory agencies. As a result, the professional labour process is being more measurable and transparent, thus more accountable, to the lay management through clinical audit and clinical guidance. Medical autonomy has been eroded by new frames of reference in healthcare management that doctors must adopt a managerial perspective in order to progress within the profession, such as upholding organizational goals of cost containment and efficiency.

In addition, the quasi-market reform splits the medical profession' purchaser and provider roles in order to discipline it with market pressures and the monitoring of those commissioning roles. These well explain the state's measure of autonomy from sectorial interests in healthcare by transforming corporatist arrangements into a less negotiable form.

While this line of argument supports the state-centric account of healthcare governance, the contention here is whether those management efforts are still controlled by the medical professionals themselves at large. Freidson (1985; 1994; 2001) and Elston (1991) argue that the medical profession as a whole maintains its autonomy because clinical audit and clinical guidance is largely anchored in the system of bio-medical knowledge that its authority and monopoly rests on. They suggest that the professional power is rather "re-stratified" as there are only the junior/ rank-and-file doctors being subject to more surveillance. As Harrison (1999, p.56) pinpoints, the marketization and NPM measures are exercised by profession-led agencies and medically qualified managers due to the technical complexity of commissioning and monitoring healthcare services. Therefore, efforts in reforming healthcare systems have mainly resulted in a shift of power within the medical profession, from hospitals to primary care groups under healthcare commissioning, from practitioners to academia under evidence-based medicine and from front line clinicians to managerial doctors under clinical management, rather than a total loss of power from the medical profession to others such as patients and lay managers.

Another significant challenge to medicine's dominance perhaps is stakeholder arrangements endorsing other health professionals and patients to participate in management and regulatory regimes, giving rise to a more pluralistic structure in health policy. Kuhlmann (2006) suggests that the strongest modernizing driver to transform corporatism in healthcare systems is a more inclusive professionalism. It is an idea to include the entire spectrum of health professions and occupations in the regulatory system and advances the primary care system with of inter-professional networks / skill mix teams (p.12). The prevalence of the nursing profession in the general management posts and regulatory representatives is a good example. In addition, the idea of consumerism and democratic renewal of civil participation in health policy brings a shift of power from the medical professionals to patients. With more lay members and non-medical professionals sitting on the board of the medical profession' self-regulatory

bodies and public control agencies in the NHS structure, they can influence health policy in stages of formulation, implementation and evaluation (Kuhlmann and Allsop, 2008; Newman and Kuhlmann, 2007). However, as early corporatism studies have revealed, the state actors may construct a system of countervailing power of opposing interests to co-manage the public sector. For example, the "concertation of action" in the West German health sector involved the representatives of the federal government, the public healthcare insurance schemes, various medical and dental associations, the pharmaceuticals industry, the pharmacists, the employers, and the trade unions in periodically negotiations over the increase in health expenditure (Lehmbruch, 1984, p.6). Such "corporatist concertation" involves "not just a single organized interest with privileged access to government but rather a plurality of organizations usually representing antagonistic interests" (p.4) with two important aspects: "intra-organizational mechanisms favouring cohesion and compliance" and "institutional constraints preventing disintegration" (pp.10-11; see also Stone, 1980). Whether those social movements are promoting the pluralist idea of networks autonomous from government ("governance without government"), or in substance, the state's influence in manipulating networks ("government of governance"), is a question waiting to be answered empirically.

3.2.2. Medical autonomy at three levels

The idea of medical autonomy is that producers of medical service, who know more than the state agencies and patients as sponsors and users, should have the discretion in running healthcare system. It is the very characteristic of corporatist arrangements in healthcare. At root, the aforementioned contention of healthcare governance is about the existence or not of medical autonomy, or how much the medical profession retains it from the state and patients/other health professions. When defining medical autonomy, Freidson (1988, p.369) suggests that the concept of autonomy as an occupation's position in the division of labour combines "the immunity from regulation or evaluation by others" (autonomy in a passive sense) and "the control over other occupations" (autonomy in an active sense, or dominance). More specifically, Alford (1975, pp.14-15) defines medicine as dominant "structural interests" that are "served by the [current] structure of social, economic and political institutions", and hospital administrators and government health planners as "challenging interests" or "corporate rationalizers" that share an

interest in "breaking the monopoly of physicians over the production and distribution of healthcare".

In respect of the relation between medicine and management and whether the former dominates, Harrison and Ahmad (2000) suggest that medical autonomy/ dominance and its challenges can be discerned at the "micro-", "meso-" and "macro-" levels. At the "micro-level", medical autonomy includes four elements which are directly related to the clinical situation: a) "control over diagnosis and treatment" (decisions about ordering texts examinations, prescribing drugs and procedure and referral), b) "evaluation of care" (judgement about the appropriateness of the care of particular patients), c) "nature and volume of medical tasks" (in the industrial sense of own movements, priorities, times and workloads) and d) "contractual independence" (unilateral rights such as engaging in private medical practice or to criticise employers). (pp.130-131) At the "meso-level", perhaps logically entailed by the micro-level, the medical profession reaches an institutional bargain with the state as we have mentioned before as a set of corporatist arrangements, including state licensure and self-regulation, joint government/ professional committees and official recognition of peak associations (p.131). At the "macro-level", it is the ideology of the biomedical model which assumes that ill health equals individual pathology and therefore consists of individual medical interventions, favouring a physician-centred approach over broader public healthcare approach. Therefore, it legitimises medical expertise in the design of health services and facilities beyond individual clinical decisions (ibid). In short, the dominance of biomedical model underpins the prevailing place of doctors, who control biomedical knowledge, across health policy broadly conceived from policy formulation to day-to-day implementation.

Early studies of the NHS offer a picture of strong medical dominance where general managers only behaved as "diplomats", whose role was not to lead or change the direction of organization, but rather to smooth out internal conflicts and to provide facilities for professionals to get on with the job of caring for patients (Harrison, Hunter and Pollitt, 1990, p.103). This is linked with the notion of clinical freedom that doctors are not subject to supervision in clinical practice by managers. As an illustration, only doctors can refer patients to hospital or admit them when they arrive, prescribe drugs and refer for other treatments such as physiotherapy; hospital consultants are often treated as having quasi-ownership of hospital beds, with the power to retain or discharge patients as they see fit. In a sense, the overall shape of the services delivered by the NHS is simply

an aggregate of such decisions made by individual physicians, rather than the work of politicians, planners or managers (ibid). This is largely because the biomedical model has underpinned the central role of doctors in the entire medical process as "clinical end-users" (of other health professionals' services and facilities, for example, nurses' support services and tests). As a result, managerial influence is not as great as that of doctors who have considerable local control over specific decisions about how to treat particular patients. Under this setting, managerial behaviours tend to be a problem-solving or reactive, rather than taking the pro-active goal seeking reform; managers are producer-oriented, paying relatively little attention to patent's needs and complaints (ibid, Ch. 4).

3.3. The state-centric position: contemporary challenges from state intervention

However, in reviewing the rise of managerialism and greater state intervention in the British medicine since the 1970s, Harrison and Ahmad (2000, p.138) conclude that "a not insignificant decline" in the medical autonomy and dominance has occurred. The decline is clearest at the "micro-level" (clinical autonomy) and at the "meso-level" (corporatist relations with government).

3.3.1. Meso-level

The challenges at the *meso-level* to medical power mainly refer to its rights to self-regulation and its partnership with government in formulating and implementing health policy (Harrison and McDonald, 2008, p.43).

Firstly, in terms of formal organization, by the late 1990s, the governing bodies of almost all NHS institutions had been modelled on commercial organizations' boards of directors with doctors in a very small minority, and the Chief Executives (few of whom are qualified health professionals) of NHS service provider intuitions had become legally and organizationally responsible for the quality of clinical services delivered, replacing the consensus team management which accorded significant veto power to doctors (pp. 43-44). As a result, the lay managers and non-medical professionals have shared medical professionals' legitimacy and power in healthcare administration that used to be the former's exclusive domain.

Secondly, the General Medical Council (GMC) has been compelled by public pressures aroused with a series of medical malpractice scandals to review its regulation on doctors' competence so as to be able to deal more firmly with cases of poor clinical performance (p.45). In 1999, the GMC was subject to a new overarching Council for Healthcare Regulatory Excellence (CHRE)'s request to modify its procedures and to refer its disciplinary decisions for review by the High Court (ibid). In 2012, the Council was renamed as the Professional Standards Authority for Health and Social Care (PSA) with more statutory duties to oversee the performance of 9 health and care regulators including the GMC. New duties include advising the candidates of the GMC members to the government and an annual review of the GMC's procedural compliance to Standards of Good Regulation on guidance and standards, education and training, registration, and fitness to practise. More importantly, the PSA reviews all final decisions made by fitness to practise committees of the GMC and carries out an audit of the initial stages of the decisions to close a case without referral to a formal hearing in front of a fitness to practise committee. The principle of self-regulation has been losing its legitimacy and modified with the strategy of "right-tough regulation" based on the concept of risk assessment and proportionate intervention (PSA, 2015). Continuing fitness to practise mechanisms have been introduced to medical practitioners whose risks are high with five-yearly revalidation at one end, and the auditing of self-reported, input based continuing professional development at the other (CHRE, 2012, para. 2.4).

Thirdly, new institutions of surveillance have been introduced.

At the *organization-level*, the Commission for Health Improvement (CHI) was established in 1999 (later renamed as the Commission for Healthcare Audit and Inspection and Healthcare Commission) to inspect and report on all NHS institutions, based on annual collation of "performance indicators" within a national performance assessment framework for healthcare regularly and allegations of service inadequacy from time to time (Harrison and McDonald, 2008, p.45). In 2009, a new Care Quality Commission (CQC) incorporated many of these functions. Applying the lessons of Francis Report on the scandal at Mid Staffordshire NHS Foundation Trust, the Department of Health (2015) pledged to re-establish the CQC as "a rigorous inspection regime for hospitals and GPs" as "the nation's whistle-blower" (para. 3).

1) More performance data are collected and disclosed. MyNHS website has been established as a powerful tool of surveillance by disclosing performance data to

the public. It allows comparison between organizations on 132 different measures that matter to patients, such as safety measures, open and honest reporting, staff survey results, healthcare associated infection rates and hospital food. In view of rebuilding the public's trust in the NHS patient's safety, it has been extended to national clinical audits of the treatment outcomes of individual surgical consultants, and later on other specialities (para. 8);

2) New Chief Inspectors have been appointed to identify failures in care, place special measures on and turnaround healthcare institutions. Fundamental standards whereby the CQC can prosecute organizations that are responsible for serious cases of poor care have also been introduced (Ch.1 and 3). In addition to the CQC measures, the UK Government has placed a new Duty of Candour to the NHS organizations to ensure that patients are informed promptly about errors in their treatments in order to counteract the defensive culture in the NHS (para. 7).

At the *individual-level*, the GMC are introducing consistent responsibilities on individual health professionals so that disciplinary actions can be taken when they are not candid about errors with their patients. This professional accountability is being reinforced through the introduction of the role of the "responsible clinician" in the Name Above the Bed initiative that NHS patients will have a named doctor to provide clinical accountability (para. 3.15-3.17). Also, a new offence of Wilful Neglect has been introduced to prosecute individuals who deliberately allow patients to suffer harm (para. 21). As a whole, these efforts have created a more robust surveillance regime with a clearer line of clinical accountability for doctors who act as a manager, or a practitioner, whatever the case may be. As Salter (2001, p.874) has put it, medical self-regulation is situated within a "state-administered apparatus of accountability".

Fourthly, the quasi-/ internal market reforms have split the purchaser role from the medical profession's provider role by creating GP-led commissioners. From GP Fund holders and Primary Care Trusts (PCTs) to Clinical Commissioning Groups (CCGs) at present, the UK government has continuously expanded the scope of choice of providers that the clinically-led commissioners could make for their patients, now including elective hospital care, rehabilitation care, urgent and emergency care, most community health services, mental health and learning disability services (Schedule 2, Heath and Social Care Act 2012). The most significant potential impact on the medical profession

perhaps is the balance of power between GPs and specialists. In addition to the specialists' higher level of professional credential, secondary care provider organizations are the more technical and costly part of the NHS services, accounting for more than three quarters of the total spending (Jones and Charlesworth, 2013, p.13). Set against this, the purchaser-provider split reforms have extended the professional capacity of GPs to referring patients to a specific provider (beyond merely gatekeeping of patients' access to secondary care) and made them responsible for 90% of the NHS spending, including secondary care (ibid). It was anticipated to result in a shift of power to GPs as the specialists now have to compete for their custom and lose the control over the biggest part of the NHS spending to GPs.

The abovementioned developments in state intervention in healthcare substantiate the state-centric governance argument that the state has managed to redraw the boundaries of medical power in the regimes of administration, self-regulation and clinical accountability wherein the medical profession used to have the authority to deny external security and intervention. In addition to those explicit external managerial efforts in rationalizing the health sector, the quasi-/ internal market reform is a more indirect "divide and rule" strategy that attempts to dismantle the unified medical power into fragmented interests, fostering certain checks and balances from inside (Harrison, 2008, p.47). As a whole, those state efforts have shaped a more vulnerable position for the medical profession as a more controllable partner in corporatist arrangements.

3.3.2. Micro-level

The *meso-level* challenges to the corporatist arrangements in healthcare described above have been accompanied by the *micro-level* challenges to clinical autonomy (Harrison and Ahmad, 2000; Harrison and McDonald, 2008, pp.46-47).

Firstly, the introduction of general management to the NHS has further entailed the notion of "clinical governance" for controlling the medical professionals. The major clinical governance body in the UK, the National Institute for Clinical Excellence (NICE), was established in 1999 with three broad functions: 1) to make recommendations to the government as to whether specific treatments are sufficiently cost-effective and affordable to be provided by the NHS; 2) to give evidence-based clinical guidelines for the management of medical conditions; and 3) to approve models of clinical audit for compulsory use by hospital doctors (Harrison and Ahmad, 2000, p.134). Under the new

paradigm of evidence-based medicine (EBM), clinical interventions are justified on the basis of the formal aggregation of published research evidence rather than personal experience or professional consensus – "clinical guidelines" or "clinical protocols", which codify and standardise the treatments, have replaced the former prominent official statements about clinical autonomy with a strong emphasis on the need for clinicians to adhere to rules and criteria (Harrison and McDonald, 2008, Ch. 3; Harrison and Wood, 2000). In addition to guidelines/ protocols, tackling "unwarranted" variance in service through measurement is another strategy of NICE. Performance data are widely used to recognize and tackle variations in clinical activity, expenditure, performance, outcomes, quality, and access cross the NHS, at the individual- and team- levels. Clinicians or clinical units with large variation from their colleagues are expected to provide an explanation; publishing data by ranking or "league tables" has also been shown to influence those with lower rankings (Charlton et al., 2011; King's Fund, 2010). Beyond the clinical terms, central specification of service models has also been developed through the creation of National Service Frameworks (NSFs) for topics such as coronary heart disease, mental health, cancer, services for older people, services for children, and diabetes (Harrison and McDonald, 2008, p.66). As a result, Harrison and Dowswell's study (2002, p.221) finds that doctors have become more "bureaucratically accountable" for recording their clinical decisions and key data relating to patient cases, resulting in a reduction in doctors' autonomy to "determine their own clinical practices and evaluate their own performance without normally having to account to others".

Secondly, under tighter fiscal control and internal markets, there is a need for cost transparency and the "currency" of treatments bridging the NHS funding bodies and the actual providers of NHS care. Methods to formalise and codify medical knowledge have been developed as means of providing standardised descriptors of medical workloads by which clinical work can be systematically measured, controlled, and finally commoditized. "Case-mix" measures, such as "diagnosis-related groups" (DRGs) are the examples (Harrison and McDonald, 2008, p.46-66). Another example is the Quality and Outcomes Framework (QOF) whereby GP practice payments are calculated on the points achieved and prevalence in a range of national achievement indicators based on the best available research-based evidence (NHS Confederation, 2016).

Thirdly, as a result, medical-managerial relationships have developed in a direction favouring managers. Managers in the NHS are more ready to take decisive decisions of

managerial interventions against medical opposition based on more information available. Harrison and Lim's researches (2000; 2003) have suggested that with growing managerial legitimacy, whilst doctors are still enjoying substantial autonomy in day-to-day clinical decisions, they have been drawn into co-operative networks with managers and more responsible to organizational goals of complying with performance indicators, targets and cost containment. As a result, central government influence on managerial agendas is strengthened and centralized management at the Department of Health is ever-increasing. The recent developments of the National Advisor for Clinical and Financial Engagement substantiate this trend. It promotes clinical and financial engagement in order to build "joined-up, collaborative working between clinical and finance teams" in which finance managers routinely work as integral members of clinically-led quality improvement teams and both groups share cost and quality data on a regular basis to improve outcomes (DOH, 2013, p.8).

In short, the consequence of rationalization of medical knowledge and expertise is that indeterminacy gives way to technicality. Clinical activities are now subject to the "scientific-bureaucratic" paradigm as clinical guidance is drawn from an externally-generated body of research knowledge and implemented through bureaucratic rules (Harrison and Wood, 2000). Combined with micro-economic analyses, the scientific and bureaucratic approaches of codification and guidelines of clinical activities eventually have created more complex systems of "managed care", "disease management" and "patient pathways" where professional discretion is restricted (Harrison and McDonald, 2008, pp.46-47). In Dent's (1993) term, the medical autonomy has transformed into "responsible autonomy".

3.3.3. Interpreting state intervention: is medicine "de-professionalized and proletarianized" or "re-stratified"?

With respect to the decline or not of medical autonomy, there is a variety of interpretations. An intuitive grasp of the above-mentioned evidences of clinical guidance and performance management (by indictors and data) is the De-professionalization and Proletarianization Theses (Freidison, 1985; see also the discussion of Chamberlain, 2009, pp.74-79).

The De-Professionalization Thesis focuses on the process of closing "the knowledge gap" between doctors and laymen by the codification of medical knowledge/ expertise into

standardised rules and procedures. Specifically, it is argued that automated retrieval systems, such as computer algorithms, for symptom assessment, would result in medicine losing its control over its defined body of knowledge, and create the tension between the public demand for accountability / transparency and the professional's insistence on final authority (Haug, 1973). Evidence-based medicine which reduces the indeterminacy of applying bio-medical knowledge best exemplifies this trend of development.

With a slightly different emphasis on the process of routinizing medical work, the Proletarianization Thesis focuses on the managerial bureaucratic control on doctors. Under large scale corporate and bureaucratic settings that uphold rules, procedures and authority undermining the autonomy of doctors as salaried employees, and in the name of economy and efficiency (particularly controlling costs and promoting consumer choice), medical knowledge and expertise is open to communication as a set of rules, procedures and operational imperatives. That means it could be passed on to others who had not received any formal training, and better controlled and measured by bureaucratic authorities. As a result, doctors lose their determination on overall working conditions and proprieties as well as other professional prerogatives associated with the principle of self-regulation (such as control over entrance criteria, training context and content, and remuneration of their labour), being proletarianized. (McKinlay and Stoeckle, 1988; Oppenheimer, 1973) This trend of development can be identified with the state efforts in promoting performance management and clinical guidance that turn medical practices into more routinized and measurable activities.

As we have discussed above, the internal division of medicine also provides the opportunity for governments to employ "divide and rule" strategies. As Harrison (1999, p.56) has argued, what actually occurs in the NPM reforms in healthcare is a "redistribution of autonomy and dominance" in three dimensions: 1) from consultant doctors to GPs for their purchasing role in the internal market; 2) from ordinary clinicians to medical managers in the general management; and 3) from ordinary clinicians to academia under evidence-based clinical governance. The first dismantles the medical power by altering its structure set around the supremacy of specialists and hospital care; the last two may also distance medical elites from identifying with rank-and-file doctors, making more cleavages that weaken the medical collegiality from within.

Freidson (1994), the key author of the Re-Stratification Thesis, refers this regime to a "new professionalism" in which individual and institutional transparency and accountability of medicine is ensured with quality control carried out by "administrative elites" of medicine, who serve in executive management and supervisory roles with workforce surveillance and disciplinary tools. Contrary to the De-professionalization and Proletarianization Theses which emphasize the external scrutiny on medicine, this line of "re-stratification" argument presents a more "relational approach" that the national agenda of NPM is achieved by co-opting those administrative elites. To rebut the over-simplified "de-professionalization/ proletarianization" interpretation, Freidson (1994) has offered two major arguments.

First, with a continual knowledge gap, the medical profession has managed to preserve its control of the monopoly over medical knowledge and expertise. Freidson argues, "[n]ew knowledge is constantly acquired that takes the place of what has been lost and thereby maintains the knowledge gap…it is the members of each profession who determine what is to be stored and how it is to be done, and who are equipped to interpret and employ what is retrieved effectively" (p.135), therefore the medical professionals "continue to possess a monopoly over at least some important segment of formal knowledge that does not shrink over time, even though both competitors and rising levels of lay knowledge may nibble away at the edges" (p.134).

Second, consequently, new techniques of clinical governance to monitor and rationalize clinical works arrangement and resources allocation do not in themselves reduce medical autonomy. Those measures, for their technical complexity, are mainly exercised in the principle of peer review; and the major agency of surveillance and evaluation on medical works is a newly emerged group of medically qualified managers co-opted to the management. As Freidson argues, the consequence of "elites" placing formal surveillance and control on "rank-and-files" is the consolidation of medical professionalism as a methodology of occupational control. While this creates the segment of elites and rank-and-files, it is a sign of "re-stratification" rather than "proletarianizaiton" or "de-professionalization" - professionalism is just being reborn in a hierarchical form that "everyday practitioners become subject to the control of professional elites who continue to exercise the considerable technical, administrative, and cultural authority that the professions have had in the past" (p.9). Based on these observations, Freidson concludes, "there is little evidence that the special status of rank

and file professionals will deteriorate so much that they will find themselves in the same position as other workers" (p.145). As they can participate in formulating standards and evaluating their own performance through some type of peer review, more discretion than other workers in performing their work will be accorded. Finally, "they will still enjoy at least occupational kinship with their superiors" (ibid).

Central to the Re-Stratification Thesis is that the collective power of medicine is retained by its control over the biomedical knowledge. As Harrisons and colleagues suggest, the dominance of the biomedical model at the macro-level remains largely intact (Harrison and Ahmad, 2000, p. 137) so that radical organizational changes or re-engineering in hospitals are rare: managers are not always able to control the day-to-day operation of the acute medical sector or to make other than incremental adjustments to services (Harrison and McDonald, 2008, p.47). The stratification or redistribution of intra-professional authority can therefore be seen as medicine's adaptive response to state interventions rather than its overall decline.

3.3.4. Evidence for the Re-Stratification Thesis

In the face of the evidences of state interventions, empirical studies suggest the producers' power is basically intact in the NHS. In respect of EBM, Armstrong (2002) argues that, as a distinctive form of formalised tools of clinical guidelines and audits, the standardization of clinical judgments through the results of randomised controlled clinical trials in the NHS primary care groups has actually upheld the "value-neutral" scientific methodology of medicine that the medical profession's authority rests on. A group of medical "administrative elites", rather than lay managers, has emerged around "the academy" and the "professional colleges" who are concerned with standardizing the everyday clinical decisions of "rank and file" doctors by evidence-based medicine. In a case study on the implementation of Obesity and Chronic Heart Failure guidelines, Spyridonidis and Calnan (2011) also reveal that doctors with the same clinical interests have worked together to develop and innovate their own rules of governance and body of expertise/guidelines to meet their clinical needs under EBM. It is argued that doctors' increasing expertise has made them more innovative and general guidelines increasingly redundant.

The implication here is the application of clinical guidelines and protocols itself, at the same time, increases the complexity of healthcare management by creating a new body

of professional knowledge and associated professional capacities. More fundamentally, as clinicians treat individuals, instead of populations, the basic assumption of EBM of moving from the knowledge of a treatment's effectiveness in a population to the knowledge of its probable effectiveness in an individual is questionable (Byrne, 2004, pp.84-87). This calls for a bottom up Critical Appraisal approach of EBM that emphasizes "the integration of best research evidence with clinical expertise and patient values" (Sackett et al., 2000, p.1) - that practitioners are not taking everything academic research or clinical guidelines offer and should assess the validity and applicability on their own. It is the medical expertise that decides whether the external evidence applies to the individual patient and how it matches the patient's clinical situation, predicament, and preferences (Sackett et al., 1996, p.72). In sum, the medical profession's monopoly over the interpretation of biomedical knowledge exercises not only in the position they hold as administrative elites but also in the non-linearity and diffusion in the process of implementing clinical guidelines day-to-day.

Consequently, such resilience of medical autonomy at the *mirco-level* has conferred considerable advantages for the medical profession to resist external intervention and negotiate for a more consensual style of clinical management at the *meso-level*. Indeed, the early work of Ham and Hunter (1988) on the NHS clinical governance strategies has suggested that, the NHS reformers tend to avoid overt confrontation with doctors but create a culture in which doctors regard themselves as having a legitimate management role in order to promote efficiency and effectiveness in health service. Among the three broad strategies of clinical governance - 1) self-help among doctors to raise professional standards by medical audits, the use of standards and guidelines, and the accreditation of hospital services; 2) involving doctors in management by the resource management initiative in which doctors are responsible for their budgets and appointing doctors as managers; and 3) external management control of doctors by changing their contracts and encouraging managers, supervise medical work more directly and extending provider competition – the first two are always the NHS reformers' focus and the last one is intentionally avoided. Kitchener (2000) has also observed that medically qualified Clinical Directors have successfully resisted any significant appropriation of clinical tasks and decisions by other groups on overall budgets, the recruitment of staff and monitoring service quality; and peer review is still the primary means of quality control in the UK hospitals. So it is concluded that clinical governance is far from an "externally driven performance analysis to reduce clinical autonomy and costs" but "proved

successful in protecting medical autonomy and resisting the increased managerial control" (p. 149). Even after the 20 years of reform in the NHS, the medical professionals' co-operation is still the key to successful implementation of health policy (Castro, Dorgan and Richardson, 2008; Nelson, Batalden, and Lazar J, 2007).

Perhaps the best example for the consolidation of provider's power is the notion of clinical engagement. Recent reforms of the NHS in the Health and Social Care Act 2012, which largely involve the role of GPs acting within the new Clinical Commissioning Groups (CCGs), are based on the principle that the commissioning of healthcare services should be clinically-led (Beasley, 2013, p.1). Besides, in a hospital setting, service-line management (SLM) is being increasingly used in view of fostering clinical leadership. In SLM, a hospital trust is divided into specialist clinical areas called service lines that are then be managed as distinct operational units; clinicians, often consultants, typically lead these service lines. By devolving management decisions to the service-line level, it is believed that the SLM structure can facilitate clinicians to lead and better manage services, i.e. to control budgets and tackle variation (Foot et al., 2012, p.3; Lemer, Allwood and Foley, 2012, p.16; NHS Confederation, 2010). The basic ideas of clinician-led management in the turn of the 21th century is not different from those in the 1970s and 1980s engaging hospital clinicians in management - "doctors have a large influence over how money is spent; they lead health care teams and can directly influence the success of initiatives to address productivity" (Lemer, Allwood and Foley, 2012, p.4).

Nor does the possibility of provider competition created by the quasi-/ internal market reform substantially affect service outcomes in the ways that English NHS commissioning policies assumed (Sheaff et al., 2015, p.v). "Negotiated order" and "discursive control", rather than "financial incentives", "provider competition" or "juridical controls", are used by the commissioners as the major media of influencing providers. It is found that the associations between competition and service outcomes were more often weak as commissioners avoid financially destabilising their main local providers and the potential bidders are concentrated. Heavily dependent on "micro-commissioning" (collaborative care pathway design) than contract negotiations or removing ineffective activities, "negotiated order" is often protracted and inconclusive when commissioner and provider interests differed. Although managerial evidence-based performance monitoring (service specifications and performance indicators) is

sometimes employed by commissioners, existing providers still play a large part in formulating it (ibid, p. xxiii-xxv).

3.3.5. The relational aspect of re-stratification: governmentalized or loosely coupled?

As a whole, the above offers a consistent picture of "soft management" in NHS which is placed at the hands of elite doctors favouring medical self-regulation in substance for their integral functional positions in healthcare service production. Whereas Freidson's re-stratification interpretation resonates with those evidences, he has also noticed that "administrative elites" are working in ways that mediate competing expectations in an increasingly managed workplace, i.e. safeguarding collective professional interests and national agendas of managing the health sector (Waring, 2014, p.692). This relational aspect of medicine's stratification, i.e. medicine's relations with the state or corporate interests, however is relatively undefined in Freidson's works and most studies of the Re-Stratification Thesis, leaving the Re-Stratification Thesis inadequate to explain the dynamics (p.696).

In this regard, Coburn, Rappaport and Bourgeault (1997) have questioned about the loyalty of the co-opted "administrative elites" of medicine to their clinical colleagues against their "corporate masters". They suggest that "medical institutions are being used, co-opted by external forces into constraining their own members" (p.18). This is because government has become very involved in managing the content of medical care beyond its financing, and those administrative elites are socialised into a less professionally dominant view of healthcare as a result of contact with other health professions, the state and regulatory agencies. Flynn (2002) offered a more pessimistic interpretation of "governmentality" in Foucauldian thought, seeing the new self-regulation regime of medicine as a system of self-surveillance which socializes or co-opts medicine into alignment with managerial ideology. Flynn argues, although the medical self-regulation has been preserved in form, in substance it has transformed into "soft bureaucracy" where "processes of flexibility and decentralisation co-exist with more rigid constraints and structures of domination" (Courpasson, 2000, p.157).

In this light, Waring (2014) further develops the conceptual tools of "administrative elites" of medicine for a better understanding of the "professional-managerial hybrid" of those elites and whether they retain or compromise the collective professional interests. He

argues, in the recent organizational context of healthcare reforms, six types of medical elites have emerged (pp.699-701):

1) "Political Elites" represents the interests of their profession within political processes and policy making. They hold formal leadership or representation appointments within professional associations, learned societies or political organizations. They help secure and maintain statutory legitimacy and status, but equally might be seen as serving to articulate political interests downwards within the profession;

2) "Knowledge Elites" are those who have moved into the realms of knowledge creation and dissemination, and often education, usually through taking up appointments within universities or learned societies. The knowledge produced by these elites is often used to inform public debate or contributes to national evidence-based guidelines that are expected to be followed by the wider profession;

3) "Corporate Elites" are those who have significant financial or commercial influence over the organization of work related to wider corporate interests or capital markets in the private practices, which are not our focus in this study;

4) "Managerial Elites" are typically located within operational organizational structures or hierarchies and have close and conjoint working relationships with various non-professional and managerial groups, such as finance, procurement, contracting, performance management and workforce planning. As discussed above of "administrative elites", these elites are at the forefront of the managerialisation of professional work and are often described as being co-opted into or colonised by management practices and identities, while they are also defined in the policy discourse as "leaders" transforming professional services without "management";

5) "Governance Elites" are those who hold responsibility for monitoring colleagues' adherence to the standards of practice or payment systems. They are described by McDonald (2012; cited in p.700) as "chasers" with specialist knowledge and skills in assessment and management of performance issues or by Becker (1963; cited in ibid) as "moral entrepreneurs". Acting as a conduit to both the local service leaders (managerial elites) and the external regulators,

they also serve to restrict management scrutiny and protect professional reputations; and

6) "Practicing Elites" are those who have influence in the immediate work setting on the basis of their specialist expertise. Working closely with the knowledge elites and managerial elites while embedded in day-to-day operation, they are able to avoid or shape organizational change and retain some local autonomy.

This extended framework of the Re-Stratification Thesis helps appraise the contingencies of the "professional-managerial hybrid" in a more recent organizational/ institutional setting, regarding expectations and sources of legitimacy from both the elites' organizational stakeholders and professional peers (p.701). Before going into detail of the research strategy addressing the issue of medical elites in the later chapters, some remarks should be made here.

First, considering those contingencies, medicine's success in retaining collective professional interests is rather a dynamic and contested process. It is bought at a price. As Evetts (2003; 2009) suggests, professional identities are being reconstructed to align with the changing expectations of the state, corporations and consumers, shifting from the "occupational" professionalism to the "organizational" one. In this sense, the re-stratification of medicine could be a case of "governmentalized" elites compromising their rank-and-file colleagues for their self-interests or national agenda. At the same time, in the real world, as the evidences of producers' power in the NHS we discussed in the previous section tend to support, it could also be a case of medicine elites leading medical organizations to "loosely couple" with their environment in order to legitimize their daily operations without substantial changes in the professional logics (Staniland, 2010).

Through the Neo-Institutionalist lens, the state's requirement for the NHS provider organizations to conform to certain processes, policies and protocols is however considered largely as ceremonial - while coercive isomorphic pressures shape organizations into similar formal structures, they lead to a focus on outputs that are unrelated to the real work of the organization (Powell and DiMaggio, 1991). Drawing evidence from the implementation of clinical governance in one English NHS hospital Trust, Staniland (2008) argues that, the external legitimacy could be achieved without any evident improvement in the quality of care received by patients, merely as a response to state coercion. Therefore, clinical guidance can be considered as essentially a

"ceremonial" body. For example, approval of protocols and policies appeared to be just a paper exercise and many inconsistencies were found in these documents; more importantly, the dissemination, implementation and embedding of protocols in working practice was obscure. Furthermore, Currie and Suhomlinova (2006, p.1) suggest that knowledge sharing across professional boundaries is difficult to realize as the means to rationalize and manage the health sector - managers, who are orienting to coercive pressures from the state, do not always recognize the cultural and political dimensions of knowledge sharing, which are oriented to within the normative frameworks of professionals. They argue this will result in the "triumph of professional power" in the "inconsistency of policy".

Second, we see empirical study of medical elites as central to resolving the theoretical contention about interpreting the decline of medicine. Medical elites are at the interface of different social forces driving healthcare reforms and the forefront of changes; their role in the balance of power between the state actors and medicine as a whole is crucial. Should they internalize the national managerial agenda and be able to discipline their rank-and-file colleagues, medicine as a whole can be interpreted as being "governmentalized"; should they maintain their loyalty to the collective professional interests, medicine can rather be interpreted as being "loosely coupled" with the state agenda, and ceremonial compliance without actual changes to day-to-day practices is predicted. Although evidence suggests that the latter is a more promising interpretation of medicine's reaction to state control, actual situations across health systems may differ and further empirical researches are called for.

3.3.6. Brief summary

To summarize, based on the notion of medicine's ultimate control on biomedical knowledge and expertise, the Re-Stratification Thesis 1) rebuts an oversimplified interpretation of the concession in rank-and-files' working conditions as de-"professionalization" or "proletarianization" for "the formulation, direction and execution of the control of professional work remains in the hands of members of the profession" (Freidson, 1994, p.144), and 2) holds that the medical profession as a whole is able to cope with the rise of managerialism and market mechanism by taking part in the reform efforts actively. At the same time, the notion that the medical profession has been re-stratified itself indicates some inroads of state control and recognizes that the

state's efforts in rationalizing healthcare still have considerable impacts on medicine, if not de-professionalizing and proletarianizing it. With the Re-Stratification Thesis, it could also be argued that the state has extended its "governmentality" in a relational approach through its co-option of medical elites, subordinating the healthcare production process to more sophisticated control (though still indirect). As one may notice, the clinical engagement program we discussed above is a double-edged sword for the state: while doctors working as managers may be receptive to EBM and heavily constrained by contractual agreements and performance targets, they gain a formal position to reinterpret them and share the authority and power of the state in health policy. This suggests that "public status" as the core corporatist structure may be far more resilient than we imagine and may support another possible interpretation of medical decline with the Neo-Institutionalist lens seeing it as a loosely coupled system, which is compliant in form but preservative in substance.

3.4. Society-centric position: challenges from other social actors

In healthcare governance literature, state intervention is not the only challenge to the medical dominance in health policy community. In a contrary position, it is also suggested that a new social movement has taken place to transform the health policy community into more pluralistic networks. The most significant "outsider" groups challenging the traditional corporatist arrangements in healthcare are patients and other health professionals.

3.4.1. Patient power: citizen participation and co-production in health service

Clarke et al. (2007) suggest that users and carers self-help groups create a social identity and possible platform for oppositional behaviour. Their own definitions and sets of behaviour increase their perceived control over their physical and social conditions, enabling their members to challenge the medically dominated institutional assumptions that circumscribe the delivery of care (Kelleher, 1994). At the micro-level, the demystification of biomedical knowledge and expertise by the more educated and internet-informed patients renders practitioners' daily clinical judgements more amenable to lay scrutiny; at the meso-level, it results in a more active participation of health consumer groups in the health policy process challenging medicine's legitimate

place. This can be epitomized by the "patient empowerment" policy in the UK that formally incorporates patient interests (Salter, 2003). As Allsop Jones and Baggott (2004) suggest, the UK health consumer groups have developed a "new social movement" as they have managed to form structured alliances campaigning effectively to amend or delay legislation and have been represented at the policy-level such as NICE and other government consultation bodies.

Bovaird (2007) further argues, health policy in the UK, as well as other areas of public services, has gone beyond simply "engagement and participation" to "user and community coproduction" - public service is directly produced by users (with providers) in terms of a range of stages of policy process such as service "planning" (e.g. deliberative participation), "design" (e.g. user consultation), "financing" (e.g. fundraising, charges, agreement to tax increases), "management" (e.g. leisure centre trusts, community management public assets, school parent-governors), and "assessment" (including monitoring and evaluation, e.g. tenant inspectors, user on-line ratings); it can also take place in a more direct role in service "delivery" such as peer support groups of patients and Expert Patients Programme (see also Bovaird and Loeffler, 2012).

Based on Pestoff and Brandsen (2008)'s modification to the concept of "co-production", Poocharoen and Ting (2015) segregate it into four sub-types with the "planning /production" and "individual/ organization" dimensions.

1) "Co-governance": the arrangement that allows the third sector to participate in the planning and delivery of the service formerly or normally produced by public service professionals (co-planning at an organization-level).

2) "Co-management": the process where the third sector organizations produce services in collaboration with government agencies (co-production at an organization-level).

3) "Co-consultation": the process where individuals as citizens, experts or stakeholders are of equal status with professionals in the planning of public services (co-planning at an individual-level).

4) "Co-production": the arrangement where individual citizens produce their own services in full or part with public service professionals (co-production at an individual-level).

These typologies all point to the core idea of co-production which is "the provision of services through regular, long-term relationships between professionalized service providers and service users, where all parties make substantial resource contributions" set against the traditional provider-centric and paternalistic form of public service seeing users as a passive receiver, or their active involvement a burden (Bovaird, 2007, p.847). In this connection, evidence suggests that active involvement of patients in health policy as co-producers of healthcare service is increasingly observable in the NHS across a wide range of stages of the policy process, from the narrowly defined end of co-production to the broadly defined end of co-planning.

At the *individual-level* of "co-production", patients have taken up some direct roles of healthcare provision in the Expert-patients Programme (EPP) that involves them in the self-management of health, especially in chronic illness, mental health and rehabilitation; carers and support groups are also important forms of involving the community in health service production. More generally, the official policy of discourse has encouraged patients to be treated as "equal partners in the decision making processes" by health professionals (DOH, 2000b, p. i). The White Paper, *Equity and Excellence: Liberating the NHS* (DOH, 2010) proclaimed the NHS's official vision to "put patients and the public first", where "no decision about me, without me" is the norm (para.1). Specifically, the measures include:

1) "Patient involvement" embedding personal care planning, shared decision-making and providing information and support necessary to enable people to manage their own condition (para. 5.10). In support of this view, the *NHS Constitution* (NHS, 2013) has added the pledge to involve patients in discussins about planning their care and to offer them a written record of what is agreed (p.9). Under the Health and Social Care Act 2012, involving each patient in decisions becomes a legal duty of the NHS commissioners (Sections 13H and 14U);

2) "Choice Framework" to set out, for the first time, the choices available to patients all along the care pathway and across services - choosing the GP practice (and the particular GP within), choosing where to go for the first appointment as an outpatient, choosing the consultant in charge, choosing to change hospital if have waited longer than the maximum waiting times (18

weeks; 2 weeks for those who see a specialist for cancer) and choosing who carries out a specialist test etc. (DOH, 2012, para. 5.32).

At the *policy planning- level*, lay members are given statutory and bureaucratic presence in the NHS structure. The General Medical Council has increased the proportion of lay members, according them more important roles in revising poor performance and revalidation procedures. In addition to the lay members presenting in National Institute of Clinical Excellence (NICE), the Healthwatch has established as a national consumer champion body that "enables the views of the people who use (or may use) NHS and social care services to influence national policy, advice and guidance" (para. 5.16). The views of the public, patients and service users will, through Healthwatch, form part of the advice to the Secretary of State, the NHS Commissioning Board, Monitor and the English local authorities, all of whom must have regard to that advice; local Healthwatch will give citizens and communities a stronger voice to influence and challenge how health and social care services are commissioned and provided in their local area (para. 5.16-17). Through those reform efforts, greater choice and voice is conferred to patients. They are not only entitled to but also able to co-produce healthcare.

3.4.2. Limitations of patient movements: still a closed policy community?

Here the question is: "to what extents have those reform efforts established a power-sharing relationship between communities and decision-makers?" As Arnstein (1971) suggests, citizen participation consists of a wide range of activities from "Manipulation" to "Citizen Control", not necessarily enabling citizens to participate in planning or conducting programs. He describes three levels on the ladder of degrees of citizen participation:

- Rungs 1) Manipulation and 2) Therapy describe the first level as "non-participation" that power-holders "educate" or "cure" the citizens;

- Rungs 3) Informing and 4) Consultation advance to the second level of "tokenism" to allow the citizens to have a voice but they lack the power to ensure that their views will be heeded. Rung 5) Placation is a higher level as "tokenism" sees some "muscle" changing the status quo, while power holders continue to decide;

- Rungs 6) Partnership, 7) Delegated Power and 8) Citizen Control are the third level as "citizen power" with increasing degrees of decision-making power. At the top of the ladder, Partnership enables citizens to negotiate and engage in trade-offs with power holders; Delegated Power and Citizen Control enables citizens obtain the majority of decision-making seats or full managerial power.

In this regard, Salter (2003) has questioned the actual power-sharing between the UK patient groups and the state and medicine as traditional power holders in healthcare: "whether at the political level their challenge to the values and organization of conventional NHS medicine has then been translated into policy networks with access to the policy community, is debateable" (p.930). Adopting the idea of "policy community", he suggests, policy networks access to policy community when they become routinized with the state's engagement, i.e. boundaries are established to identify "insiders" and "outsiders" in the policy domain, and a policy paradigm is institutionalised based on shared values, a common understanding of "the rules of the game", trust between its members, and an acceptance that cooperation is the best way to achieve common goals. He further refers to Coleman's (1999) concept of five phases of the policy process ("agenda-setting", "evaluation of alternatives", "policy formulation", "policy implementation", and "policy evaluation") in the sense that a stable policy community shall be able to dominate all of the five phases.

Salter (2003) stresses, "whilst the process of policy *formation* may adjust to pressures for greater patient power, how far those policies can be *implemented* will depend on the malleability of the patient-doctor relationship" (p.929). He further suggests that in the traditional patient-doctor relation, patient demand is defined within the orbit of medically defined patient needs. This has helped the state to perform implicit rationing in the name of clinical judgement and conferred legitimacy to the health policy making and operation. In the early and mid-1990s, the UK government recognized that the strategies insisting that doctors be more accountable to their patients would bring about possible effects of destabilising the policy community. It sought to return to a reluctant acceptance of the importance of the medical profession in the policy community (see also Hunter, 1994; Klein, 1995). Therefore, an approach of "sponsored consumerism" was adopted as "consultative, strong on rhetoric, and ambiguous in its commitment to patient influence" (Salter, 2003, p.931). In practice, purchasing agencies simply created a novel form of patient dependency organised at the level of population rather individual patients and

doctors. A "consultation industry" as "technologies of legitimation" developed with no firm commitment to following the results of the consultation, with local NHS managers treating user groups "as a recognised feature of the organizational landscape, but not one to which any superior degree of legitimacy was accorded" (Harrison and Mort, 1998, p.66). Likewise, the reforms introduced by the profession's self-regulatory bodies generally aimed to improve their internal efficiency rather than opened themselves to the external scrutiny of health consumers (Salter, 2001, pp.875-891). As Salter (2003, p.931) argues, it has resulted in the ability of doctors to hinder or facilitate "policy implementation" remained unchecked by the patients at large: "medicine's entire system of autonomous professional governance continued on its serene, unaccountable course, a separate and parallel system of power within the NHS with which all service delivery policies must engage in one way or another".

In addition, the fragmented character of health consumer policy networks also undermines their ability to provide resources (such as expertise) which policy makers need and value (Salter, 2003, p.933; see also Allsop, Baggott and Jones, 2002, p.61). As discussed earlier in this chapter, health consumer groups are usually issued-based and divided by objectives, interests, size, structure, strategy, tactics and degree of stability. Therefore, their co-option to policy community is "value-based", differing from the "expertise-based" and "production-based" co-option of medical profession (Saward, 1990). For example, Wood's research on orthodox, disease-based patients' associations found that, at the local level, they usually lack political legitimacy in the eyes of Health Authorities (later Strategic Health Authorities and now Trust Development Authorities), which prefer to rely on consultative methods (Wood 2000, p.14). In this regard, Salter (2003) goes further to suggest, "of itself, consumer involvement in the policy process is no guarantee that the state has recognised the political utility of this contribution in anything other than a symbolic sense…the immaturity and fragmentary quality of the health consumer policy networks renders them potentially unreliable allies, should the state choose to incorporate them at the agenda setting stage of *policy formation*" (p. 934; my emphasis).

So have the recent developments in the NHS, as we discussed in the previous section, reversed this development? Counter evidences to patient power at both the individual- and policy planning- levels suggest that barriers to genuine citizen participation and power sharing in healthcare are still strong.

At the *policy planning- level*, a recent systematic scoping review by Conklin et al. (2015) find that evidence of longer-term impact of public involvement is limited. This is consistent with previous studies which found the influence of public involvement minimal or uncertain on decision-making of healthcare organizations (Anderson, Shepherd and Salisbury, 2006; Baggott, 2005; Milewa, 2004; Mitton et al. 2009). When public involvement initiatives aimed to engage diverse actors or had constraints on the involvement of the public, minimal effects on strategic decisions were found (Bauld et al., 2005). In respect of the representativeness and legitimacy of public involvement in health service management, Martin (2008) suggests, health professionals tend to retain control over decision making by two strategies: 1) as academic studies have found, undermining the legitimacy of involved members of the public, particularly by questioning their representativeness (Crawford et al., 2003), and 2) as found in the cancer-genetics projects he studied, downplaying the legitimacy of public representatives by technocratically defining their contribution as patient-hood or biomedical lay subjects, bounded to the narrow questions of patient satisfaction and information provision. This suggests the knowledge gap based on the technical complexity of clinical activities continually upholds the medical dominance in the symbolic struggle over legitimacy in decision-making and representation.

In line with this argument, the case study on hospital planning in the UK by Jones and Exworthy (2015) further suggests that managers and doctors have managed to constrain public participation in decisions with clinical rationale. They defined hospital planning as a clinical issue and framed decisions to close hospitals or hospital departments as based on the evidence and necessary to ensure safety. This identifies a shift in the framing of the policy, from one that presented the policy as a means of improving access and making services more responsive to patients, to the centralized policy under the name of clinical necessity. Likewise, McDonald et al.'s (2014) case study reports that the Council of Governors (CoGs) meetings of Foundation Trusts may rather be "business as usual" than promoting accountability as they are bureaucratic, requiring governors to engage with dense, and sometimes technical, paperwork, leaving limited opportunities for questions, debate and agenda setting. In the absence of strong supporting mechanisms such as effective subcommittees feeding meaningfully into CoGs' business, user governors are precluded from holding the trust to account on service delivery issues. In addition, Rose et al. (2014) find that user-led organizations (ULOs) were being forced to adapt in an organizational climate of change and complexity, and that decision-makers

no longer claimed the high moral ground for working with ULOs, but expected them to work within a system of institutional behavioural norms. Service Users Governors of the NHS Foundation Trusts, too, had to work within a system of norms deriving from the organizational structure and culture of the NHS, and this impacted on how far they were able to exercise influence. In respect of the patient safety issue, the Health Foundation's (2013) recent evidence scan reveals that patients are likely to be involved in educational initiatives and strategies designed to make them more aware of, and comfortable with, raising the subject of safety and feeding back safety issues to professionals on an individual basis, than in making collective contributions to system improvement.

As Hardyman, Daunt, and Kitchener (2015) would argue, "value co-creation" in health services by citizens is a process that mainly happens at the micro- level and therefore should be articulated in a micro-level research approach. Veronesi and Keasey (2015) also suggest that, those "micro-dynamics of interaction" are more significant than the "macro-abstractions of organizational engagement" (p.562) - the "administrative approach of patient involvement" (hierarchical and highly structured implementation) limits discretion, yielding compliance and almost by default the intended results; these top-down policy efforts have generally shown a poor fit with the contingent situation at the local level (see also Wright et al., 2012). Nevertheless, the flexible strategies within the implementation process, on the other hand, can reshape aims and purposes of health policies locally, leaving the impact of patient involvement uncertain or subject to willingness of particular professional groups to co-operate.

At the *individual- level*, there is ample evidence that patient involvement may be vulnerable to medicine's resistance or manipulation. Firstly, the patient involvement process is highly selective by health professionals in terms of eligibility and scope. In an ethnographic study (Fudge, Wolfe and McKevitt, 2008) of user involvement programme to improve stroke services in London, only a small proportion of the stroke population actually participated, and the domains in which users could exert their expertise were limited. Users were more interested in participating in time limited projects with tangible outputs related to training health care professionals, developing information and supporting stroke survivors rather than project management. So it is concluded that patient involvement did little to alter patient-health professional relationships. Drawing on an in-depth case study in mental health between 2008-2012, Enany, Currie and Lockett (2013) suggest, unrepresentative involvement occurs through a combination of

self-selection by those wanting to be involved, and professionals actively selecting, educating and socializing certain users. The selected users tend to be more articulate and able to work with professionals, and are more complicit in the processes. Interestingly, "user stratification" also occurs as the selected users pursuing their own professional status by delineating a distinctive body of "expert" management knowledge and excluding those who they perceive as "less expert". Renedo and Marston (2011) observe that involvees of the PPI activities of CLAHRC (Collaboration for Leadership in Applied Health Research) in London must negotiate professionals' negative discourses to develop self-images that reflect their own interests. They struggle first to "assert a legitimate identity" as a public participant, second to "survive" as a lone outsider and a minority in complex expert-systems, third to "exercise agency" when having to adapt to institutional top-down forms of PPI, and fourth to "cope with threats to lay identities and derogated common-sense knowledge". It is argued that these processes can hinder successful patient participation even where there is an institutional infrastructure to promote civic engagement with healthcare. In the case study by Ledger and Slade (2015) on two patients support groups (mental health and chronic illness) in the UK, it is further revealed that "expertise by experience" of facilitators (who are former users) does not lead to a clear transfer of power from professionals. Although developing new knowledge over time, facilitators' expertise was downplayed as the solely a result of their past experiences of illness and care, and they seldom articulate it as expertise; neither acknowledgment of professionals and users' equal contributions nor their reciprocal relationships, which is the co-production notion's emphasis, is found.

Secondly, self-management of illness and choice themselves do not imply more patient control over the treatment process. As Fotaki (2011) highlights, researchers have recently pointed out that the project empowering patients as "citizen-consumers" to challenge providers' dominance is at the risk of turning them into a "responsibilized agent" who is free to choose but has little control over available choices (Newman and Clarke, 2009; Newman, Glendinning and Hughes, 2008; Scourfield 2007). It is suggested that : a) under efficiency considerations, choices offered to patients could be affected by the resource constraints in terms of doctors' time during the consultation; b) due to an inherent asymmetry of information between patients and doctors, patients still rely on doctors' involvement in decisions concerning their treatment; c) patient choice is mainly concerned with the time and place of treatment, rather than patients' autonomy or their involvement in decision making which are the more striking mechanisms of individual

involvement; d) and most importantly, effective co-production of treatment requires an increase in consumers' skills and knowledge, or health literacy, which in many cases the patients are unable or reluctant to acquire. Fotaki (2011, p.947) then turns to argue that the policy ideal of empowering patients as a "citizen and consumer" assumes that they are acting as a co-producer with voice and political influence (for the former), and exit and control over resources (for the latter) - however, in case they lack those resources, or they are forced to produce services that are no longer available against the background of cost containment, a "forced-coproduction" by "responsibilized agent" would be the result instead. Renedo and Marston (2015), in their studies of PPI activities of CLAHRC in London, have also revealed that the neoliberal ideals about individual responsibility and discipline moves patients away from the idea of the accountable state and healthcare providers for upholding patients' quality care, towards the idea of citizens needing to work on self-improvement.

Thirdly, patient choice and shared-decision making in treatment is redistricted by another major theme of healthcare reforms, evidence-based medicine. Sanders, Harrison and Checkland (2008) interviewed doctors in heart failure care and found that their content and style of the consultation is affected by evidence-based clinical protocols. They argued that the scientific nature of EBM acts to limit the degree to which doctors solicit patient involvement in decision-making. For instance, references to big studies and treatment being proven to work were used to persuade patients to take treatment and to pre-empt resistance. As evidence in favour of treatment is so compelling, doctors are more concerned to persuade and cajole their patients than to engage them in any meaningful discussion. In contrary to the new paradigm of patients' rights to decline beneficial interventions, patient participation in decision-making can only occur at the margins. In addition, Solomon et al. (2012; 2013) interviewed GPs and patients about the compatibility of prescribing guidance and doctor-patient partnership. They reported that evidence-based guidance served to limit patient choice: guidelines are written from a state actors' perspective of financial costs (budget control), efficacy, risks and clinical evidence at a population level, different to the worldview of patients, and they tend to downplay the criteria most important to patients, such as personal financial cost (affordability), human cost (bereavement and loss of ability) and personal experience. Although GPs tried to adopt a mid-point between the two polar views for maintaining a good relation with patients and trust, certain patient choice and participation in decision-making was compromised.

In sum, basically remained valid is Salter's (2003, p.931) notion of "sponsored consumerism" which is a controlled inclusion of patients in the policy process where they are consulted on a preordained agenda acceptable to medicine and the state, conferring legitimacy on the latter as a "symbol legitimating device". Again, it is the ultimate control over biomedical knowledge and expertise which confers the medical profession autonomy and legitimate place in the stable community of health policy. Here the conceptual distinction between "formation" and "implementation" in health policy process well annotates Corporatist theory of welfare governance - producer groups' interests are mainly mediated through implementation rather than formal representation. Such mechanism well matches the ideal of all the three types of formal co-option ("value", "production" and "expertise"; see Seward, 1990) and accords them an "insider status" in policy community; in contrast, patient's influence is indeed restricted to the symbolic representation in policy formation.

3.4.3. Inter-professionalism: renegotiating professional boundaries

Finally, as Kuhlmann (2006) suggests, the strongest modernizing driver to transform corporatism in the healthcare system is a more "inclusive professionalism" or inter-professional teams/networks which include the entire spectrum of health professions (p.12). Given that corporatist arrangements are anchored to the producer's control on policy implementation, the idea of "inclusive professionalism" promoting multi-professional management in welfare production seems to be the most direct challenge. It is suggested that the rationalisation of health care, in terms of the expansion of health promotion and prevention in primary care, has created considerable potentials for enabling GPs and allied health workers to take over some tasks hitherto carried out by specialist doctors and therefore eroding their hegemonic position. Furthermore, the circle of actors which does not belong to the orthodox medical knowledge system is increasingly in demand. As a result, new global models of decision making and new patterns of quality of care are also introduced (Kuhlmann, 2006, p.52). This is the "future health workforce" anticipated to better sever the demands for co-operation and integrated care, bringing about flatter hierarchies to the healthcare workplace (Davies, 2003).

In the UK context, GPs and nurses are seen as the key players in modernising the NHS. Polices to "shift the balance of power" away from hospitals initiated in the 1990s under Conservative governments to empower GPs as commissioners of care in an internal

market, and advanced under successive Labour governments (DOH, 2001). To further shift services delivery from hospital to primary care settings, and "build jobs round patients, rather than round professions" (DOH, 2002, p.7), the new General Medical Services (GMS) contract was implemented in April 2004. GPs and the allied health professionals they employ are given greater discretion to innovate and make decisions about services delivery. In addition to expanding the GPs-led commissioning, which we have discussed in the previous section, this shift saw also 1) specialist services such as ear, nose and throat (ENT) and dermatology carried out in new community hospitals/ GP surgeries as alternatives to second care hospital admission, and 2) nurses, pharmacists and other health professionals being given more responsibility in managing chronic diseases (DOH, 2006). As Currie, Finn and Martin (2009) put it, the subtitle of *The NHS Plan*, "More Staff Working Differently" (DOH, 2002) has epitomized the idea to "change traditional roles, conventional team structures, hierarchies and existing care processes, and allow greater scope for overlapping responsibilities, flexibility, multi-skilling and generic work" (Currie, Finn, and Martin, 2009, p.269).

Those changes were in company with Agenda for Change (DOH, 2004a), a new system of remuneration based on an evaluation of job roles, skills and knowledge rather than the traditional hierarchy based on professional status. It applies to all health professionals in the NHS, providing new flexible career progression pathways and therefore the basis for their extensions to "mini-doctor" roles, such as nurse specialist, prescribers and consultants (Currie, Finn and Martin, 2010, p.946; McDonald, Campbell and Lester, 2009, p.1206). Also, NICE has developed Clinical Pathways as "a documented sequence of clinical interventions, placed in an appropriate time frame, written and agreed by a multidisciplinary team" (The National Assembly of Wales, 1999, p,10). The Pathways represent the ideal patient journeys that map out healthcare activities and specify the input of various professionals, functioning as a shared language for discussing patient care and encouraging inter-professional communication (Hunter and Segrott, 2014, p.721).

New professional roles, most prominently GP with specialist interests (GPSI) and Nurse Practitioners (NP), have emerged to take over clinical duties and blurred the traditional boundaries drawn by bio-medical specialism. The key roles of GPSI, as foreseen by the government, are to take referrals from their fellow GPs, offer diagnostic and some treatment services, and provide leadership in primary care re-shaping services around

particular disease areas (DOH, 2004b). Regarding these new functions performed by GPSI's bypassing specialist doctors, Gerada, Wright and Keen (2002) suggest that the boundary between hospital-based and primary care is spanned by GPIS's disseminating expertise, smoothing care pathways and acting as "champions" within primary care for the clinical speciality of interest; Harrison (2002) also argued, decisions previously in the hands of hospital consultants might now lie in the hands of GPs.

Other than this intra-professional dimension, the development of Nurse Practitioners (NP) presents an inter-professional dimension of challenges to medicine. The upgrading of nurse training to academy has conferred nurses considerable legitimacy and power to deliver health services in their own right, together with the Nursing and Midwifery Council's (formerly UKCC) changes in its code of practice, which emphasize "principles for practice" (a holistic concept of nursing) rather than "certificates for tasks" (based on activities) (Witz and Annandale, 2006, p.41). In the NHS, NPs are experienced nurses who work with patients with long term conditions and provide preventative healthcare in the local community, offering aspects of care previously carried out by GPs, such as consultation, physical assessment, diagnosis, prescribing, research and health promotion. With a prescribing qualification and master-level training, Advance Nurse Practitioners (ANP) are even able to: take a full patient history, carry out any physical examinations, use their knowledge to identify a likely diagnosis, request appropriate tests to aid diagnosis (blood tests, x-rays, scans), refer patients to an appropriate specialist (in the practice or hospital), prescribe medicines and non-medical treatments, and arrange follow up/ ongoing management (Health Education England, 2015).

Studies suggest that practice nurses are becoming the first contact providers of care with minimal input form GPs in relation to the management of chronic disease (Campbell, McDonald and Lester, 2008; McDonald et al., 2007; McDonald, Campbell Lester, 2009). For example, PN-led clinics/teams are providing preventive care to patients with coronary heart disease, prescribing of hypotensive agents, lipid lowering and antiplatelet drugs, recording of blood pressure and ordering serum cholesterol and plasma cotinine levels, integrate rehabilitation services with secondary prevention for people who survive a myocardial infarction, and long-term optimal care (Hoare, Mills and Francis, 2012, p.972). Quality assessment is another example of new nurse management roles in relation to the increasing emphasis on patient care and customer satisfaction as the health service organization's remits (Witz and Annandale, 2006, p.40). In view of assisting patients to

return to work, increasing responsibilities have also been placed upon nurses and physiotherapists in sickness absence management and access to state funded occupational health. To endorse such role extension, the government has expanded the professional capacities of nurses and physiotherapists to sickness certification (Welsh et al., 2014, p.3). Gemmell et al.'s (2009) study of work diaries of staff in general practices indicates that nurses perceive expanding nursing staff roles that routine care for people with long-term conditions are almost wholly provided by nurses. The increase in nurses' autonomy is followed by their job satisfaction (Maisey et al., 2008).

In short, the UK Government's strategic move towards inter-professional practice, with a team-based approach to health service, has increased the likelihood of role blurring and relinquishing claims of exclusivity and ownership to health care practices and knowledge by the medical profession (Masterson, 2002). King et al.'s (2015) systematic review of the literature on the contested professional boundaries resonates with those findings and supports that healthcare management is based not on "immovable professional boundaries" but on "dynamic shifts" which "may not always favour the traditionally most powerful profession" (p.7). Yet, they argue that this may signal "a reduction in professional power and autonomy by some of the professions, each of which is increasingly vulnerable to the vagaries of the healthcare market, and the fiscal restraints imposed on healthcare budgets" (ibid). It presents a state-centric account of "de-professionalization" or "proletarianization" of all health professionals, more than a society-centric account of pluralistic network of empowered healthcare providers. Indeed, some also suggest that it is not the push from the representative bodies of the subordinate professional groups to make their role expansion, but the state's agenda of cost containment by creating a flexible (or controllable) healthcare workforce to deal with unmet demands at lower costs (Nancarrow and Borthwick, 2006, p.898 and 912). As we will discuss as follows, compared to the medical profession, those subordinate professional groups are actually more vulnerable to the state's efforts in breaking professional boundaries and centralizing control in healthcare, offering a little hope of checking the medical dominance.

3.4.4. Boundaries reproduced: substitution or delegation, expansion or enhancement?

Paradoxically, the state-sponsored challenge to medicine by subordinate professional health workers is at the same time hindered by another NPM agenda of healthcare reform, accountability/ efficiency. It is reported that the emphasis on EBM (e.g. population-based clinical protocols/guidance and performance targets) has undermined the holistic or patient-centred approach of care on which the GPs' and nurses' professional identities and legitimacy claims are rooted against specialist doctors. As a result of the skill-mix policy, the medicalization (being more bio-medical and disease-oriented, for example, being more involved in prescribing controlled drugs) of GPs' and nurses' clinical work has also strengthened the position of specialist doctors in the division of labour in healthcare for the latter's ultimate authority over bio-medical knowledge. It is suggested that while GPs and nurses are encroaching the territory of previously superior groups by the reallocation of tasks, their activities are now at the risk of further subordination to latter's regulation (for doctors, see Checkland et al., 2008; Martin, Currie and Finn, 2009; Currie, Finn and Martin, 2009; for nurses, see McDonald et al., 2009; McGregor et al., 2008; Latimer, 2014; Witz and Annandale, 2006; we will turn to a more detailed discussion of these studies later). In view of patient safety and cost efficiency, training, accreditation and regulation by specialist doctors are crucial to maintaining a controlled and accountable delegation of clinical works to the less specialized groups of health workers.

As Currie, Finn and Martin (2010) argue, new professional roles introduced by policy initiatives inevitably have to interact with the pre-existing institutional orders of profession, involving "formal recognition of new sets of knowledge" through training, accreditation and regulation" (p.945). Therefore, "professional bodies can mediate state influence on professional work jurisdictions and roles through the extent to which they support and institutionalize developments" (ibid). Considering that the line of the organizational accountability, control and power in healthcare system is largely underpinned by the institutional (professional) one, it is not surprising that the latter has considerable mediation effects on the reforms to the former. Moreover, the state' emphasis of the on accountability/ efficiency has actually strengthened the position of the medical professionals who are at the top of the line of institutional accountability.

We then turn to the second line of analysis that focuses on the institution of profession power itself. As Abbott (1988) suggests, in the "professional jurisdictions wars", professions can gain privilege by successful claims to jurisdictions, but can also lose privileges too; during this process, there are certain constant "boundary work" by which the professionals preserve and expand their territories (Fournier, 2000). On this basis, Nancarrow and Borthwick (2006) further develop a framework of the four directions of change in the professional boundaries among health workers: 1) Diversification; 2) Specialisation; 3) Vertical Substitution; and 4) Horizontal Substitution. It is argued that, overall, the medical profession is pivotal in defining professional boundaries in healthcare.

"Diversification" involves the creation of new tasks, or simply new ways of performing existing tasks, resulting in the expansion of the role for that discipline. The ownership of powerful technologies such as antibiotics and anaesthetic by doctors are early examples; the use of video laparoscopy that expands of the roles of surgeons is another. Based on the access to new research knowledge and ability to control or regulate the new technology, medicine, as the oldest formal profession in healthcare, has the greatest control over its scope of practice of all the health disciplines, as well as other health professions' diversification (pp.905-906).

"Specialisation" is "the adoption of an increasing level of expertise in a specific disciplinary area" with "membership to a closed-subgroup of the profession' by which "profession recognises a specialist technology or skill in healthcare delivery that extends beyond the core, pre-registration training for that discipline" (p.907). In medicine, specialisation arises to enhance medicine's superiority over their technical assistants and lay therapists (ibid). While diversification and specialisation enables the professionalization and expansion of the medical workforce, in order to have enough time and capacity to undertake new roles, doctors have to discard the routine or less skilled components of their work (p.908).

"Vertical Substitution" therefore is needed as an "internal closure" strategy by which subordinate sub-groups within a profession are undertaking lower status duties to free the professionals to specialise and pursue higher-status and autonomous "virtuoso" roles. GPs' own specialisation moving into the domain of specialist practitioners as GPSI is a good example. In a down-up direction, it may also promote the paraprofessionals' specialisation, for example, the extension of nursing roles to prescribing as nurse

specialists that trespasses the traditional medicine's domain (pp.909-910). However, while vertical substitution generally increases the scope of practice of a historically subordinate profession, the level of increase in their status or rewards varies and the extent of substitution tends to be controlled by the more powerful disciplines. For instance, nurse prescribers and GPSI are not rewarded the same status or financial rewards as doctors and consultants. Their works are regulated and supervised by the latter who are responsible for the final outcomes of care. Nor can they be employed in isolation from the latter or access to the medical components of the tasks unless adhered to the formal training recognized by the latter (p.910). Delegation of routine or less desired/ skilled tasks to subordinate groups therefore is not only a policy requirement but also driven by the internal logic of the profession system to expand the workforce, providing the most powerful group with the capacity to diversify and specialize, and the subordinate groups the chance to extend their supplementary roles.

"Horizontal Substitution" mainly arises as a result of the inter-professional practice that aims at creating a flexible workforce, and involves role overlap between practitioners of similar status and power. Good examples are the training of physiotherapy and occupational therapy assistants to become generic assistants, and the sharing of tasks of physical functioning and transfers between occupational therapists and physiotherapists (p.911). Horizontal substitution is rarely to be associated with an increase in professional status, power or income. It occurs more frequently between the subordinate healthcare occupations whose roles lack of clarity, than with medicine whose roles are well diversified and specialized (better defined, protected by regulation and access to restricted technology) (p. 912). While nurses and therapists are also introducing their own supporting workers, it is seen as a devaluation of the respective professions rather than an opportunity to "delegate the dirty work" as it acknowledges that less qualified workers could do components of the work (p.913).

In this light, compared to para-professions such as nurses and therapists, the medical profession is indeed the less vulnerable group to the state's efforts in breaking professional boundaries. As Nancarrow and Borthwick (2006) conclude, while the dynamics have "the potential to challenge the monopoly of all the healthcare professions", the professions appear to be safe if they can: 1) retain a high level of demand for their specialised services, 2) retain sufficient control over their own roles, 2) diversify to deliver new roles or retain ownership over the technology required to deliver them, or 3)

compete with existing providers on the basis of cost, quality or novelty for the delivery of those tasks (p.914). Undoubtedly, the medical profession is that one in a relatively safe position considering all these conditions.

Although their later work (King et al., 2015) presents a more pessimistic picture of overall decline of professional power seeing the "boundary work" steered by the state as "a reduction in professional power and autonomy by some of the professions, each of which is increasingly vulnerable" (p.7), we hold that the corporatist account of medical service providers' power is a more promising explanation for the dynamics in healthcare reforms. As discussed above: 1) overall, the medical profession still maintains its control over its professional boundary through effective diversification, specialization and vertical substitution, and is less vulnerable to horizontal substitution than para-professionals, 2) the internal conflict of NPM agenda between *accountability/control* (evidence-based clinical governance) and *decentralization/networks* (skill mix and inter-professional approach to preventive care near patients) has opened a window of opportunity for medicine elites to reclaim power in the course of interpreting and operating the monitor regime on behalf of the state, reinforcing the traditional institutional force of professional hierarchy. These two arguments find further support from recent researches.

For GPs, Checkland et al. (2008) identify a real shift towards the delivery of a more biomedical or disease-orientated model of care as a response to the imperatives embodied in the new GMS contract. The clinical indicators in the Quality and Outcomes Framework (QOF) are very specific and narrowly medical in focus, specifying quite challenging targets that are unlikely to be met without the adoption of a pharmaceutical approach (pp.793-799). Also, GPs turn to seek legitimacy with a specialist role as community-based specialists (GPSI) mirroring the past strategy of moving closer to the secondary care setting (e.g. appointment as "clinical assistants") (p.800). However, in these moves, GPs' unique identity and legitimacy claims to holistic and patient-centred care against their hospital colleagues are undermined.

Currie, Finn and Martin, (2009) find that, in the case of Genetics, Geneticists who are the established experts in the field have the power to constrain the development of the GPSI role in two related ways. First, to define the nature of Genetic expertise and knowledge, control access to it, and thus the right to practise (p.275). Upon indeterminacy of professional knowledge, Geneticists claim that immersion in the day to

day Genetics work (lengthy professional training and socialization/ ongoing interaction with other experts) is required to achieve necessary experiential and situated knowledge to practise (p.281). Second, to place GPSI in a "relationship of dependency" where they depend on Geneticists' ongoing support for everyday practice (p.275). Some of the GPSI are restricted to the educational role; others are restricted to a role that supplements existing service provision (e.g. to take account of family histories and made referral decisions) under the auspices of the Regional Genetics Centre, whereby Geneticists take on the role of appraiser, inspecting all referrals to the GPSI and filling an ongoing supervisory role (pp.276-277). Remarkably, Geneticists are found supportive to the complementary role of GPSI, as long as they can be relieved of workload pressures whilst retaining ultimate control of services (p276). As a result, GPs are at the risk of becoming "clinical assistants" to expert Geneticists (p.278). The state' efforts in building a collaborative healthcare workforce may paradoxically render GPs more subordinate to specialist doctors in hospitals.

For nurses, Laughlin, Broadbent and Willig-Atherton (1994, p.117) have depicted nurses as an "absorbing mechanism" that absorbs unwanted GPs' workload. This notion resonates with the national policy agenda to extend nurses' roles to provide out of hours and other enhanced services that GPs may choose to opt out of (DOH, 2003). Witz and Annandale (2006) also suggest that primary practice nurses simply take on routine tasks formerly performed by GPs without necessarily expanding decision-making role (p.39) as nurses are still the employees of GPs whose control of resources and management is intact under the new GMS contact 2004. Interestingly, she identifies a reluctance of nurses themselves in unstreaking new tasks for more liabilities they will bear (p.24). Studies of the new GMS contract 2004 (Gemmell et al., 2009; McDonald, Campbell, and Lester, 2009; McGregor et al., 2008) confirm that that the workloads generated by the new GMS contract are basically absorbed by nurses without adequate rewards in financial terms or involvement in decision making in GP practices. It is also revealed that those new nurses' activities are target-driven and narrowly defined by template - taking responsibility for meeting the contract targets, nurses are described as engaging in excessive data recording, the tick-box approach, and the stringent focus on incentivised QOF areas. These are seen as detrimental to the more holistic, patient-centred approach of nursing rather than encouraging innovation of services (McDonald et al., 2009, pp.1209-1210; McGregor et al., 2008, p.6). Those evidences suggest that task reallocation between GPs and nurses in the primary care setting is basically an effective

"vertical substitution" strategy used by GPs to discard less desired tasks whilst maintaining overall control.

The systematic review of Niezen and Mathijssen (2014, pp.163-164) on the task reallocation from the medical to nursing domains further suggests that full substitution, that medical responsibility is entirely transferred to the nursing domain, rarely happens as the extent of delegation or substitution is linked to the ownership of medical responsibility. The full substitution is also hindered by the organizational (e.g. availability of protocols) and institutional environments (e.g. legislation and financial support), as well as the complexity of tasks affects the probability to standardise the tasks and thus legitimize the substitution (ibid). A good example is the uncertainty in the nurses' role extensions to the core medical domain of prescribing. Analysing the NHS workforce database, Drennan, Grant and Harris (2014) find that the prescriptions written by nurses in primary care in England is minor in comparison to physicians (only 1.5% of all items). In most PCTs, Independent Nurse Prescribers contribute under 0.5% of items (p.5). The largest volume of items prescribed by nurses in primary care are those items used in common nursing care activities practice, such as wound dressings, incontinence and stoma devices. Beyond these, the medicine categories are those that could be bracketed as health promotion, such as contraception and smoking cessation (p.6).

In a hospital setting, Latimer (2014) suggests the expansion of nurses' roles is no more than a "delegation of work without power". Firstly, with clinical practice having to conform to clinical decision-making protocols on the one hand, and the demands of administrative agendas on the other, discretion are located at an ever-increasing distance from the bedside. For example, admission and discharge are now not simply matters of clinical discretion that they may share with doctors (p.540). Secondly, being increasingly preoccupied with financial and administrative responsibilities, nurses are spending less time in specific nursing activities with individual patients; however, minimal meaningful status and authority seem to accrue when nurses shift from clinical roles to managerial ones. Although former nurses occupy leading managerial positions, few have sufficient voice at key strategic points in the NHS over the setting of policy, organization design, and distribution of resources (p.538). In the NHS, it is clinical authority that still matters, though the authority is being centralized top-down under EMB.

As a whole, the tasks reallocation of in healthcare workplace does not imply a role substitution in the profession system between the dominant groups (doctors or specialists)

or the subordinate groups (para-professionals or GPSI) as anticipated by the skill mix and inter-professional management policies. It is rather a controlled delegation as the scope of tasks reallocation is predefined and limited by the dominant groups. Moreover, the subordinate groups are further subject to supervision; and the role expansion of the subordinate groups to supplemental works does not see a definite enchantment of their status, autonomy or rewards. In sum, health policy communities are still closed networks dominated by strong corporatist forces of medicine. The state's efforts in re-negotiating professional boundaries have turned into reproducing those boundaries.

3.4.5. Brief summary

Stakeholder arrangements in healthcare systems appear to challenge medicine's dominant position and support a pluralist account of health policy networks. However, they are not as successful as at first glance.

Firstly, citizen participation in health service co-production and co-planning is far from a full control over health services but in some way manipulated by healthcare professionals. Due to the technical complexities involved in health services, doctors as professional bureaucrats have always managed to control the access to key information for agenda setting, downplay the legitimacy of patient's opinion, and predefine the scope of patient involvement. Interestingly, clinical guidelines provide a solid base upon which doctors can stand to deny or limit patients' influence in clinical decisions and their rights to choice. Patients' lack of time and knowledge to excise choice also help this asymmetry to flourish.

The control over biomedical knowledge again offers an overarching protection for medical autonomy from patients influence. Noticeably, this protection is reinforced by the state's agenda of cost-containment and accountability - under cost-efficiency considerations, the ideal of patients' choice and voice has to be compromised, and this mediation process relies very much on the medical profession's interpretation of clinical rationales. In view of effective governance, the state may also need to sponsor patients' participation in the health policy community under the banner of public control and accountability. However, patients' power has to be controlled and symbolic in nature to reconcile it with another principal legitimating device working in parallel, the "implicit rationing" function of medicine.

Secondly, the state-sponsored challenge to medicine from inter-professional networks/ skill mix team policy is also found as hindered by the state's own efforts to rationalize healthcare governance. With the strategy of clinical guidance and substituting core health professionals by less trained workers, "de-professionalization" or "proletarianization" occurs, but more likely among para-professionals than the medical professionals. In contrast to the medical profession whose effective diversification, specialization and vertical substitution are guaranteed by their ownership over biomedical knowledge and final liabilities for clinical decisions, allied professionals can merely extend, not enhance, their roles in task reallocation. They simply take on routine tasks formerly performed by doctors as an absorbing mechanism; but if they encroach into the medical domain, the dilemma is that, they are at the risk of being more bio-medical oriented and subject to the regulation exercised by medicine. Also, they are more vulnerable than the medical profession to the downward substitution of work by ward assistants and horizontal substitution by other para-professions.

If we apply the De-professionalization or Proletarianization Thesis to the entire healthcare workforce, it may simply predict the triumph of the state with an overall decline in producers' power; while it could also lead to a consolidation of corporatist arrangements favouring medicine as discussed in this review. At best, it may leave other health professionals in a more vulnerable position offering a little hope for challenging medicine. Furthermore, the state actually accounts heavily on medicine to interpret and implement clinical governance. In view of a controlled and accountable delegation of clinical works to the less specialized groups of health workers, the inter-professional networks/ skill mix team policy may at the same time create a demand for extending the jurisdiction of clinical governance, which is based on medical science, to the formally unchartered areas of non-medical activities. The intra-professional conflicts between GPSI and specialist doctors are of no exception. In this sense, the re-stratification within medicine does not necessarily favour GPs over specialists.

In sum, stakeholder arrangements in healthcare are aligned with the capitalist welfare state's dedication to more rationalized or manageable systems. The shortcomings of patients and other health professionals, as well as the advantages of medicine (specialist) in controlling over bio-medical knowledge, make the latter's a more stable partner for the state in the rationalization project. Two functions performed by medicine (specialist) are identified as core to the corporatist relation: the "implicit rationing" of welfare

consumption and the rationalization of the whole line of clinical activities. In such dynamics of the state cum medicine versus patients and other health workers, evidence-based medicine arises as the major mediation mechanism and deserves further empirical investigation.

3.5. Closing remarks

This review attempts to make three contributions to the theoretical debate of healthcare reforms. First, to calibrate the socio-political theories of medicine with general theories of governance in welfare production, referring the De-professionalization or Proletarianization Thesis to State-centric Theory, the Re-Stratification Thesis to Corporatist Theory, and the "citizen-consumer" and "jurisdiction war" theses to Society-centric Theory. With special attention to the field of welfare production, this review proposes Corporatist theory to assimilate the state-centric and society-centric arguments by suggesting that doctors as welfare producers are actually partners cum challengers of the state in healthcare governance.

Second, given that the Re-Stratification Thesis is generally supported by literature, to further identify the role of medical elites (as at the top of the strata) in balancing between the state power and collective professional interests/ autonomy, and to depict the dynamics with the "governmentality" thesis and the "loose coupling" thesis respectively. While the former implies a proneness to the state control that leads to the "de-professionalization/ proletarianization" of the rank-and files in medicine, with medical elites being co-opted to the managerial ideology, the latter implies a proneness to medical power that its collective professional interests/ autonomy are preserved by ritually coupling to the state-sponsored monitoring systems without any substantial changes in the professional domain of daily operations.

Third, to put such state-medicine conflicts in a wider context of their relation with other societal actors, such as patients and subordinate health workers. In the face of an overall tendency of "de-professionalization/ proletarianization" in the entire healthcare workforce, it could be argued that the medical profession has relative advantages over other health professions, who are countervailing actors in the health policy community, in buffering the impacts. On a contrary premise, interestingly, the active participation of those challengers to medicine in the health policy community are not only providing an

opportunity for pluralistic policy networks to flourish, but also creating an extra demand for medicine's enrolment into corporatist arrangements to maintain the states' effective governance.

In this regard, certain important concepts have already been outlined in this review and some further research questions can be asked as follows: what are the role of "medical elites" in managing a re-stratified healthcare system? How do they maintain their authority over the rank-and-files? Are there any cleavages or noise created in corporatist arrangements? How do they reconcile the state and professional agendas of healthcare governance? To what extent is this group of pivotal players being "governmentalized" to impose self-surveillance, or leading a ritual "loose coupling" with the institutional structures without substantial changes in the professional logics of day-to-day operations? The next chapter will attempt to develop research strategies to examine those power dynamics in healthcare governance.

Chapter 4

Researching physician managers

4.1. Introduction

The last chapter highlights the theoretical relevance of physician managers (clinicians who are medically qualified and carrying management duties) in healthcare governance studies. Due to the interdependence of the state and medicine in running healthcare systems, as Corporatist Theory suggests, dynamics and struggles rarely take an extreme form of overall dominance of one group. Rather, it is the state "colonizing" medicine by the co-optation of doctors into healthcare systems management to impose a tighter self-surveillance regime, or conversely, medicine "capturing" the state by the enrolment of themselves into it to preserve their control on daily professional operation. In this process, the medical profession undertakes a significant restructuring as "re-stratification", dividing into two functional sectors: "producers" who work in clinical practice as rank-and-files, and "elites" who work in academic and administrative posts as the proxies of state regulation (defining and implementing clinical protocols, reporting systems and performance measurements). In this *relational approach*, physician managers act as the intermediaries between the state and medicine negotiating managerial and professional agendas/ interests. They face conflicting expectations arising from the organizational and institutional logics, i.e. the managerial agendas of efficiency (value for money, productivity) and accountability, and the professional agendas of effectiveness (quality of care) and autonomy. Regarding the balance of power in healthcare governance, a more empirical examination into this pivotal position of physician managers is required.

This chapter will attempt to develop strategies for researching physician managers in this study. Firstly, we will look further into the discussion of physician managers in the Re-stratification Thesis. Secondly, we will offer a more sophisticated theoretical understanding of physician managers per se, locating relevant studies in the research tradition of social-political theory on managerial hegemony versus professional resistance. Finally, we will develop our own research design with reference to the review of relevant studies' methodology.

4.2. Physician managers and the Re-stratification Thesis

4.2.1. Knowledge elites, administrative elites, and rank-and-files

The very characteristic of the re-stratification of medicine, according to Freidson (1984), is "the formalization of the methods by which professions control their members" (p. 1). Under the political pressure or the administrative requirement of greater accountability and control, a) "an administrative elite of professionals" who serve as professionally qualified administrators, e.g. supervisors, managers, and chief executive officers, "is being formed in order to guide and evaluate the performance of rank and file professionals"; b) the "knowledge elite" based primarily in professional schools devise the technical standards employed by administrative elites; and c) "rank-and-file" practitioners are "no longer as free to follow the dictates of their individual judgments as in the past" although they can still exercise some discretion on a daily basis (ibid). While such stratification in medicine has always existed, Freidson argues that it has become more "formal and overt" than in the past, leading to divisions and conflicts within the profession (p.1-2).

It is suggested that the re-stratification of medicine has transformed the traditional controls of professionals, which were "largely informal, sustaining a live-and-let-live relationship among colleagues and preventing open conflict between professional elites and ordinary practitioners", and has "weakened the grounds for such a relationship, while reinforcing and formalizing the differences in prestige and authority" (ibid, p.13). In particular, formal review and evaluation of clinical decisions by colleagues have become mandatory. Given physicians must now judge each other, formally and sometimes publicly, the "facade of equality in probity and competence", or the "conspiracy of silence / tolerance" has been defied (ibid, 15). The "trust in one's colleagues' discretion and good" (ibid), which was guided by the traditional norms that "prevent that control from being exercised judiciously and systematically" (ibid, p.3) and informal methods of control, has also been undermined.

Freidson further suggests that it is especially the case for healthcare organizations that are large enough to require full-time administrative officers: physicians who serve in executive, managerial, and supervisory roles are "clearly delineated by their formal rank", and "their authority is distinct from that of their rank and file 'colleagues'" (ibid, p.15).

Most importantly, the re-stratification of medicine involves "differences in official authority and power that in tum produce varying perspectives on the professional enterprise": rank and file physicians are primarily preoccupied with their own view of the "intrinsic practical problems"; supervisory physicians are "accountable for the aggregate performance of the workers under them", and tend to "have an organizational perspective" and "identify….with the type of professional organization they represent as with the practicing profession" (ibid). As a result, administrative elites will have "a less collegial and a more superordinate relationship with their subordinate colleagues" (ibid). Issuing directives governing the work of rank-and-file practitioners, they "violate the traditional etiquette of an earlier day and so mark their distance from their nominal colleagues" (ibid).

The formalization of controls on the rank-and-file practitioners also involves the knowledge elites who aim at formulating and evaluating their work. It is an authority of expertise that the administrative elites lack and must invoke from the knowledge elites. As standards and guidelines of the knowledge elites are "grounded in the abstract world of logic, scientific principles, and statistical probabilities rather than in the concrete world of work", there has always been resentment and tension between "town and gown" (practitioner and academic) (ibid, p.16). With the use of standards and guidelines in the increasingly formal and public control of everyday professional practice, practitioners have become even more sceptical to the knowledge elites. If the former were to ignore the standards established by the latter, "a deeper division between them than existed" (ibid).

Freidson concludes that such formalization of collegial relations will be followed by "a division into administrative elites, knowledge elites, and rank and file workers" as "distinct and separate corporate entities" (ibid, p.18). Also, the level of conflict will intensify as "the formalization of professional control creates organized groups with different perspectives, interests, and demands" and "poses new and unaccustomed obstructions which reduce practitioners' capacity to perform their daily work in a manner that satisfies them" (ibid). In Freidson's subsequent work (1985) on the reorganization of medicine, he further elaborates:

> [T]he authority of both the physician-administrator and the physician-researcher has
> become more extensive and definite and has become more binding on the practitioner.
> Formal administrative authority and formal cognitive authority analogous to "line" and

> "staff" authority in industry become much more definite, leaving rank and file practitioners with considerably less freedom of action than existed in the past. This does not mean that they are no longer professionals with a significant degree of discretion; rather, it means that their discretion must take into account the authoritative norms laid down by other members of their profession that they become in some sense subordinate to a select group of their own colleagues (p.29)

Whereas the knowledge elites are excising their power at a rather remote distance from everyday clinical workplaces, direct contact or conflict with rank-and-file practitioners will be more observable for the administrative elites, who apply standards and guidelines they create in the supervision over the rank-and-files. As will be shown later in this chapter, researches of physician managers tend to focus on those who have management roles in healthcare organizations rather than academies.

4.2.2. Identity and ideology

Freidson's discussion on the formalization of collegial relations in medicine stresses the "perspectives, interests, and demands" that are different from rank-and-file practitioners which medical elites identify themselves with.

Above all, medical elites are suggested to be more committed to the "macro care" of populations, emphasising the "rationalization of practice in the interest of scientific or therapeutic knowledge" as "adequately serving a population or organization within the limits of available resources" (Freidson 1985, p.30), while practitioners are oriented to the "micro" or clinical care of individuals. These are, what Freidson sees as, "the major lines of cleavage within the profession with far deeper implications for the unity of the profession as a whole" that are "more than mere differences of specialty, prestige, or income" (ibid). Freidson depicts "the organized division of interests that arises between practitioners as a whole and physician-administrators, policymakers, and researchers" (ibid, p.30) as:

> Where once all practitioners could employ their own clinical judgment to decide how to handle their individual cases independently of whatever medical school professors asserted in textbooks and researchers in journal articles, now the professors and scientists who have no first-hand knowledge of those individual cases establish guidelines. Where once all practitioners were fairly free to decide how to manage their relations with patients, now administrators attempt to control the pacing and scheduling of work in the interest of their

organization's mission, which may regard the collective interests of all patients (or of investors or insurance funds) to be more important than the interests of individual practitioners and their relations with individual patients. (ibid, pp. 30-31)

As Freidson stresses, such "organized division" within medicine is not "mere differences of specialty, prestige, or income", but different perspectives of practicing medicine and associated interests based on their different positions in the re-stratified medicine. In this regard, he agrees with Alford's (1975) distinction of medical elites from practitioners as "corporate rationalizers" versus "professional monopolists" for the "important differences in their aim and orientation" (Freidson 1985, p.30).

However, Freidson also argues that Alford is "wrong to separate them because all three are essential parts of the same organized profession" (ibid). Without physicians serving in administrator and researcher roles, Freidson suggests, the profession "could only sustain a position that is at best like that of the crafts, dependent on its organization but at the mercy of others' technological innovations and administrative practices" (ibid).

In relation to the knowledge elites:

Those in medical schools, teaching hospitals, and the like control, codify, refine, communicate, and augment the profession's body of knowledge and skill: their activities maintain control by the profession over knowledge and technology and discourage "expropriation" by outsiders. (ibid)

In relation to the administrative elites:

Those in administrative positions in practice organizations balance the necessity to carry out the collective ends of a governing board, municipality, state, firm, or whatever against the needs and desires of those who do the medical work, thereby buffering the practice of medicine against the political and economic pressures of the environment. (ibid)

With those new roles in the re-stratified medicine, Freidson suggests, the profession as a whole may "sustain the plausibility of that part of its ideology that claims to be concerned with the collective, public good" (ibid). In particular, Freidson mentions the "occupational kinship" with the superiors by which rank-and-file practitioners can "probably continue to have distinct occupational identities, rather than being mere jobholders" and "participate in formulating standards and evaluating their own performance through some type of peer review" (Freidson 1984, p.18).

The picture offered by Freidson of medical elites' social identification and ideology therefore is ambiguous: medical elites are depicted as having a "macro" orientation to rationalize medicine on the one hand, and as the advocates of medicine aiming to maintain the profession's control over knowledge and autonomy on the other. This leads to the question that we have discussed in the last chapter: whereas medical elites are working in ways that mediate competing expectations in an increasingly managed workplace, i.e. safeguarding collective professional interests and national agendas of managing the health sector (Waring, 2014, p.692), how can we assume an equilibrium as implied in Freidson's Re-stratification Thesis, and if so, what are the dynamics and process by which such equilibrium can be achieved? In this regard, "governmentality" (Flynn, 2002) and "co-option" (Coburn, Rappaport and Bourgeault, 1997) as well as "loose coupling" (Doolin, 2001) and "soft autonomy" (Levay and Waks, 2009) are possible outcomes of physicians' enrolment into management of healthcare organizations.

In conclusion, Freidson has correctly identified physician managers' social identification and ideology as the core issue of the re-stratification of medicine, but leaves its future tendency and overall implication for the balance of power in medicine unclear: on the one hand, he does not "see changes that will actually transform rather than merely alter the position of the medical profession in either the nation or the health care system", one the other hand, he warns "there is the real possibility that medicine is losing its cohesion and thus its capacity for effective political organization" (1985, p.32). In the coming sections, we will explore how more recent researches and theories on the re-stratification of medicine can further develop our understanding of the identity or loyalty issue regarding physician managers, as well as its impact on the balance of power. Before that, we will first briefly discuss how two important issues, namely specialism and gender, can be related to the Re-stratification Thesis, i.e. how physician managers' ability to exert authority and to claim legitimacy over their medical peers is affected.

4.2.3. Specialism and the encroachment of managerialism

While Freidson's (2001) later work does not provide further empirical examination for the Re-stratification Thesis, it clarifies the ideological elements of professionalism that must be preserved if medicine is to maintain its dominance.

Above all, the "ideological core of professionalism is its claim to a discretionary specialization" (p. 109) and it has been challenged by "populist generalism" (consumerism) and "elite generalism" (managerialism).

There are three major claims of specialism. First, it stresses "the lack of uniformity in the problems its work must contend with, therefore emphasizing the need for discretion" and "its capacity to be flexible and adaptive in dealing with qualitative differences among individual tasks" (p.111). Second, it claims that "the work of a trained and experienced specialist is superior to that of an amateur" and "the work of a specialist with professionally controlled training is both superior to and more reliable than that of someone who may have experience but lacks training" (ibid). Third, as a result, "only the specialists who can do the work are able to evaluate and control it properly" (p.115).

Contrary to specialism, generalism claims "a general kind of knowledge superior to specialized expertise that can direct and evaluate it". "Populist generalism" (consumerism) is "deeply embedded in the assumptions of liberal economics and closely related to those of liberal democracy" that "average people with ordinary human abilities are capable…to make economic and political choices that will serve their own best interest without specialists to choose on their behalf" (p.116). "Elite generalism" (managerialism) goes beyond consumerism and claims "the authority to command, organize, guide, and supervise both the choices of consumers and the productive work of specialists" (pp.116-117). It emphasizes "a special kind of preparation for positions of leadership" which is "an advanced but general formal education that equips them to direct or lead specialists, consumers, and citizens" (ibid). With this form of general knowledge, management is superior to specialization because it can organize production rationally and efficiently.

As discussed in the last chapter, consumerism on its own can hardly present significant challenge to professional dominance in medicine. The real threat rather comes from the managerialism that aims to standardize and monitor clinical work and "governmentalize" professionals themselves under the banner of science. This sheds light on the discussion of re-stratification by clarifying the ideology that drives the transformation of the traditional forms of professional controls: "elite generalism" serves to legitimatize management as another kind of expertise that is

superior to medical specialism in organizing the delivery of healthcare services. It challenges specialism which is the central claim of professionalism.

Drawing on this understanding of the contesting ideologies in health politics, the physician managers' identity issue is largely determined by how well medical specialism is replaced with generalism (managerialism). The following sections will explore recent studies on the re-stratification of medicine that attempt to operationalize that generalism and specialism as embodied in physicians' acting as managers.

4.2.4. Gender and the Re-stratification Thesis

Whereas the divisions or internal differentiation in medicine are not perceived by Freidson as overlapping with gender, critics attest that the Re-stratification Thesis is a gender-blind theory (Riska, 2001). Yet, the feminization of medicine is a major change in medicine's structure in recent decades. Theorizing the future of medicine whilst neglecting a gender perspective would undermine the whole theoretical enterprise.

Feminist studies in medicine suggest that "a gender perspective would have implied an identification of women physicians as increasingly occupying the rank-and-file positions" with men maintaining the positions of medical elites (p.15). So it is "possible to include gender in the accommodation argument of the restratification thesis" (ibid). This is what called by Reskin and Roos (1990) as the "ghettoization" version of the Feminization Thesis of medicine, as opposed to a version that emphasizes women's genuine integration in the profession.

The "ghettoization" version of the Feminization Thesis of medicine suggests gender segregation is created by two types of dynamics (Riska 2008, p.5). "Horizontal dynamics" refer to the male dominance in specialist area, which is rooted in "gender essentialism" that "defines women as more competent than men in service, nurturing, and social interaction" (Charles and Grusky 2004, p.15), e.g. women in paediatrics and men in surgery. "Vertical dynamics" refer to male dominance in the most desirable occupations and positions, which is reproduced by "male primacy", a view that "represents men as more status worthy than women and accordingly more appropriate for positions of authority and domination" (ibid.). As a result, it

is suggested that "the female-dominated niches are characterized by low status and pay, while the high-status specialties and the organizational leadership of the profession tend to be dominated by men" (Riska 2008, p.6).

In theory, there could also be a "sociology of numbers" (Kanter, 1977) that predicts the feminization of medicine will change the professional identity, favoring more humane and empathic attitudes toward practice. In this connection, female physician managers may act as the agency of change as to turnaround the current structure of medicine which is male-dominated. Also, the shifting of power in medicine from specialist care to primary care and public health, as discussed in the last chapter, may interact with its feminization conferring these female-dominated niches more resources and authority.

The NHS's recent workforce statistics echoes to "ghettoization" arguments aforementioned, suggesting that women physicians' increasing numbers does not imply their equal status in the profession, and pointing to the ghettoization prediction that structural and cultural barriers will prevent women's full integration. Even nowadays, female doctors are still facing a glass-ceiling in terms of horizontal and vertical barriers. The former refers to the male dominance in specialist posts (the proportion of females was only 34% in 2015; the figure for Surgery was only 12%) (GMC 2016, p.32), and the latter refers to the male dominance in consultant grades and GP providers (only 34% of consultants and 39% of GP providers were female) (NHS Digital, 2016).

More importantly, it has been argued that both professions and organizations are inherently gender-biased, favoring features associated with masculinity such as scientific objectivity, efficiency, hierarchical structures, autonomy of the professions (Riska 2008, p.6). Under "inequality regimes" (Acker, 2006) of medicine where the knowledge and power of the profession is controlled by men, it is suggested that "the profession's values and organization of work will remain male-gendered" and "organizational equality projects have failed or have had minor impact" (Riska 2008, p.6). The challenges facing female physician managers therefore are twofold. As the world of management is as male-dominated as the medical one, being a physician manager female physicians may have to overcome two barriers they face – one for becoming a manager and one for becoming a medical leader. Moreover, recent studies of female physicians' gendered skills, i.e.

more caring and empathic towards patients than male colleagues, have suggested that these skills have not been shown to "generate gender differences in the biomedical content of practice" (ibid).

The difficulties this study encountered in recruiting female physician managers perhaps are testament to the pessimistic explanation for feminization in medicine, suggesting that gender integration has largely stalled. At the time of recruitment, there were only three female Chief Executives out of all forty-one public hospitals in Hong Kong. The final fieldwork sample included only one female physician managers at the frontline level. This has limited the study's capacity to capture adequately gender issues. Yet, it does not mean gender is unimportant in the study of healthcare governance. With a focus on gender, future studies that strategically recruit enough female physician managers may concentrate on how gender has mediated the way they act as a manger and medical leader as compared to their male colleagues, how gender identity has interacted with identities in other dimensions (e.g. organizational versus professional), or the other way round, the implication of feminization for healthcare management as women physicians are increasingly occupying the rank-and-file positions.

4.3. Conceptualization of hybrid managers in healthcare

4.3.1. Uncertain truce between competing logics

In a recent systematic literature review, Byrkjeflot and Jespersen (2014) summarise over 60 studies on the new healthcare management role that combines the managerial and the professional one. They search the terms *hybrid leadership*, *hybrid management* with *hospital* and *health care* and define "hybrid" as combinations of "two or more elements that normally are separated" (p.442). In the case of healthcare management, the term denotes a mixture of "various types of expertise, structures and logics", i.e. a mixtures of medical and managerial forms of expertise, and their associated institutional logics (ibid).

Based on their findings, there are three conceptualizations of hybrid management in healthcare: 1) the "clinical manager" who combines professional self-governance with a "general management logic" that implies "a stronger management and a more efficient and hierarchical system of management with less ambiguous accountability relations"

(p.442); 2) the "commercialized manager" who combines professional self-governance with an "enterprise logic" that implies "budget and delegated responsibilities for results and quality" (p.448); and 3) the "neo-bureaucratic manager" who combines professional self-governance with a "neo-bureaucratic logic" that implies soft regulation where "professionals scrutinize themselves and are controlled at a distance" by professional-led clinical audits, performance reviews, customer feedback schemes and league tables (p.451). These three specific sets of institutional logics are imposed by New Public Management on healthcare systems challenging the originally dominant professional one.

However, Byrkjeflot and Jespersen argue that "hybrid managers seem to have been able to cope with the management reforms in ways that do not threaten their established positions. In most respects clinical professional autonomy is maintained or only marginally affected" (p.452). At the same time, they also run the risk to be bureaucratized / managerialized and isolated from their professional colleagues. Therefore, it is "an uncertain truce between competing logics" more than "a replacement of some dominant professional logics with others" (ibid). Given that the certain extent of combination of managerial and professional roles/logics is enacted in healthcare management, a meaningful question for Byrkjeflot and Jespersen is "in what way different logics or roles have been combined and what kind of effects such combinations have had on the organization" (p.453).

4.3.2. Continuum from hegemony to resistance

In a hegemony/resistance framework, Numerato et al.'s (2012) systematic review of 139 studies classifies the impact of management on medical professionalism in five ideal-typical outcome categories. Searching the terms *professionalism*, *professional control*, *professional autonomy*, *professionalization* or *professionalization*, they find: (1) Managerial Hegemony; (2) Co-optation; (3) Negotiation; (4) Strategic Adaptation; and (5) Professional Resistance. At the two ends there are hegemony and resistance where one dominant role/logic unconditionally entrenches. In these extreme cases we may conceive that the possibilities of combination are actually precluded. In reality, forms of combination and associated effects are often in-between *hegemony* and *resistance* in this continuum. In a governance perspective as we discussed in the last chapter, the equilibrium will be determined by the relative capacity of the state to govern and the medical profession to co-produce/plan healthcare service.

"Co-optation" is a relative state-centric account of management-profession combination. It is characterised by "soft bureaucracy" (Courpasson, 2000) and "top-down introduction of expert networks/ flexible corporatism" (Sheaff et al., 2004) where the responsibility for monitoring process is delegated to professionals to secure the centrally and managerially defined objectives. As proxies for management, local professional leaders assimilate techniques of learning and reporting into their everyday clinical practice as their own systematic self-scrutiny (Numerato et al., 2012, p.633). Although direct management interference into professional practice and surveillance is reduced to the minimum necessary reporting, this process is identified as the co-option of the managerial ideology by professions during which the utility of some management tools and the ideas of audit and accountability is recognised as an integral part of professional jurisdictions (Harrison, 2009). Under Co-optation, the traditional informal peer regulative regime has transformed into a durable and collective formal one adherent to the content and objectives defined by the state (Numerato et al., 2012, p.634). Empowerment of professional leaders is based on their position in the state-sponsored networks of professional management and regulation, exposing medical professionals to increased accountability and transparency (p.630).

Nearer to the end of professional resistance in the continuum is "Strategic Adaptation". This account of management-profession combination emphasizes the professionals' ability to absorb changes by proactively negotiating and influencing the implementation of managerial measures. Such form of combination can be conceptualized as "reverse colonization" (Waring and Currie 2009, p.755; Thorne, 2002), "adaptive regulation" (Waring, 2007) and "soft autonomy" (Levay and Waks, 2009). By expending professional jurisdiction for management knowledge, medical professionals manage to legitimatize the professional-led scrutiny regime which is customized and localized, and on this basis, adapt to or circumvent the management-led one, rather than being drawn into management roles or bureaucratic ways of working. In this process, professional involvement took the form of translation and negotiation in expert networks, and the mediation effects of local and informal professional networks and subcultures are substantial (Holtman, 2011; McLaughlin, 2001; Southon, Perkins, and Galler, 2005). Noticeably, with maintained professional control over evaluation criteria and content, professionals also internalize originally non-professional ideas of auditing. Therefore, it is "restrained by a certain resistance towards external monitoring, but driven by an interest in legitimizing and developing professional work" (Levay and Waks, 2009,

p.509). Under Strategic Adaptation, medical professionals are still in a way "governmentalized", but in the form of "soft autonomy" instead of "soft bureaucracy" we discussed above that characterizes Co-optation. "Soft autonomy" denotes a centre of power exerted by the profession side that is able to redefine, accommodate and sometimes circumvent new management or regulative regimes in its own right, "by doctors, for doctors" (Waring, 2007, p.176). The distinctive natures of this form of management-profession mix are voluntary adaption in view of improving professional work and the determinative role of informal professional networks in determining the substance (Numerato et al., 2012, p,631-635).

Another theoretical interpretation of strategic adoption is "loose coupling" (Doolin, 2001). In an Institutionalist perspective, medical organizations gain external legitimacy by retaining external facets of managerial ideology and discourse as isomorphic institutional structure, such as total quality management (Audet et al., 2005) and accreditation (Pawlson and O'Kane, 2002). Under "loose coupling", professionals comply with managerial and regulative procedures selectively and ceremonially, such as paperwork compliance and the use of standardised formal language to hide the real aspects of work (Berg et al., 2000). This institutional interpretation of strategic adaptation as loose coupling predicts a rather unenthusiastic and opportunistic compliance of professionals (Numerato et al., 2012, p.630).

Interestingly, situated between Co-optation and Strategic Adaptation is "Negotiation". It is defined by the enrolment of doctors into management posts mediating professional and managerial agendas/interests (p.634). Rather than favouring one group, hybrid managers merge managerial and professional skills, values, tools and knowledge to achieve "compatibility" between efficiency/accountability and clinical quality (p.634). Specifically, border ideas of justice and morality at the level of overall healthcare system, beyond the level of individual-patient interaction, are integrated to professional behaviours (Ten Have, 2000); management tools such as human resources and managerial accounting are not seen as a real threat to clinical autonomy but a facilitator of improvement in service quality (Kurunmäki, 2004). Under Negotiation, hybrid managers stress the collaborative nature of the relationship between management and profession through trust, openness and cooperation (Hoff, 2001); negotiation and respect for diversity (Allen, 2009); or the acknowledgement of managers' or professionals' areas of competence (Griffiths and Hughes, 2000). They bridge profession and management as

two existing "cultural codes" acting as active change agents of medical organizations that have dual loyalties (Mo, 2008).

Noordegraaf's works give an exclusive focus on the physician managers' negotiation role. He distinguishes hybrid managers from the "purified" and "controlled" professionalism as a third form, the "managed" professionalism. He (2007, p.774) argues that professionals under "managed professionalism" actually form a distinctive social category/class which called by Schön (1983, p.49) as "reflexive practitioners" that bring artistic, intuitive processes to situations of "uncertainty, instability, uniqueness and value conflict". Specifically, they hybridize professional and organizational logics to cope with clients and cases in the face of costs and capacities: (Noordegraaf, 2007, pp.778-779).

> By mixing-up control types, new occupational linkages between working floors, street levels, clients, and organized action are established. Professionals who become (partly) managers and managers who become professional are not necessarily about destroying professional practices - they may be coping with clients and cases in the face of costs and capacities. Problems do not so much arise because professional work is controlled; they arise because neoliberal and business-like paradigms are at odds with the inferential nature of professional case and client treatment. Hybrid professionalism may offer new ways of controlling or "standardizing" practices, with soft and selective standards…that do not prescribe how trade-offs must be made but provide direction for making trade-offs. Ethical, budgetary, and service standards enable professionals - managers and non-managers - to meaningfully align clients, costs, and capacities.

To further elaborate this negotiation process, Noordegraaf (2015) later suggests a fourth from of "organizing professionalism" in which hybridization become normal and natural rather than combined as different features and values, i.e. values of both quality and efficiency belong to professional work and the organizing work is taken within professional fields and actions. He argues that in "organizing professionalism" (p.15):

> Values are not singular, but multiple. Professionals know how to serve multiple values at the same time, forcing them to make trade-offs which are not a matter of quality inside professional work and efficiency outside work. Quality and efficiency both belong to professional work. In addition, organizing professionals are aware of the fact that their work must be seen as legitimate in order to be valued. This explains the strong emphasis on responsibility, connections and stakeholders.

According to this organizing perspective, hybrid managers organize their work at three levels (p.12-13): 1) "case treatment" - professionals know how to organize the updating of expertise, usage of new technologies, implementation of innovations, working in teams and cooperating with others. Instead of managers who try to initiate collaboration and innovation, professionals take an active share in organizing better case treatment; 2) "multiple case treatment" - professionals know how to select cases, prioritize case treatment, make treatment efficient and establish collaborative cultures. Instead of organizational (decision) systems that formalize how organizations deal with client flows, professionals are (co-)responsible for selecting and prioritizing patients or judicial cases, related to professional/organizational considerations, including strategic and budgetary decisions; and 3) "case treatment in context", they know how to detect and prevent risks, deal with errors and failure, and account for action. Instead of merely implementing organizational safety systems and formal procedures around professional work, active coping with stakeholders, risks, and outside pressures becomes embedded within professional practices.

Similar to Numerato et al., Waring and Currie's (2009) suggest three "mediated responses" of professionals to management power, namely Co-option, Adaptation and Circumvent between Compliance and Resistance, representing an axis of the locus of power shifting between management and professionals. They elaborate this classification with the case of hospital knowledge management (KM): 1) under Co-option, professionals assimilate management practices and have extensive experience in the management system; 2) under Adaptation, professionals modify and apply management practices and have little experience in the management system; and 3) under Circumvent, professionals reject management practices by giving superiority to the existing one in national professional systems (p.774). This typology is basically compatible with Numerato et al.'s (2012) one, with Circumvent being clearly defined as an indirect form of professional resistance and Co-Option as an indirect form of management encroachment.

While the term Adaptation here is not equal to Strategic Adaptation in Numerato et al.'s (2012) power continuum and is placed further far away from the end of professional resistance, they actually have the same connotation that forms and content of regulative regimes are proactively channelled by the medical professionals. Indeed, In Waring's earlier work (2007), all those three strategies fall under the category of Adaptive

Regulation where "management techniques are co-opted into professional work as a form of resistance, with professionals becoming competent in management" (Waring and Currie, 2009, p.774). This understanding of adaptation is rather akin to Strategic Adaptation which is near to the end of professional resistance in the hegemony/resistance continuum.

However, it is also stressed that Adaptive Regulation is a two-way street of managerial and professional influences, potentially fostering professional compliance to managerial intent under the soft bureaucracy that gives an impression of autonomy (p.775):

> As professionals internalize management techniques in an endeavour to stave off management encroachment, they become increasingly managerial in terms of their practice and identity - the implication being that it negates the need for top-down management controls over professionals, as it foster conformity from within professional work.

The implication is that "adaptation" is rather a vague concept that can be specifically defined as a "strategic" one and another one that is in a more enthusiastic or unquestioned manner. Here the usage of "adaptation" is not different from *hybrid* that denotes a wide range of intermediate accounts of management/profession mix.

Table 1 (see below) summarizes the major conceptualizations of the management/ profession mix in healthcare offered by researchers. Against the background of NPM reforms and resilience of medical power, researchers conceptualize a broad range of intermediate accounts in-between the absolute dominance of either management or profession. As abovementioned, Doolin (2001) and Levay and Waks (2009) argue that such mix should be conceptualized as "loose coupling" systems or "soft autonomy" that favours professionals; Sheaff et al. (2004) and Harrison (2009) argue that it is rather management-led as a "co-optation of bio-medical model by management" and "flexible corporatism" that runs in a logic of "soft bureaucracy". In the hegemony/resistance continuum, these two intermediate forms of management/ profession mix are termed as Co-optation and Strategic Adaptation. The negotiated position in-between is best conceptualized as "organizing/ managed professionalism" (Noordegraaf, 2015) and "adaptive regulation" (Waring 2007; Waring & Currie, 2009).

Table 1   Typologies of management/profession combination in healthcare governance

Studies/Power centre	Management				Profession
Numerato et al. (2012)	Hegemony	Co-optation	Negotiation	Strategic Adaptation	Resistance
Doolin (2001)				Loose coupling	
Sheaff et al. (2004)		Flexible Corporatism			
Harrison (2009)		Co-option			
Levay and Waks (2009)				Soft autonomy	
Noordegraaf (2007;2015)	Controlled		Organizing / managed		Purified
Waring and Currie (2009)	Compliance	Co-option	Adaptation	Circumvent	Resistance

4.3.3. Clarifying the "negotiation" position and the "subjectivity" issue

While the ideal types of Co-optation and Strategic Adaptation are discussed in detail in Numerato et al.'s (2012) notion of power continuum, Negotiation is relatively ambiguous. As they suggest, all the five ideal types in the power continuum are only the theoretical possibilities for conceptualization (p.628). In reality, the Negotiation position, as well as the two extremes cases of managerial and professional dominance, may not exist; and the actual situation probably falls in certain kind of Co-optation or Circumvent/Strategic Adaptation. As Noordegraaf (2015, p.16) also admits, the speculative account of organizing professionalism, i.e. valuing both quality and efficiency perhaps, may only be a normative account (what "should" be done to be an "organizing" form of professionalism beyond the management/profession conflict) rather than a descriptive one (an existing model). In addition, there are two specific problems in giving Negotiation a conceptually crystallized definition.

Firstly, the enrolment of physicians into management is not an exclusive definition for Negotiation because Co-optation and Strategic Adaptation may also involve hybrid managers. Strategic adaptation is defined by the local control over evaluation criteria and content by professionals as "soft autonomy"; Co-optation is also referred as managerial ideologies and being incorporated by physician managers in the self-surveillance regime of "soft-bureaucracy".

Secondly, the hybridization of professional and organizational values may also occur in Co-optation and Strategic Adaptation". Numerato et al. (2012, pp.630-631) argue that the "continuity of an imaginary axis delineated by the hegemony⁄resistance framework" and "the nature of ideal-typical categories" can be well captured by Waring's (2007) definition of "adaptive regulation" of medicine as (p.176):

> In being adaptive and seeking to limit managerial involvement, doctors are seemingly re-articulating what it means to self-regulate, absorbing managerial assumptions and recreating themselves as the managers.

However, while "soft autonomy" emphasizes the professionals' local control over evaluation criteria and content, it is also defined by the professional leader's acceptance to the needs of medicine to be regulated. Also, the concept of "soft bureaucracy" itself is to denote a self-surveillance regime in which managers regulate themselves by absorbing managerial assumptions. One could equally argue that this form of "professional rationalizers" (Checkland, Harrison and Coleman, 2009), as opposed to "professional monopolisers" and "cooperate rationalizers" (Alford, 1975), is even closer to the idea of governmentality and soft bureaucracy where the objects of surveillance internalize and justify it as self-discipline. Therefore, simply define Negotiation as the medical professionals' openness to managerial ideas or a collaborative relation with management may offer little clarification for its distinction from Co-optation and Strategic Adaptation.

Perhaps Waring's (2007) definition of Adaptive Regulation as "by doctors" and "for doctors" can help crystalize the conceptual difference between those ideal types. Following the abovementioned quotation, Waring indeed goes on to interpret another scenario of professional resistance (p.176):

> It remains important, however, to consider the limitations of this interpretation and to recognise that the extent of self-surveillance and governmentality maybe overstated or partial in nature. It may well be the case that, rather than internalising this discourse, doctors are in fact "going through the motions" of taking up these new procedures in an effort to resist regulatory change.

Obviously, Waring has noticed an important issue of *subjectivity* in the uncertain outcomes of hybridization of management and medicine. In the first half of the statement, the process of professionals' "recreating themselves as the managers" or internalizing the managerial discourse involves their "re-articulating what it means to self-regulate"

and "absorbing managerial assumptions"; while in the second half, another possibility of "going through the motions" is also a physiological process that involves professional leaders' intentions. As Levay and Waks (2009) also define, "soft autonomy" is "driven by an interest in legitimizing and developing professional work" (p. 509). It is in the same way defined with the intention of professional leaders to pursue certain outcomes. In this connection, Co-optation and Strategic Adaptation are both "by doctors". The only difference is how well they are "for doctors".

If the question whether the professional leaders are governmentalized or strategically adaptive to change (by loose coupling or active channelling) must be examined with the subjective interpretation of their own actions, how can we define Negotiation as part of the "continuity of an imaginary axis", situated between Co-optation and Strategic adaptation? If Negotiation cannot simply be defined with physicians' enrolment into management ("by doctors"), then what is the subjective dimension ("for doctors" or not) of their position as Negotiation?

In this connection, we may have to explore the *identity* issue of hybrid managers in the negotiation between management and professional interests/ agenda with the conceptual tool of subjectivity. Should such alternative identity exist, hybrid managers are able to act independently from their management and professional identities. Specifically, they 1) keep a psychological distance to *both* the management and professional identities and 2) aim at rationalizing *both* management and profession. In Noorgraff's (2007) terms, that is to form a social category/class as "reflexive practitioners". If the notion of "adaptation" refers to a locus of change that is neither top-down nor bottom-up as Waring and Currie (2009) suggest, then changes should be manipulated by this group of pivotal players who act independently from neither the top nor bottom. Although we can identify the Negotiation position with relatively objective criteria, i.e. balance between management and profession interest/power/agenda in a particular setting of policy/procedure/structure, an independent identity is the prerequisite for its existence.

Taken together, identification of the three possible hybrid identities, namely *co-opted* (managerial), *strategically-adaptive* (professional) and *negotiating* will be an indispensable part of researching physician managers. With special attention to the ambiguousness of the negotiation position, the next section will also attempt to search for feasible criteria to define it in previous studies on the identity issue of physician managers.

4.4. Operationalization of hybrid identities

4.4.1. Scoping review

To further inform our research design regarding the three possible hybrid identities of physician managers, this section attempts to systematically review the previous studies relevant to the concepts of *hybridity* and *identity*. Our own review first narrowed down the scope of search to all peer reviewed articles related to physician managers written in English. We searched the terms *physician manager*, *clinician manager*, *medically qualified manager* and *medical manager* in the electronic data bases of ProQuest Applied Social Sciences Index and Abstracts (ASSIA) and Scopus and Web of Science. A total of 14,539 articles (including duplications) were found in this pool of literature (see Appendix Six). With the research focus of hybrid identities, we further searched the terms *hybrid* and *identity* and got 433 articles (including duplications) for the next round of abstract screening (see Appendix Seven). Finally, there were 14 articles selected for full-text review based on three inclusion criteria. They are: 1) empirical studies on physician managers, 2) relating to identity work or hybridity, and 3) relating to the theme of professionalism versus managerialism (see Appendix Eight).

The characteristics of selected studies are listed in Appendix Nine. Most of them (12 out of 14) are published in 2000 or later. Six studies are conducted in the UK; three in Norway; two in Australia; two in the US; and one in Ireland. Only two studies are questionnaire surveys using random sampling; twelve are qualitative semi-structured interviews using purposive sampling to get a small number (approximately 30) of key informants. In those twelve studies, five further employ the method of field observation or document review to supplement interview. The most common roles of physician managers are department-level managers /consultants, and medical/ clinical directors who are responsible for more than one department. A few of selected studies also include section-level first line supervisors or board-level managers. Noticeably, while nine studies focus solely on physician managers, the other five studies include other personnel into their sample as well, such as physicians without management duties, nurses, allied healthcare professionals and managers without medical qualification. For the time frame of study, there are five studies collecting data in different phases to evaluate the impacts of certain reform or policy on physician managers (usually before and after). The lengths of those studies vary from six months to five years; the other nine studies that are one-

off survey or one-phase designed interview/observation, usually finished in 3 to 15 months (with an exception of 5 years).

Analyses of the findings are presented in the main theme of the operationalization of physician managers' hybrid identities. In those 14 studies, managerial and professional identities are conceptualized and measured in different ways. In this regard, the aim of this section is to give a comprehensive summary of those conceptualization and measurement, and to create our own indicators and theme of analysis informed by it.

4.4.2. Managerial acculturation overwhelming professional identities

There are three studies presenting a picture of managerial acculturation of physician managers that overwhelmed their professional identities.

Using quantitative method, Martinussen and Magnussen (2011) measure physician acceptance to managerial identity with how they viewed the effects of the reform in the Norwegian public hospital system. Since 1997, there have been three reforms in Norway that could be labelled as NPM: first, the introduction of (partly) activity-based financing in 1997; second, the introduction of the free choice of hospitals in 2001; and third, the recentralization of hospital ownership from the counties to the state in 2002. Based on a random sample of 1,200 hospital physicians drawn down from the register of medical practitioners, the authors use questionnaire survey to collect respondents' answers to four questions related to effects of the reform in a 5-point Likert scale. The first question is about how physicians perceived the reform's overall impact on the hospitals ("Overall, did the hospital reform mainly have negative or positive results for the hospitals?"; 1= *very negative*, 5 = *very positive*). The second to fourth questions are about whether they believed that the reform has led to "more equal access to health services"; "better medical quality", and "increased hospital productivity" ("To what extent do you feel that these goals have been realised?"; 1= *moved substantially away from the goal*, 5 = *moved substantially closer to the goal*). Against the background of a generally critical attitude to the reform among physicians (almost 50 per cent viewed the reform as having had "very negative" or "negative" effects for the hospitals; 38 per cent viewed the reform as having failed to achieve better medical quality and 54 per cent reported that no change has taken place), individual physicians who were involved in management work reported a statistically higher acceptance to management identity.

Three explanatory variables are identified. The first one is *"being department chief physician/ clinic"*. Respondents with managerial responsibilities were significantly more positive than others to the reforms. This correlation suggests that managerial positions typically reflected a greater degree of responsibility and benefits, associated with higher loyalty to the organization and greater identification with its goals and values. The second is *"the amount of time allocated to direct patient-related work during an average week"*. Independent of physicians' position in the hospital organization, those who had less affiliation to clinic and patients rated the reforms higher than those who were working closer to the patients. This correlation suggests that involvement in management work had an impact on physician's professional identity. The third one is *"the percentage of department leaders with medical backgrounds"* at the hospital-level. Physicians whose department were more dominated by physician-managers were more positive in their assessments on the reforms. This correlation suggests that those co-opted managers had the capacity to buy-in their professional peers.

Also in a Norwegian setting, Mo (2008) employs qualitative method interviewing 10 department managers in a large teaching university to understand their perceptions of management, professional practice, new roles and identities. Specifically, they ask those department managers to describe their new practice in relation to existing institutional boundaries (their professional background and managerial function), and how they have chosen to perform within a new regime, based on how they interpret the manager role in their context. They reported *"an extension of managerial scope in physician managers' identity"* and *"a strategic use of their affiliation to clinic"*.

Firstly, managers saw themselves as responsible for the department as a totality, including personnel administrative responsibility for all professional groups. They described a change in perspective and an opportunity to change practice, e.g. to relate to the nurses much more than before. Regarding their responsibility for strategic planning, they faced the conflicts between the professional goals/norms of expert groups and the narrowly defined organizational goals pursued by management. Taking treatment options in the department as an example, while the urge to developing one's professional field could be strong, daily activities related to well-known diagnoses did not have the same professional appeal. As a result, they had to balance professional development and treatment of patients in the department.

Secondly, affiliation to clinic is found to be central to physician manager's identity work. They had to keep their clinical engagement as authority in a medical setting would have to be maintained through a clinical affiliation, such as being present when medical matters were discussed, participating in morning meetings, going rounds or taking on late night shifts, consciously doing certain procedures or operating techniques to maintain specific technical skills, being on-call, and doing extra work when needed. They were also aware that colleagues could give negative comments if they "chose to be in the wrong place", to attend administrative meeting rather than working in the clinic. In this light, they constructed management as someone who was "elsewhere", doing other things than department managers, and who did not understand the department, in contrast to themselves as managers being part of the department and belonging there. Moreover, affiliation to the clinic is negotiable. It could be postponed (being manager for a limited time period), reduced (being in the clinic on and off) or re-shaped (being present at meetings, participating in discussions, etc.). In this connection, it was rather a symbol of belonging in a strategic use than a wholehearted commitment. This actual relinquishment of physician manager' clinical commitment and affiliation is consistent with Martinussen and Magnussen's findings above-mentioned.

Focusing on the facilitators and barriers encountered along the way physician managers moving into a management role, Ham at el. (2011) interview 22 medical chief executives in the UK HNS. Interviewees expressed certain level of *"compromise of clinical commitment"* and *"re-definition of their professional identities"*.

Firstly, the transition from senior medical leadership roles to chief executive led most interviewees to relinquish clinical work. Consistent with Mo's findings, some physician managers had a reduced level of clinical work to retain credibility among clinical colleagues and maintain the stimulation of seeing patients. Moreover, to avoid the perception of being merely keen amateurs, and given the risk of being seen to be partisan, some physician managers in this study suggested that it was not appropriate to continue practice in their own specialty. They also saw the management role as opportunities and challenges that brought about organizational and service improvements on a bigger scale than they could in clinical work.

Secondly, while some interviewees continued to see themselves as "first and foremost doctors who were also chief executives", others redefined themselves as "a general manager first and a doctor second". The former described a sense of loss, "going over to

the dark side" and "leaving the professional family"; the latter, however, felt they were well placed to overcome the tribalism in the NHS because they were able to bridge the worlds of management and medicine. Ham et al. suggest that a more common response for interviewees was to describe themselves as leaders who combined clinical and managerial experience taking on a dual identity. Yet, the authors do not explain in detail about such dual identity. Considering the impacts of managerial acculturation on physician managers' self-definition, their findings can be taken as foreseeing a more robust management identity.

4.4.3. Professional identities overwhelming managerial acculturation

On the contrary, there are six studies presenting a picture of professional identities overwhelming managerial acculturation.

Similar to Ham et al., the study of 13 physician managers in the Norwegian public hospital system by Spehar, Frich, and Kjekshus (2015) identify a moderate view on being managers as "ambivalent" between the other two views they call "positive" and "negative".

The *"positive"* group spoke of themselves as "managers first and doctors second". They expressed the enjoyment of being able to plan their own workdays and influencing decisions as a key factor in sustaining their management position. They saw increased responsibility and an ability to see the larger picture, e.g. length of stay. They also used the word "fun" to describe their work and stated that management had become more fun as they had gained more experience and become more competent in management.

The *"negative"* group spoke of themselves as "doctor first and manager second". They were frustrated with the managerial role, experiencing little freedom in how they could enact the role, because of a high amount of administrative work and a lack of support staff. They also spoke of the managerial role as a form of extension of their professional identity, serving as a means to protect or promote their professional sub-discipline.

The *"ambivalent"* group found enjoyment in influencing decisions but also spoke of a desire to be closer to the staff and to reduce the amount of administrative work. They expressed a sense of being lonely or left in the managerial role, having few social arenas for meeting other clinical managers. They considered activities in which they had less

experience and competence, such as finance, as a less rewarding part of their role; while clinical and academic activities were perceived as more interesting. This group of physician held a moderate stand but was far from being "reflexive practitioners" as an independent social category. Neither the authors of this study nor Ham et al. can identify a distinctive group of physician managers holding an independent *negotiating identity* that aimed to rationalize both management and profession.

Focusing on healthcare professionals' difficulties in reconciling their professional role with the role as manager, Spehar, Frich, and Kjekshus (2015) also reveal the prominence of the medical identity. Physicians in general expressed a sense of loss in relation to the termination of their clinical commitments and a sense of disillusionment as they took up the role as "not to let the others down" (or just did not want to impose the role on the others). In this connection they often expected to use more time on clinical activities than on administrative tasks when they became a manager. Administrative work was usually described as "boring" and something that interfered with their attempts at being good leaders. They would have liked to be more visible and engage in more small talk with their staff. In relation to their peers, they saw professional background as personal assets in their role as managers and expressed a sense of pride related to their professional background. They also mentioned the need to demonstrate clinical competence in meetings with staff to maintain legitimacy, as well as a sense of meaning and satisfaction.

Another attempt to understand the effects of physician managers' dual role in healthcare organizations is Kippist and Fitzgerald's (2009) study on a clinical leadership development program in a large teaching hospital in Australia. They find two distinctive attitudes towards management role among physician managers who participated in the program. On one hand, the role of the hybrid clinician manager was attractive to some clinicians as it allows them more autonomy, decreasing their clinical workload and having a broader range of tasks and responsibilities in the health care organization. They also identified the need for assistance with staff issues and increased performance management knowledge and skills. On the other hand, not all hybrid physician managers see management training or education as important. They did not they see themselves as an organizational leader, nor desired to taking on full time management roles. Time to devote to management education or training is not the only challenge. Many of them had to juggle several roles as they did not wish to be seen as a "traitor" by their medical peers.

As managerial responsibility increases, more conflicts and frustrations arose with the lack of autonomy and little control over their budget.

However, when the recruitment process and organizational conflicts among physician and managers are further looked into, the representativeness of those proactive physician managers is doubtful. The authors suggest that most of them did not take on a dual role as an attractive role or as part of their career path. Rather, they took the role reluctantly to prevent someone else from getting the role. The lack of succession planning and recruitment process for the role further supported that the hybrid role was not part of a physician's career development. Interestingly, there was no evidence of the human resources department being involved in the recruitment of the physician managers in this department. So physicians could select who they wanted for the role; and the lack of job descriptions allowed freedom in the role as incumbents saw fit. Organizational-professional conflicts sometimes resulted in one hybrid manager going off management meeting under the banner of to do some "real work" of direct patient care. This statement indicated that clinicians who took on managerial roles saw their clinical role as their profession and legitimate career. In this connection, the dual role of physician managers seemed not effective in bridging the two worlds of management and profession.

In an Institutionalist perspective, the resistance of local professional leaders can be interpreted as "loose decoupling". In Doolin's (2001) study on the reform of an Australia Crown Health Enterprise (public hospital) that enrolled doctors into management, the majority of unit directors were found as reluctant managers and maintaining their day-to-day professional practice unchanged despite evidences of managerial acculturation of senior physicians.

"Managerial acculturation of unit directors" is identified by their open mind, a high degree of cost-consciousness and the opinion that the reform was fundamental and likely to persist. Senior directors exhibited an interest in management and found the new roles challenging. They deliberately developed more managerial skills and knowledge, including formal management education, e.g. MBA degrees. Working closely with managers, they reframed clinical issues in economic terms using management tools such as budgets and contracts. Those proactive physician managers acted as carriers or translators of market and managerial values into the medical culture, with some of them becoming spokespersons for the new strategy. The reform therefore provided a vehicle for subjecting professionals to managerial parameters such as budgets.

Conversely, from the physician' point of view, the involvement of senior clinicians in the management of clinical units offered a way to protect their clinical freedom. Firstly, physicians held *"generally poor opinion of managers and management"* as something separate from medicine, and that becoming a manager would involve a rejection of their professional identity. In addition, managers were seen poorly qualified and that management was just common sense or easily learnt, contrasted with the medical profession, academic qualifications, research and publications that are academically oriented and highly valued. Also, they felt that management of clinical practice ought to be in the hands of clinicians, i.e. control by unit directors. The part-time nature of the unit director role, which enabled unit directors at the hospital to continue with their clinical practice and maintained credibility with or acceptance by their peers, in addition created the perception of the superiority of medicine over management. Secondly, such devaluation of management constrained the roles of unit directors in relation to their peers. Most of them were found to be *"reluctant managers"*. They did not define themselves in the role of clinician manager in the clinical leadership strategy. Often they did not want to take on the role but were "drawing the short straw", nominated by colleagues to be the consultant team's representative or spokesperson. Such collegiality created their difficulties in managing clinical colleagues or "to be too bossy". In action, they diverted the role defined for unit directors by adopting a coordinating role in their dealings with their colleagues and operating the clinical unit as self-managed work groups on collegial and clan basis. As a result, decision making remained firmly within the team of consultants, and the director acted more as the unit's titular head working on consensus. While shifts in identity of the physician managers were taking place, their primary socialization remained in their professional clinical role. These physicians were not being transformed into surrogate general managers. Although they acquired attributes of management practice and discourse, these attributes were constrained by their traditional medical ethos.

Taken all these evidences together, while some senior clinicians who became unit directors increased their participation in management practices and discourse, other unit directors were just performing a less active, but necessary, legitimating function within the new organizational structure. The author therefore argues that the hospital studied was "loosely coupled systems". Within their clinical units, decision making remained group-based and consensus-oriented in the traditional collegial mode. Many of the unit directors acted as a buffer between their medical colleagues and the demands placed on

them by management, so that the actual internal operations of the unit remained separated from the formal unit structure. Some senior consultants suggested that the changes associated with the health care reforms had little impact on their day-to-day professional practice. The lack of perceived benefits of organizational changes in patient care strengthened the tendency for clinicians to remain decoupled.

The notion that the collective autonomy of physicians is shielded by the majority of hybrid managers finds some further support from a study by Spyridonidis, Hendy and Barlow (2015). With special attention to cognitive and social dynamics that occur as a result of the emergence of physician manager roles, they collect data on 62 physicians who had taken on manager role in the UK NHS Collaborations for Leadership in Applied Health Research and Care (CLAHRC) in two phases. Core questions in the first phase include: the nature of physician managers' involvement with the CLAHRC; their relationship with the CLAHRC programme; their understanding of its aims and objectives; their own professional role within the programme; and their understanding of what it meant to be an effective professional in the CLAHRC. The second phase then captures how they made sense of their developing role and any shifts in the themes identified in the first phase. The authors find that physician managers' identity can be categorised as "Innovators" and "Sceptics", and also "The late majority" who were initially resistant but gradually became reconciled to their new role as manager after CLAHRC introduced a strategy that emphasized the importance of clinical leadership.

"Innovators" emphasized the positive elements of their CLAHRC role. They embraced new techniques to facilitate quality improvement, believing that by embracing CLAHRC's managerial tasks of knowledge translation they could enhance the quality and safety of their own team's clinical practices. Systematically taking on more responsibility under the banner of service improvement, they saw their new organizational identity as a service improvement manager a potential avenue to enhance their professional identity and their organizational status and legitimacy. In this sense, they were trying to minimize the potential conflict between physician and manager identities by building an alignment between evidence-based medicine and the service improvement approach of CLAHRC.

"Sceptics" never fully engaged with the CLAHRC. They balanced their clinical interests with a conditional acceptance of CLAHRC's approach. They mentioned that the loss of their historical autonomy in setting priorities and targets was the key constraint to

engagement, and expressed how CLAHRC sought to reconfigure authoritative control through external regulation on physicians. This reveals their desire to maintain control and autonomy over their work, centring on the formation of their own rules of governance. Differentiating between CLAHRC and their beliefs, they emphasized that they could not understand the CLAHRC tools and could not find enough time to engage with them, and even distanced from the CLAHRC work that they felt was inappropriate. In this way they sought to construct a role that was as close as possible to their existing one with limited engagement with the CLAHRC.

"The late majority" also emphasized the negative sides of a physician manager identity. They saw the new organizational structure as a constraint on their professional discretion and autonomy, and felt that their physician role was devalued and their clinical competence was not appreciated. They also maintained boundaries between themselves and the CLAHRC, to the extent of talking about "them" and "us". Responding to the resistance, senior physician managers at the hospital level attuned the program to a more professional-led one that emphasized "clinical leadership" and gave some degree flexibility within the new role. As a result, the majority of physician managers 1) delegated management activities that are less compatible with their physician identity to other project members, 2) give away any part in the new role they saw as robbing their recognition to the identification as hybrid managers, and 3) ultimately decides whether to enact this role individually. The authors argue that this does not only reflect the organizational leadership of senior physician managers to buy-in their more junior colleagues, but also the resilience of the medical identities. While the majority of physician mangers perceived themselves as holding a hybrid role, they prioritized physician clinical discretion ensuring that their engagement in management was maintained in a manner compatible with being a physician.

Russell et al.'s (2010) study on the social identity of hospital consultants resonates to those findings on the general negative attitudes among physician managers towards management role. They interview 15 consultants in Irish public hospitals holding appointments in health boards, management and academic positions with the following questions: 1) their perceptions about their position in society, 2) their salient targets of social identification for hospital consultants, and 3) the extent which they view management and management roles as a potential target for social identification. All interviewees perceived public attitudes towards hospital consultants as a group to be

negative, and were generally involved in management with little enthusiasm and considerable caution.

Firstly, consultants' perceptions on their position in society are negative. All interviewees perceived public attitudes towards hospital consultants as a group as unsympathetic and often hostile, although patients' attitudes at the one-to-one level were perceived as generally positive. Linked to their personal discomfort with this negative stereotype, their own perceptions were as powerless to influence change in the wider system. Some distanced themselves as individuals from the characterisation of hospital consultants as primarily motivated by the financial rewards of private practice.

Secondly, consultants' salient targets for social identification most derived from sense of belonging from group membership within their immediate work area (department). It was based on a shared purpose, on experiences of personal efficacy and of interdependency with other in achieving consultants' clinical goals. In contrast, identification with larger organization is not evident, i.e., consultants conveyed a sense of detachment, ambiguity and confusion in describing their relationship with their employer members of the group - not an employee of the broad. In this connection, they also expressed a sense of being removed from the more strategic elements of healthcare delivery.

Thirdly, management as a salient target for social group identification was perceived as unattractive and associated with powerlessness and lack of respect. Most hospital consultants regarded the prospect of greater involvement in management with little enthusiasm and considerable caution. Fears of associated loss of autonomy, diminished recognition and esteem were commonly expressed, while the alternative options of clinical work and academic activities were seen as offering more status and recognition. In addition, consultants regarded 1) freedom from external financial pressure in the area of clinical decisions and 2) the principle that do not report to each other in a hierarchical manner as preconditions to their acceptance of formal management roles.

In a different approach, Hoff's (2000) US-based survey confirms that physician managers' social identity is largely and stably professionally oriented. 294 respondents from the American College of Physician Executives (ACPE) were asked to answer a set of statements including their professional commitment, belief in individual physician autonomy and collective self-regulation, in a seven-point scale ranging from strongly

disagree to strongly agree: *"Professional commitment"* (the extent to which physician executives identified with and were attached to the medical profession); *"Belief in individual physician autonomy"* (to the extent to which physician executives believed that individual physicians shall have a high degree of discretion in their clinical work); *"Belief in collective self-regulation"* (to the extent to which physician executives believed in the exclusive right of the medical profession, as opposed to an external entity, to regulate collective norms and behaviors).

"Professional commitment" was the strongest belief held by respondents in the study (mean = 5.14, S.D. = 1.05). This finding supports the idea that physician executives remained oriented to professional interests. Contrary to the assumed correlation between management commitment and the seniority in management post, it is also found that physician executives increasingly saw themselves as a doctor over time across management career stages. However, for those physician executives who perceived erosion in their clinical skills, intensive involvement in management work would undermined their professional loyalty.

Noticeably, compared to "professional commitment", physician executives on average held weaker beliefs in the traditional value of "individual autonomy" (mean = 3.27; S.D. = 1.18). At the same time, the traditional value of "self-regulation" remained strong (mean = 4.63; S.D. = 1.52). These findings suggest that physician managers accepted the managerial idea of accountability in medical work but insisted their control over its process to preserve self-regulation in a collective form.

Moreover, physician executives' belief in collective self-regulation was positively correlated (r = 0.161, p < 0.01) to their professional commitment after controlling other factors. It can be argued that physician executives experienced greater professional commitment to the extent that they believe in the exclusive right of the profession to police itself. This further confirms the relevance of physician managers' identity work in the maintenance of professionalism.

4.4.4. Mixed outcomes and identity work

There are five studies presenting a rather uncertain picture of the power dynamics between management and profession. Instead of predicting the outcomes on the balance of power, those studies identify a hybrid identity of physician managers.

Fitzgerald's (1994) early work interviews 31 clinical directors/medical directors in a NHS health-care provider unit and find that they saw themselves as playing *a critical boundary role* between management and clinical professionals. Those directors presented a mixed perception of both management and collegiality. Firstly, although they perceived managers as not well qualified and management as easy to learn or relatively unsophisticated, they *realized areas of management* which were outward looking to the interfaces between the whole organization and its competitors, customers and suppliers. Secondly, while they suggested that issues of professional performance and professional standards should be addressed and handled by clinical managers, they saw themselves as separated or *isolated from clinical colleagues*. Whereas some were facing a degree of downright hostility from medical colleagues for employing management terms which are not understood, some commented on the importance of not exhibiting too much missionary zeal on management topics, as this would have a dysfunctional effect on some colleagues.

Such multiple occupational identities of physician managers are also reported in Spyridonidis and Calnan's (2011) study on the implementation of National Institute of Health and Clinical Excellence (NICE) guidelines in 2 PCTs and 2 NHS hospitals in the UK. Using two phases of face-to-face informal interview with 8 hospital consultants, 8 doctors and 12 other personnel, they collect data of 1) the events associated with the implementation of NICE guidelines, 2) the roles of doctors and managers, how they organised their work, the reactions of doctors and managers to these guidelines, and 3) consequences from NICE guidelines implementation. Three major themes emerged from the analysis on doctors' receptiveness to NICE guidelines implementation.

The first one is *"organizational values"*. It was found that senior physician mangers tended to be more receptive to performance-managing their peers. Whereas they emphasised that to have more doctors into management positions was a way of exercising professional influence, they also claimed that medical professionalism should be wider than treating patients effectively. They interpreted targets as a good and legitimate thing to do and the target-driven culture currently dominant in the NHS as an initiative that could deliver benefits to patients, although they might be used against their professional interests. In addition, they were receptive to the development of "strong vertical structures" that assured adherence to demands from government policy.

The second one is *"proactive professionalism"*. It is defined as the tendency for doctors to establish local flat professional networks with their peers that shared similar clinical interests. Led by the local experts, those networks enabled doctors to form their own rules of governance, influence the priorities of the local health service, and introduce alternative forms of organising at work. They showed more support for clinical guidelines such as those developed by professionals: guidelines produced by Royal Colleges were seen by doctors as more legitimate forms of knowledge, while NICE guidelines were considered implying a greater degree of centralised control over medical work. They portrayed medical work as being beneficial to patients and patient care as the primary aspects of their agenda. For example, in order to meet clinical needs, some doctors used their specialist knowledge to create clinical guidelines attracting funding from their Trusts for new care Patient Pathways.

The third one is the *"prominence of clinical autonomy"*. Consultants involved solely in clinical practice (without senior management posts at the hospital level) showed a degree of caution, reluctance to adhere to NICE guidelines. They deliberately strove to escape from the pervasive features of top-down driven performance control, and favoured individualised critical appraisal approaches that operated within social interactions with peers when necessary or desirable. In making medical judgments, they invoked moral reasons concerning particular circumstances of their patients, rather than performance management. In this way, they exercised clinical freedom with their discretion in the daily routine of the implementation, ignorance and non-compliance of NICE guidelines. Also, they showed low receptiveness to complying with management demands, and systematically avoided any attempts by management to standardise their labour process. Doctors' disengagement from and non-adherence to local implementation plans for guidelines was justified on the grounds of non-relevance (to the specialised knowledge of medicine) rather than resistance.

Spyridonidis and Calnan conclude that multiple occupational identities have emerged as a result of hybrid manager roles. While senior physician managers showed some managerial acculturation and acted to balance their peers' clinical interests, those who have more clinical commitments and affiliations tended to be more resistant to management demands. Interestingly, as a compromise, senior physician managers also delegated power to their local peers to control the local policy agenda as to mediate both the worlds of management and profession. This involved networks of social relationships

connecting physicians who were involved in developing local clinical guidelines to who were largely insulated from top-down driven governance structures to achieve shared clinical interests. The authors suggest that it may also be interpreted as the use of multiple occupational identities as a form of proactive professionalism, where the doctor is both clinician and entrepreneur.

The last three studies below present not only hybrid identity or uncertain outcomes of management/profession confrontation, but also offer their own typologies that focus on the identity work itself to capture the managerial and professional sides of the hybrid identity.

Forbes and Hallier (2006) offer a typology of "Reluctants" and "Investors" to capture how clinicians tackle and assign meaning to their new roles in middle management. They interview 18 clinical directors based at NHS acute hospitals in the west of Scotland in five core aspects: 1) the reasons for moving into management roles; 2) experiences of the transition from a clinical to an emerging management role; 3) expectations of the management role; 4) whether these expectations were met; and 5) conflicts and ambiguities associated with the move. Three strategies of self-enactment of physician managers were identified according to Social Identity Theory, namely "Individual Mobility", "Social Creativity" and "Social Competition".

"Reluctants" came into management not because of a desire to manage, but because they felt pushed into accepting the role for worries about being managed by someone they objected to (e.g. other medical specialities or non-physicians), or the need to defend their specialism in the wake of restructurings within their hospitals. They expressed a profound reluctance to be identified with management, a lack of commitment to the role, and a negative attitude towards management intrusions into the clinical arena. Accordingly, Reluctants felt no need to develop a "managerial self" and perceived that managerial duties were simply an additional burden tagged onto their clinical role.

"Investors", in contrast, came into management with a specific agenda and saw potential opportunities for influencing health service delivery, or as an escape from the pressures of clinical work. Some of this group also viewed themselves as transferring their qualities of leadership and innovation in clinical arenas to the managerial one, providing an opportunity to influence the delivery of health care. They saw management concepts as being easily acquired, whereas leadership and purpose were qualities intrinsic to a few.

A "managerial self" was developed even at the expense of their clinical role and enabled them to develop an explicit managerial agenda.

"Individual Mobility Strategy" was easily identified in the group of Reluctants. It was associated with a belief in the possibility of advancement through transferring to a higher status group. They disassociated themselves from the clinical group and were attracted to pursuing personal goals to improve their position; in identifying with management, they saw their role as one of contributing to the new group and living up to the norms of management. They saw their career advancement as coming from reinforcement with hospital management.

While it is suggested that Reluctants could use *"Social Creativity Strategy"* to continue management's perceived inferior status by certain psychological withdrawal from management imperatives, a more common case the authors observe is physician managers using *"Social Competition Strategy"* for self-protection where the management role itself was used as the means to challenge the legitimacy of management's authority. In case medical autonomy was increasingly threatened by management advances, the status of hospital doctors was perceived as declining and insecure. Physician managers' role dissatisfaction and opposition to the hospital management would take the forms of 1) hostility towards particular senior figures in the organization, and 2) exploiting weaknesses in the management system in order to distance themselves from aspects of their managerial duties. The latter includes: being unwilling to represent management interests neither to colleagues nor to hospital management; doing the bare minimum required in the management role, but in ways that still attempted to represent the local interests of patients, their specialisms and their clinical colleagues. Such selective approach to non-compliance was provided by the way that they chose to absent themselves from management activities because of clinical commitments. In doing so, they were also intended to signal to their clinical colleagues their desire to "return to the fold".

Hoff's study (1999) on 22 physician managers in an American MCO (Managed Care Organization) identify two vastly diverging portraits of the management role by physician managers as *"Profession-Compatible" (PC) and "Organization-Compatible" (OC)*. With special attention to how physician managers see themselves and others as managers, and what types of social relations are associated with these views, Hoff compares PC and OC in three dimensions: 1) attitudinal distinction, 2) belief and

orientation, and 3) strategy/ action. This offers a distinctive example of operationalizing the managerial and professional identities.

Firstly, *"attitudinal distinction"* among PC and OC is compared in 7 themes.

1) View of management role: PC saw themselves as "advocators and protectors"; while OC saw themselves as "supervisors and leaders". PC defined their role chiefly in terms of protecting and serving the interests of physicians employed in their immediate office setting, and was proud of being advocates for these physicians when dealing with the organization. They originally assumed the role to prevent someone "who would make their lives hell" from taking it. Also they expressed empathy for rank-and-file seeing them as overworking, increased alienated and unfairly targeted by recent HMO policies. In contrast, OC did not mind thinking of rank-and-file doctors as employees who they had to manage.

2) View of responsibilities: PC saw themselves as "communicators and doctors' lobbyists"; while OC saw themselves as "educators, salesmen and decision makers'. PC regularly voiced their opinions during management staff meetings about new policies complaining that the HMO was projecting problems onto physicians. They defined their responsibilities as keeping fellow clinicians fully aware of the MCO's attempts to exert greater control over medical work. Quite differently, OC believed that their primary management responsibilities were two-fold: to persuade physicians that change was necessary and to implement policies directed at that change. They were feeling bound to meet organizational expectations as well as to avoid the resentment and opposition from frontline colleagues. In this connection, they expressed an awareness of the risk of getting "caught in the middle" and were hesitant to act too authoritative, and mentioned the strategic importance of collegiality in running the department well.

3) View of management: PC held that management "should help practicing physicians but not dictate"; while OC saw it as "legitimate means of control over other doctors" - at management staff meetings, various members of the OC group consistently defended HMO policies as legitimate and necessary.

4) View of management work: PC described it as "boring", not what "real" doctors do with their time and believed that the practice of medicine was where they could contribute the most as physicians. They made it clear that they had

gone to medical school to be doctors and not managers, having little training for the job and less interest in doing it on more than just a token basis. In contrast, OC described management work as "challenging" and "an alternative to practicing medicine".

5) View of practising physicians: PC saw those physicians as "doing best they can" and "needed to be left alone to do jobs"; while OC saw them as "coddled, insulated and needed to wake up". PC argued that "practising physicians are not the problem in the organization" and "people in the trenches are sick of being micromanaged". Conversely, OC argued that rank-and-files were too protected from the reality of a healthcare environment that they saw everyday as managers. They had few sympathies for physicians of the bottom line who perceived new HMO policies as limiting professional autonomy. Some even criticized that what practising physicians were doing was more often in the best interests of physicians rather than patients' well-being.

6) Common verbiage: PC used "squeezed, remaining loyal and enduring headaches"; while OC used "buying in, credibility and being accountable". PC referred to their management responsibilities as headaches and "pains in the ass"; their language also reflected anxiety about being "sucked into" the role. On the other hand, OC were convinced that the rank-and-file needed to become more business-oriented in their work. They also believed that the rank-and-file needed formal guidance to "buy into" this view.

7) Goal/value alignment: PC showed loyalties to "doc in the trenches" and reflected scepticism toward management and the HMO. In contrast, OC's values and commitments were more multidimensional and management-oriented, aligned to the organization mostly. They saw themselves as "doing the job right" and "understanding the bigger picture" in relation to managed care, and reluctantly accepted the possible negative consequences of management reforms for physicians (i.e., layoffs, physician turnover, decreased clinical autonomy, etc.)

Table 2 Summary of attitudinal distinctions among physician managers

View/attitude	Organization-Compatible Group	Profession-Compatible
View of management role	Supervisor, leader	Advocate, protector
View of responsibilities	Educator, salesman, decision maker	Communications, doctors' lobbyist
View of management	Legitimate means of control over other doctors	Should help practicing doctors but not dictate
View of management work	Challenging, an alternative to practicing medicine	Boring, not what "real" doctors do with their time
View of practicing Physicians	Coddled, insulated, need to "wake up"	Doing best they can, need to be left alone to do jobs
Common verbiage	Buying in, credibility, being accountable	Squeezed, remaining loyal, enduring headaches
Goal/value alignment	The organization mostly	The doc in the trenches

Extracted from Hoff (1999, p.331)

Secondly, PC and OC have their respective *"beliefs and orientations"* promoting and reinforcing their physician manager identities.

PC stated that "those in full-time management positions are non-doctors" when asked about how they viewed who had largely given up practicing medicine for management. PC saw them as "administrators" in contrast to "providers", and even as "outsiders" and "traitors" to their profession as the deviants from their agreed norm (i.e., treat patients). PC also stated that "the only people who understand and can comment on my work are colleagues in the trenches with me every day" when were asked about whether they believed that only rank-and-file colleagues in their immediate work setting could exert control over their work. They believed that full-time physician-managers had no clue about the everyday life and thinking of the rank-and-file doctor, and talked to members of the OC group in full-time management positions as if the latter had never even seen the inside of an exam room. The final belief PC held was "I'm committed to my fellow clinicians". They expressed this localized solidarity when lecturing OC group members on what they perceived as "lies" propagated by the HMO.

OC stated that "going from medicine into management full-time is like 'crossing a point of no return'". At medical staff meetings, OC appeared speaking with rank-and-file physicians about various clinical issues at ease. However, in private they spoke of being "afraid of harming patients" and "having to learn things all over again" if they went back

to doing clinical work, left little choice but to pursue a full-time management career. In action, no one from this group gave up management work for patient care. OC also stated that "I'm committed to the organization" and "I'm committed to my management job" to the extent that they interpreted policies as correcting problems of the rank-and-file's work.

Table 3   Summary of beliefs and orientations of physician managers

Belief or Orientation	Expressed by
"Those in full-time management positions are 'non-doctors'"	PC
"The only people who understand and can comment on my work are colleagues in the trenches with me everyday"	PC
"I am committed to my fellow clinicians"	PC
Going from medicine into management full-time is like crossing a point of no return"	OC
"I am committed to my management job"	OC
"I am committed to the organization"	OC

Extracted from Hoff (1999:336)

Thirdly, PC and OC have different *"strategies/actions"* based on their respective identities. OC adopted three "strategies of manipulation" out of the belief that practicing physicians would naturally resist formal control over their work and thus control had to be exerted unobtrusively:

1) "Participatory Rituals" were used intentionally to legitimate the decision-making process in the eyes of rank-and-file physicians and PC group members. To convince those physicians that they could influence decisions already made at higher levels of the hierarchy, "going around the room" - framing a policy in vague and nonthreatening terms, then asking each physician at the meeting to give an opinion on it, such as personal feelings about the specific policy, venting concerns about its fairness in relation to practicing physicians - was a common form of this strategy. OC defended this approach as they believed the hospital would never get anything done if it was to be totally democratic.

2) "Rationality Strategies" involved using data selectively to convince physicians of the logic behind a particular policy or decision. OC only presented data with new policies when confident that the data strongly supported the policy. They filtered data before they were made available to physician-managers at lower-level meetings, on the basis of whether or not the data supported the particular

decision they wanted to make. Sometimes they asked PC at lower-level or rank-and-file physicians to provide data to support a different policy or approach, which are probably not available for the latter.

3) "No-Choice Appeals" was a reflex or last resort action through mimetic-type "sales pitches" that emphasized how other HMOs were doing the same thing, or through "coercive-type appeals" that stressed negative factors in the environment (such as increased competition) and presented specific policies as alternatives to worse actions that could be taken by the HMO toward rank-and-files.

On the other hand, PC adopted another three "strategies of resistance" out of the belief that the HMO was using physician managers as tools to gain greater control over rank-and-files, and it was not necessary to "play manager" in the meetings because their views were only being cosmetically sought:

1) "Tuning Out" took the forms of a) little or no note taking in management meetings, b) almost no questions asked about new policies, decisions, or issues except questions that challenged the organization with respect to its treatment of rank-and-file doctors, c) a general lack of interest and effort in discussing meeting agenda items from any kind of management perspective, and d) the disregard shown by the PC group towards any management duties that exercised formal authority over other physicians. An example of the last one was spending their allotted management time doing clinically related tasks, including updating patient charts, returning patient phone calls, following up on lab work and tests, and seeing additional patients, rather than the utilization, personnel, and productivity issues that were part of their management duties.

2) "Undermining the Data" involved one or more PC group members openly questioning the integrity or appropriateness of data used to support a specific policy. Instead of quickly buying into a specific policy, PC used data to undermine the policy by asking whether better information could be obtained to supplement existing data. In this way PC individuals claimed a normative basis for their behaviour using the same general approach in the debates of clinical policies and actions.

3) "Work Group Empathy" toward non-physicians in their local practice setting involved physician managers viewing nurses, physician assistants, and even receptionists as victims of management control. PC expressed a concern for how other employees were treated by the organization and included other employees with rank-and-file physicians into their discussion. Some saw non-physician administrators in their offices as allies against organizational intrusion on their clinical work, as long as physicians themselves are legitimate authority in their local practice setting.

Although more physician managers were found to be "organization-compatible" than "professional-compatible", Hoff reminds that the generalizability of this study is limited. More importantly, consistent with the findings of abovementioned studies, characteristics of those two groups were quite different. Members in the professional-compatible group were usually in first-line management positions practicing medicine for most of their weekly work time (50-100%), and had a shorter management tenure (4.37 years); while members in the organization-compatible group primarily were in the higher ranks of management spending little time with patients or practicing physicians (0-50%), and had a longer management tenure (8.5 years). Taken together with the struggles between those two groups observed in this study, social relation between physician managers were characterized by conflict, distrust, and game-playing, moving towards more communal notions of cohesion from the collective solidarity ideal implied by the professionalism model. In short, the homogeneity of physician managers as a social group is questionable.

Another breakthrough in typology is McGivern et al.'s (2015) study on 43 hybrid managers' professional identity work. They use comparable data from three of their previous studies on organizational changes in the English NHS, relating hybrids' identity work to managerialist institutional logics. Synthesizing the findings of many studies aforementioned, they offer a typology of "Incidental Hybrids" and "Willing Hybrids" to classify physician managers and a two-dimensional operationalization as "role claiming" and "role use".

"Incidental Hybrids" claimed their roles in three narratives.

1) "Passive professional obligation": they claimed to be volunteered by professional colleagues for hybrid roles and felt obligated to do a "turn". This

identity work downplayed agency and highlighted the maintenance of a professional social identity.

2) "Reactive professional obligation": they claimed to take a hybrid role to address departmental or wider organizational or managerial problems. They acknowledged the need to engage with management (hybrid roles) to maintain professionalism and buffer managerialism, which was a reality other professionals did not see.

3) "A senior professional representative": they saw themselves not taking a substantively managerial role. They asserted professional identity downplaying the managerial component of hybrid roles.

"Willing Hybrid", conversely, claimed their role in two other narratives.

1) "The fruition of formative identity work": it involved early hybrid role models, positive experience of management, and inter-professional working. They reconciled managing and professionalism as complementary, but recalibrated medical management as more interesting and difficult than medicine, positioning medical management as an elite professional subspecialty.

2) "A mid-career opportunity": they saw hybrid roles as providing a permanent career or autonomy to organize services. They looked for a promising career path more than clinical role. Taking on the corporate ethos, they distanced from clinical colleagues and were seen as "selling out".

In terms of *"role use"*, incidental and willing hybrids acted in quite different ways.

- "Representing and protecting professionals" vs. "transcending/disrupting professional boundaries": incidental hybrids buffered professionalism and good patient care (constructed individually) from managerialism. They also noted the importance of being seen to represent professionals to "get their support" rather than being seen as a "management nark". To improve patient care, however, willing hybrids reconstructed professionalism as involving inter-professional teamwork, focused on delivering "the best service" for patients collectively, as opposed to institutionalized mono-professional working focused on individual patients.

- "Using habitual interpretive agency" vs. "using practical/evaluative and projective interpretive agency": incidental hybrids valorised professionalism and demonized managerialism by glorifying past professionalism and drawing upon lessons from history to interpret the potentially disruptive effects of managerialism. Also, they enacted hybrid roles on a clinical basis, contrasting "jumping through hoops and fill in lots of forms" to "professionally appropriate ways of assessing your achievements". The latter was specified as "looking after patients within the constraints" and "trusting professionals while keeping a professional eye on them". Acting in "practical/evaluative and projective interpretive agency", willing hybrids however used their management role to challenge unrealistic and outdated professional mentalities and practices. Weighing up collective good against individual needs, they also questioned professionals who ignored resource limitations in providing public healthcare and acknowledged doctors' role in rationing healthcare.

- "Co-opting and loose-coupling managerialism" vs. "using/integrating professionalism and managerialism": incidental hybrids concealed and buffered ongoing professionalism by conducting appraisal "like a parallel universe" and putting a "professional spin" on it "translating professional speak into managerial". To loosely couple manageralism, they completed "tick box" paperwork to provide the impression of managerial regulation. In this way they created a "cocoon protecting the boundaries" where professionals were able to "get on and do their thing". For willing hybrids, managerial targets and patient care were positioned as complementary. On one hand, they believed the medical profession has got to be a lot cleverer about using politics to get where they want; on the other hand, professionals could use targets to benefit patients by improving professional work.

- "Influencing maintenance of professionalism" vs. "regulating and auditing professionalism". Engaging in managerial processes as "regulating/auditing work", willing hybrids challenged professional indeterminacy to discipline professionals resisting service improvements. They legitimized professionalism using organizational processes and calculative expertise to discipline poor professional practice. Such hybrids' roles as gatekeepers of professional

indeterminacy were believed to provide significant professional influence in relation to the quality of care.

- "Validating professional identity from professional colleagues" vs. "validating a permanent hybrid identity"; "maintaining flat intra-professional relations" vs. "positioning hybrid as an elite within their profession": incidental hybrids saw themselves as "a professional temporarily in a hybrid role engaging with management by necessity", and interacted with their peers in institutionalized modes of professional communication, i.e., informal chats in corridors. Willing hybrids developed a permanent hybrid identity that distanced from rank-and-file doctors. Unapologetically describing their role in managerial and remarking that the management post "looks like the career path", they developed an identity work which was more individual-oriented than towards the professional social identity. As a result, incidental hybrids' were seen by professionals as a professional; willing hybrid were seen by professionals as a hybrid or sometimes a manager.

Taken together, incidental hybrids' maintenance of professionalism was an endogenous institutional work, while willing hybrids' identity involved professional hybridization aligning professionalism with managerial organizational and policy contexts which was exogenous. Noticeably, being in increasingly senior hybrid roles was correlated to more managerial hybrids' identities as incidental hybrids were often in Clinical Director or PEC Chair roles and willing hybrids in Medical, Network, or Public Health Director roles. Yet, the authors argue that many hybrids in Clinical Director roles actually chose not to advance in their careers as hybrids in order to avoid losing their professional identity. Therefore, the underlying driver for claiming senior hybrid roles was identity work that cultivated a hybrid self in the first place.

The authors go on to conclude that, physician managers drew on professional and managerial institutional logics as part of their identity work, and this reversely affected professionalism. Such understanding of the interrelation between institutions and micro-level identities does not see hybrids as a homogeneous group affecting professionalism and public organizations uniformly. Rather, the authors argue that the impact of managerialism/regulation on public services is largely depended on the extent to which they were enacted in practice or loosely coupled as a result of hybrids' identity work in the local setting.

Table 4   Typology and operationalization of hybrid identities of physician managers by McGivern et al. (2015)

	Incidental Hybrids	Willing Hybrids
Roles	Clinical Director; PEC Chair.	(Associate) Medical Director; Public Health Director; Network Director.
Role claim	Passive professional obligation to take a "turn" in a hybrid role at professional colleagues' request	The fruition of formative identity work, involving early hybrid role models, positive experience of management, and inter-professional working
	Reactive professional obligation to take a hybrid role to address departmental or wider organizational or managerial problems	
	A senior professional representative (not a substantively managerial role)	A mid-career opportunity providing a permanent career or autonomy to organize services
Role use	Representing and protecting professionals, professionalism and good patient care (constructed individually) from managerialism	Transcending/disrupting professional boundaries to improve patient care (constructed collectively)
	Using habitual interpretive agency to valorize professionalism and demonize managerialism.	Using practical/evaluative and projective interpretive agency to influence and challenge unrealistic and outdated professional mentalities and practices
	Co-opting and loose-coupling managerialism to conceal and buffer ongoing professionalism	Using/integrating professionalism and managerialism.
	Influence maintenance of professionalism using institutionalized modes of professional communication	Regulating and auditing professionalism, challenging indeterminacy and poor professional practice.
	Validation of hybrid role use and professional identity from professional colleagues	Experiences in hybrid roles validate a permanent hybrid identity
	Maintaining flat intra-professional relations	Positioning hybrid as an elite within their profession

Extracted from McGivern et al. (2015, p.420)

Table 5   Summary of findings on the operationalization of managerial and professional identities (without clear focus on typology)

	Managerial	Professional
Mo (2008)	• extension of managerial scope in physician managers' identity • strategic use of their affiliation to clinic	
Kippist and Fitzgerald (2009)	• for more autonomy and less clinical workload • a broader range of tasks and responsibilities	• did not they see themselves as an organizational leader, nor desired to taking on full time management roles • juggled several roles as they did not wish to be seen as a "traitor" by their medical peers • took the role reluctantly to prevent someone else from getting the role • saw direct patient care as "real work" and clinical role as their profession and legitimate career
Hoff's (2000)	• moderate belief in individual physician autonomy	• strong profession commitment • strong belief in collective self-regulation
Fitzgerald (1994)	• realized areas of management which were outward looking to the interfaces between the whole organization and its competitors, customers and suppliers • separated or isolated from clinical colleagues	• issues of professional performance and professional standards should be addressed and handled by clinical managers • managers as not well qualified and management as easy to learn or relatively unsophisticated
Russell et al. (2010)		• self-perceptions on their position in society were negative • sense of belonging from group membership within their immediate work area (department); detached from the larger organization • manager identity was unattractive and associated with powerlessness and lack of respect.
Doolin (2001)	Managerial acculturation (senior managers) • exhibited an interest in management and found the new roles challenging • cost-consciousness • formal management education	Generally poor opinion of managers and management • poorly qualified, just common sense or easily learnt compared to medicine • clinical practice ought to be in the hands of clinicians, i.e. control by unit directors Reluctant managers (the majority) • nominated by colleagues to be the consultant team's representative or spokesperson • performing a less active, but necessary, legitimating function to buffer medicine from management • co-ordination role; consensus-based; constrained by professional ethos

Table 6   Summary of findings on the operationalization of managerial and professional identities (with attention to mixed identity work)

Study	Managerial	Hybrid	Professional
Ham at el. (2011)	*"A general manager first and a doctor second"* • compromise of clinical commitment	*Dual role* • leaders who combined clinical and managerial experience taking on a dual identity	*"First and foremost doctors who were also chief executives"* • a sense of loss, "going over to the dark side" and "leaving the professional family"
Spehar, Frich and Kjekshus (2015)	*Positive* • "manager first and doctor second" • increased responsibility and an ability to see the larger picture • able to plan work and influence decisions	*Ambivalent* • a sense of being lonely or left in the managerial role	*Negative* • "doctor first and manager second" • frustrated with the managerial role, experiencing little freedom in how they could enact the role • as extension of their professional identity to protect or promote their professional sub-discipline
Spyridonidis and Calnan (2011)	*Organizational values* • receptive to performance-managing their peers • medical professionalism should be wider than treating individual patients • targets/ vertical structure/ policy as a legitimate tool for patients' good	*Proactive professionalism* • used clinical guidelines to attract funding for new clinical services • local professional network that enabled doctors to form their own rules of governance • portrayed medical work as being beneficial to patients and stressed that patient care to be one of the primary aspects of their agenda	*Prominence of clinical autonomy* • a degree of caution, reluctance to adhere to clinical guidelines • favoured individualised critical appraisal • placed moral/medical higher than management considerations in clinical activities • exercised clinical freedom with their discretion in the daily routine of the implementation • low receptiveness to complying with management demands and its attempts to standardise labour process
Spyridonidis, Hendy and Barlow (2015)	*Innovators* • embraced new techniques and organizational identity as service improvement manager to facilitate quality improvement and enhance professional identity • built an alignment between evidence-based medicine and the service improvement approach	*Late majority* • gradually accepted the management role for the emphasis of "clinical leadership" that gave flexibility in enacting the role (i.e., delegated undesired tasks) • maintained boundaries between medicine and management ("them" and "us")	*Sceptics* • never fully engaged in management • saw management as authoritative control through external regulation on physicians • distanced from management (beliefs, time, understanding) • balanced their clinical interests with a conditional acceptance of management

Table 7   Summary of findings on the operationalization of managerial and professional identities (with clear focus on typology)

Study	Managerial	Professional
Forbes and Hallier (2006)	*Investors* • influencing decisions, or as an escape from clinical work • transferring their qualities of leadership and innovation in clinical arenas to management • a "managerial self" was developed even at the expense of their clinical role • used individual mobility strategy	*Reluctants* • not because of a desire to manage, but because they felt pushed to defend their specialism • reluctance to be identified with management, a lack of commitment to the role, and a negative attitude towards management intrusions into the clinical arena • felt no need to develop a "management self" and perceived that managerial duties were simply an additional burden tagged onto their clinical role • used social competition strategy
Hoff (1999)	*Organization-compatible (OC)* Attitude towards • physician managers: "supervisor and leader"; "educator, salesman and decision maker" • management: legitimate means of control over other doctors; challenging, an alternative to practicing medicine • practicing doctors: "coddled, insulated, need to "wake up" Belief and orientation • "Going from medicine into management full-time is like crossing a point of no return" • "I am committed to my management job" • "I am committed to the organization" Strategies of manipulation" • "Participatory Rituals" • "Rationality Strategies" • "No-choice Appeals"	*Profession-compatible (PC)* Attitude towards • physician managers: "advocate and protector"; "communicators and doctors' lobbyist" • management: should help practicing doctors but not dictate; boring, not what "real" doctors do with their time • practicing doctors: doing best they can, need to be left alone to do jobs Belief and orientation • "Those in full-time management positions are non-doctors" • "The only people who understand and can comment on my work are colleagues in the trenches with me everyday" • "I am committed to my fellow clinicians" Strategies of resistance • "Tuning Out" • "Undermining the Data" • "Work Group Empathy"
McGivern et al. (2015)	*Willing hybrids* (see Table 4 for details)	*Incidental hybrids* (see Table 4 for details)

4.5. Remarks on methodological issues

There are several remarks on the findings of precedent studies to inform our own research design. First, whereas the portraits of the balance of power between management and profession vary in different studies, we see more attention are given to hybrid identities in recent studies (2011 and later on) comparing Tables 5 and 6. The latter exhibits the variation in doctors' stances or heterogeneity of the group of physician managers as being categorized into three potential identities or responses to management intrusion.

Second, however, thoe portraits of hybrid identity between management and profession in Table 6 fail to identify independent position they hold in the mediation process as "Negotiation" in Numerato et al.'s (2012) power continuum. The notions of "proactive professionalism" (Spyridonidis and Calnan, 2011) and "the late majority" (Spyridonidis, Hendy and Barlow, 2015) can actually be seen as "Strategic Adaptation" in the power continuum near to the end of profession dominance. The former stresses the importance of local professional networks and using management means to achieve clinical ends; the latter is actually a proof of the resilience of the medical identities to the extent that physicians' engagement in management has to be maintained in a manner compatible with being a physician. Nor the notions of "dual role" (Ham et al., 2011) and "ambivalent" (Spehar, Frich and Kjekshus, 2015) provide further clarification of the concept of "hybrid", merely defining it as "leaders who combined clinical and managerial experience taking on a dual identity" and "a sense of being lonely or left in the managerial role". As discussed in the previous section, indicators of an independent *negotiating identity* as "reflexive practitioners" (Noorgraff, 2007; 2015) should include a clearly expressed psychological distance to both the management and professional identities, and an aim to rationalize both management and profession manipulating changes in healthcare independently from neither the top nor bottom. Unfortunately, such ideal type can draw very little on precedent studies.

Third, studies with a focus on typology, as shown in Table 7, well capture managerial and professional identities in the *idea* and *action* dimensions offering a framework to adopt indicators used by other selected studies. The idea dimension is specified as "attitude" and "belief and orientation" by Hoff (1999) and "role claim/use" by McGivern et al. (2015). It includes the personal motivations of why physician managers come into the management

role (as individual mobility or professional obligation) and that in relation to their understanding of the professional and management work (to regulate or represent their peers). The action dimension is specified as "strategy of manipulation/resistance" by Hoff (1999) and "individual mobility/social competition strategy" by Forbes and Hallier (2006). It includes particular actions in physicians' organization life overserved by researchers' field work.

Hoff (1999) offers a template of specification to operationalize physician managers' identity breaking down the attitudes and belief dimensions into various aspects (views of physician managers, administration, and practicing physicians; commitments to the role, to the profession and to the organization). This codification can enrich McGivern et al.'s (2015). For instance, "role use" of "representing and protecting professional" (ibid) can be identified with physician managers' "view of responsibilities" as "doctors' lobbyists" and their "view of management" as "helping practicing doctors but not dictating" (Hoff, 1999, p.331). Comparing Tables 5 and 6 with Table 7, most of the indicators used by selected studies fall in Hoff's specification, while some of them are exclusive. For instance, Russell et al.'s (2010) "self-perception" approach to physician managers' self-perceptions on their position in society as a group, and Hoff's (2000) quantitative method that measures physician managers' professional commitment and belief in clinical autonomy with their acceptance to relevant statements. Those indicators can be added for a more comprehensive understanding of physician managers' identity. In the next section, we will have a more detailed discussion on our own interview and coding protocol with reference to Hoff's one (1999, pp.347-348).

4.5.1. In search for a possible definition of "negotiating" identity

Fourth, as related to the second and the third point, typologies of those studies in Table 7 are based on a set of contradictory attributes of managerial and professional identities, and preclude the possibility of an independent *negotiating identity*. While it is logically impossible to claim as being "first a doctor" and at the same time "first a manager", those studies may overlook the potential of a hybrid identity that a physician manager may at the same time have both organizationally and professionally oriented values/ attitudes in different aspects of their identity. Whereas physician managers are classified into the

organizationally and professionally oriented groups in precedent studies, one may still be puzzled of whether they must fulfill the same set of criteria as others in their group.

For example, as shown in Hoff's (2000) study, physician managers exhibit a strong professional commitment whilst distrust to their peers' individual autonomy. They may also see non-medical managers as inappropriate to regulate professional work and thus hold a strong belief in collective self-regulation where they can have clinical governance in their hands. One can argue that in this case physician managers accept the need to manage their peers while act intentionally to preserve their collective control. However, a critical distinction should be made here between this "soft autonomy" (Levay and Waks, 2009) or "proactive professionalism" (Spyridonidis and Calnan, 2011) and *a salient social identification of physician managers* seeing themselves as the only group that can serve the best interests of the organization, patients and profession as a whole or bridge the gap between them.

Here "loose coupling" may also occur in an exceptional case where the institutional forces of management and profession *co-exist*. As healthcare studies suggest, instead of the physicians' resistance or control, it could be the inconsistency among intuitional logics (Reay and Hinings, 2005) and the underspecified nature of guidance and protocols (Staniland, 2019) that leaves some aspects of healthcare organizations relatively untouched by reforms with professionalism being persistent as the guide of behavior. In an Institutionalist perspective, the state-sponsored monitoring systems are actually a modern myth to maintain good faith in public organizations as well accountable and managed, while the substance are often neglected (Meyer and Rowan, 1983). Segregation between formal structures and reality may arise from the impractical nature of the rationalizing tools (e.g. quality control guidance/ protocol) in guiding day-to-day actions as well as the conflicting institutional logics (DiMaggio and Powell, 1983; DiMaggio, 1988). In a healthcare setting, with reference to Corporatist Theory we discussed in the last chapter, medical authority and autonomy is an important "technology of legitimation" (Harrison and Mort, 1998, p.66) or "symbolic legitimating device" (Salter, 2003, p.931) of the state in health policy. In order to maximize legitimacy of healthcare organizations in such a complex institutional environment, physician managers may have little choice but loosely coupling with the reform rhetoric,

e.g., tick-box approach of appraisal (McGivern and Ferlie, 2007), while adhere to professionalism that guides daily operations of professional work.

This interpretation of "loose coupling" attributes the persistence of the logic of medical professionalism to the institutional pattern of public organizations rather than the power of medical professionals in Numerato et al.'s (2012) control/ resistance framework. Based on this nuanced Institutionalist interpretation of "loose coupling" as beyond a specific form of professional resistance, we suggest that it may at the same time offer a more promising theorization of the ambivalently defined "negotiation" position in Numerato et al.'s control/ resistance framework. Defining the power dynamics as rather than one institutional logic becoming dominant and organization leadership as settling the conflicts among them, it enables us to capture a relatively autonomous or independent way of being physician managers in the mediating process.

In addition to a salient social identification of physician managers and "loosely-coupling" of conflicting institutional logics, a third possibility of defining Negotiation is "satisficing" (Simon, 1956). Following the complexity arising from the conflicting institutional logics, there is lack of guidance for organization managers about how to avoid subsequent identity conflicts. As "the real world in all its complexity" (p. xxiii), managers cannot "maximize" by selecting the best alternative from among all those available to him as an "economic man", but "satisfice" by looking for a course of action that is satisfactory or "good enough" as an "administrative man". Simon stresses that the "satisficing path" is "a path that will permit satisfaction at some specified level of all its needs" (p.136). Applying that to healthcare organizations, to avoid failing either professionalism or managerialism, physician managers are expected to be negotiate between their clinician- and manager- roles, trying to be "a doctor and also a manager" by fulfilling a minimum level of both professional and organizational goals. Instead of denying one's attachment to clinician- and manager- roles ("neither a doctor nor a manager"), "satisficing" presents another promising way-out to identity conflicts for physician managers. We will discuss those possible explanations for Negotiation in Chapter 7.

Chapter 5
Methodology

5.1. Introduction

In this chapter, we turn to both conceptual and technical issues of how to collect empirical data of physician managers in the Hong Kong Hospital Authority (HA). As a background, we will first clarify some theoretical assumptions of qualitative case study approach as adopted by this thesis.

A general definition for case study is "a detailed study of a single social unit" that may comprise a person, an organization, a policy, or a social movement (Exworthy and Powell 2011, p.6). For Gerring (2004), in such intensive study of a single unit, "the scholar's aim is to elucidate features of a larger class of similar phenomenon" (p.341); for Hammersley (1992), to make empirical generalisations from single cases is possible. Among others, a rich description of "context" is essential for determining whether the cases are universalistic or contingent (Exworthy and Powell 2011, p.7). In the background and theory chapters, we have discussed how the HA case is relevant to the NHS model of healthcare governance given the shared landscape, such as strong government presence in health policy as sponsor and provider and the dominance of modern medicine.

Indeed, the case study method was heavily utilised in defining the subject matter of early health policy studies - the role of occupational groups within institutional settings and their role in providing health services (ibid, p 27). Classical examples include Eckstein's (1958) study on the NHS, Strauss et al.'s (1964) study of the psychiatric profession, and Eliot Freidson's (1961) study on American medical practices. These cases were detailed and intrinsic in nature and went beneath the surface to understand micro-sociological processes at work (Marinetto 2011, pp. 28-29). While the 1970s' saw the rise of quantitative method in social sciences with the methodological value of focusing on a specific case being increasingly questioned by social scientists, it is still widely accepted that case studies can furnish the basis for establishing theory (ibid, p.30). In this thesis, the case study around physician managers in the HA will serve as the first step to modify the current dichotomized framework of their identity, proposing an alternative identity as the third type.

As Marinetto (2011) also suggests the case study method "uncovers the complex influences that impinge on public bodies and the context-bound, event-driven nature of policy decisions" (p.21) and "generates detailed, narrative-like description, which can be of interest in its own right" (p.26). For Yin (2009), case studies have a strength when: a) the research question is about "how" or "why", b) the research subject is not "historical" but "contemporary" set of events; and c) the investigator has little or no control over the research subject (where experiments are not available) (pp.8-13). Yin also stresses the case study method as a better option for "an empirical study that investigates contemporary phenomena within a real-life context, when the boundaries between the phenomenon and context are not clearly evident" (p.18). In this thesis, I attempt to offer a snapshot of how the professional system is working in parallel with the increasing government efforts in controlling the Hong Kong healthcare system. It focuses on the system or process itself through the investigation on the key players, physician managers, and how they negotiate between the institutional forces of professionalism and managerialism. Here the context (institutional forces) is interacting with the system or process and can be used to explain the outcomes (success, failure or mediation of policies). Whereas the pivotal role of physician managers is given as a background by the current theories, the empirical value of this case study is largely to answer "how" the balance of power is tipped.

With the shared emphasis on holism, everyday life, the particularities of culture, and a strategy of immersion, there is a "methodological affinity" between case studies and qualitative research approaches, i.e. ethnography and semi-structured interviews (Gerring 2007, p 36). It is suggested that in qualitative researches the researcher's role is "to gain an overview of the whole of the culture and context under study", and such holism is "pursued through inquiry into the particular…with extremely small matters" (Shaw and Gould 2001, p.7). In doing so, qualitative research is also interpretive as to "explicate the ways people in particular settings come to understand, account for, take action, and otherwise manage their day-to-day situations" (Miles and Huberman 1994, p.7), and involves "thick description" (Geertz, 1973) about the context of how meanings are created.

In this regard, Constructionist strategies are essential for qualitative researchers. Above all, qualitative method centres on "speech acts" (Giddens, 1993) by which structures are constituted and reconstituted "as the reproduced conduct of situated actors with definite

intentions and interests" (pp. 133-134). Researchers then must "crystallize institutional texts by glossing over the various contingencies and other contextual factors associated with the texts' production and use in institutional settings" (Miller 1997, p.78). The significance of language, speech intentions and structures has been illustrated by recent developments in conversation analysis, membership categorization analysis and applied discourse analysis (Shaw and Gould 2001, p.20). The study of physician managers' narratives in this thesis on their role in governing healthcare system can be regarded as rooted in this research tradition. The in-depth interviews allowed physician managers to explain how they reacted to the frames of meaning, which were mainly given by the institutional forces of professionalism and managerialism. As Miller (1997) suggests, meanings are sometimes contested, and it is possible for institutional actors "to construct and justify meanings that might be called 'dis-preferred'" (pp.79-80). As will be shown in the following chapters, physician managers interviewed did exercise their agency negotiating between their dual roles and identities, trying to satisfice both but not fully embracing either one.

Following Giddens' (1984; 1993) argument of "structuration" that sees structures as "both condition and consequence of the production of interaction" (p. 165), such reaction to frames of meaning by individuals, while was a consequence of structures in the first place, would in turn create new structures setting rules for a new cycle of social actions. For analytical purposes, in the later analysis chapters I will borrow from Sociological Institutionalism defining the new structures mediated by physician managers' agency to blend identities as "structural hybridity" (Raynard, 2016). With a focus on the of physician managers who acted as "satisficers" of both professional and managerial values, and the loosely-coupled system where a boundary between the professional and organizational hierarchy was maintained, this study will offer a field-level examination of how physician managers were situated in the "competitive" and "cooperative" tensions of conflicting institutional logics (Besharov and Smith, 2014; Goodrick and Reay, 2011; Jay, 2013; Meyer and Hollerer, 2010). Instead of passively reacting to those frames of meanings, physician managers coupled with them in a selective manner to avoid being squeezed by both their clinician and manager roles.

In sum, based on a non-deterministic model, how individuals react to pre-existing frames of meaning – creating meanings with them and for them – is a dynamic process that requires a flexible method open to such contingency. Qualitative case study approach will serve as a

good starting point of generating theoretical insights about that process. The following sections will unfold the technical details of research design and data collection, as well as methodological issues concerning the validity and the appropriateness of the research method in this study.

5.2. Research design and data collection

5.2.1. Source of data and sample

The basic characteristics of our target population in this study are as fellows. In the Hong Kong Hospital Authority, a corporatized public organization responsible for the centralized delivery of public healthcare in Hong Kong, there are two layers of managers: a) 127 "pure managers" (Chief Executive, Directors, Heads, Cluster Chief Executives, Hospital Chief Executives, Chief Managers, Senior Managers, Executive Managers or General Managers) for overall service planning or monitoring, and b) 799 consultant doctors responsible for clinical departments as Heads, Chiefs of Service or Clinical Service Directors/ Co-ordinators (Hong Kong Hospital Authority, 2015, Appendix 11b; full-time equivalent staff). The first level may represent the organizationally-oriented physician managers who are commonly reported in precedent studies as losing affiliation to clinical work, while consultant doctors at the second level may represent the professionally-oriented group. The bottom layer of the hierarchy is the rank of 5,000 front-line doctors, including 2,872 Medical Officers/Residents and 1,785 Senior Medical Officers/Associate Consultants (ibid).

To sample physician managers, I emailed the HA in January and February 2016 for the access to physician managers but our request was rejected. I also emailed and telephoned all the Cluster Chief Executives and Hospital Chief Executives in March 2016. Unfortunately, I did not manage to make any successful invitations through such open access route. With reference to the selected studies in Chapter 4, a purposive and snowball sample can serve as an alternative when a large number of physician managers from a statistically representative sample are unavailable. In this study, our access to physician managers was made through two key informants. They were Prof Yun-kwok Wing, Associate Dean of the Faculty of Medicine at the Chinese University of Hong Kong, Chief of Service in the Department of

Psychiatry at Shatin Hospital and Prince of Wales Hospital, and Dr the Honourable Ka-lau Leung, Legislative Council Member (Medical Constituency) from 2008 to 2016, Council Member of the Hong Kong Medical Association, former President of Hong Kong Public Doctors Association. Practicing medicine in Hong Kong for 30 years and holding senior academic and political positions, they have personal contacts to a wide range of medical leaders which are highly valuable to this research.

In December 2015, I met Dr Wing and Dr Leung seeking their comments on our research design and their referral of participants. They nominated 8 physician managers as our first group of participants. Then a snowball sampling stage commenced based on the nominations made by those participants. Nominated physician managers were contacted via e-mail with an invitation letter, information sheet and consent form as requested by the Social Policy and Social Work Department Ethics Committee (see Appendices Ten, Eleven and Twelve). From February to June 2016, totally 15 physician managers participated in our study. Eight of them were "front-line managers"; the other seven participants were "pure managers" (1 Cluster Chief Executives; 4 Hospital Chief Executives; 1 Chief Manager and 1 Senior Manager at the Head Office). As McDowell (1998, p.2135) suggests, social networks and serendipity are the key to the success of gaining access to elite subjects. Although I had sent invitation email to all Cluster/Hospital Chief Executives in the HA as abovementioned, all five interested interviewees at that rank were recruited by personal referral of the two informants or snowball strategy.

To collect data on the identity issue as a subjective matter and allow participants to extent our scope of understanding of physicians' organizational life which outsiders may know very little, individual interview was the primary source of our data collection. To supplement interview, interviewees were asked to fill-in a short questionnaire before interview. Most of the interviewees handed in their questionnaires during the interview and some of them sent a soft copy through emails.

The interviewees were interviewed face-to-face by me, except one that was done through a telephone call. The length of the interviews ranged from 30 mins to 60 mins. To be realistic about the available time of elite members could spend in interviews, and to ensure access in the first place, I used a leeway suggested by Dexter (2006) to "specify a time a little, but not much, less than the normal time which interviews on the particular project take" (p.49). I

asked for 30 minutes as Dexter suggested and over one-third of the interviews were extended to 45 minutes or an hour.

Full transcripts were produced after the interviews based on digital audio records taken under consent. Two Interviewees rejected our request for digital recording so I transcribed those interviews with our handwritten records. As English is the working language of the medical sector in Hong Kong, the default language of research materials and interview with participants was English. On the interviewees' request, 4 interviews were conducted in Cantonese, the language commonly used in Hong Kong. As a local Hong Kong citizen, I did the translation to English after the original transcripts in Cantonese had completed. As scholars in qualitative method suggest, it is a common and widely accepted method in social science research as the risk of misinterpretation can be lowered by researchers' translation of interview words on their own (Marshall and Rossman 2006, p.112), and by their role as "cultural broker" finding equivalent meanings in the translated language and conveying cultural context from the original language (Temple and Young, 2004, p.171; see also Temple et al., 2006; Park and Lunt, 2015).

5.2.2. Interview protocol and questionnaire

I adopted Hoff's (1999, pp.347-348) interview protocol as a template for our semi-structured interviews. The original interview questions were organized in four general aspects of how physician-managers in an US HMO see themselves and others as managers. There were some revisions to it based on Forbes and Hallier (2006) and the HA setting (see also Appendix Thirteen):

1) Reasons for going into management and relevant experiences

   a. How did you first get involved in the physician-manager role? What were your reasons for getting involved?

   b. Can you tell me about your experiences in the transition from a clinical to an emerging management role? What did you expect of the management role? Were these expectations met? Any conflicts and ambiguities associated with the move?

2) Role-related attitudes and behaviours

    a. How do you act in this role toward others such as administrators, other doctors, and senior management?

    b. How do you think you relate to other doctors in your office in this role? Do you see yourself primarily as their advocate? Can you give me an example when you were/were not acting as an advocate? How do you personally feel about telling other physicians what to do or coordinating their work? Does the manager role interfere at all in how you get along with them?

    c. Do you see any differences between those in full-time, senior medical management positions and those in first-line supervisory positions?

3) Attitudes toward the HA management

    a. Do you think physicians as a group are treated fairly in this hospital/ the HA? Can you give me an example of both fair and unfair treatment? How about other groups in this hospital/ the HA?

    b. Tell me about how you think decisions regarding physicians and providers get made here. Do you think senior management communicates enough and seeks input regarding decisions that affect physicians? Do you feel that you can affect decisions in this hospital/ the HA?

4) Handling of professional-organizational conflicts

    a. How do you feel about the changes in this hospital/ the HA is going through, in terms of having to focus on things like utilization and productivity among physicians? Are you willing to stand behind it, even if it means significant changes for physicians and how they do their work as a group in this hospital/ the HA? When wouldn't you stand behind it (example)?

Interview transcripts were preliminary coded by Hoff's (1999; please see Tables 3 and 4) original specification as "attitude" and "belief" of "Organization-compatible" and "Profession-compatible". I added "role claim" and "role use" of "willing hybrids" and

"incidental hybrids" used by McGivern et al. (2015, pp.416-419; see Table 4) to cover those concepts that are not exhausted by Hoff. These predefined themes of coding and analysis also guided the me in the interviews soliciting relevant content from interviewees.

I also used Hoff's (2000) questionnaire to collect more measurable and comparable data that can be benchmarked against his findings (please see the previous section and Appendix Fourteen for the details of breakdown indicators).

1) Professional commitment (the extent to which physician executives identified with and were attached to the medical profession)

2) Belief in individual physician autonomy (the extent to which physician executives believed that individual physicians shall have a high degree of discretion in their clinical work)

3) Belief in collective self-regulation (the extent to which physician executives believed in the exclusive right of the medical profession, as opposed to an external entity, to regulate collective norms and behaviours)

4) Year(s) served in the management post

5) Year(s) served in the HA

6) Management training (whether have a degree)

7) Proportion of time spent in clinical work

Although we may not be able to generalize statistically significant results with a limited sample, those quantified data on their attitudes and characteristics still enables us to classify physician managers into the organizationally and professionally oriented groups on a more objective basis and compare our sample to other studies using representative samples.

To further explore the potential of an independent *negotiating identity*, special attention shall be given to interviews' inconsistency in their institutionally-driven ideas and critical stand to both organizational and professional interests, i.e., distrust in physician individual autonomy coupled with strong belief in collective self-regulation (to be revealed with the

questions in the questionnaire), and detachment from management/ professional identity (individual mobility) besides the "loose coupling" strategy (revealed with the interview questions of why they go into management, how they see different parties in healthcare organizations, and whether they will stand behind the management reform). Based on Hoff's (1999) and McGivern et al.'s (2015) codification schemes, I developed an analytical approach to take conflicting identity work of professionalism and managerialism into consideration. With codified transcripts, interviewees' combination of professional and managerial attributes can be further analysed. The empirical findings based on the above-mentioned research design and data collection will be reported in the coming chapters. Before that we will first discuss some reflections concerning our research design.

5.3. Methodological issues

5.3.1. Definition of elites and access

The empirical part of this study is largely inspired by the research tradition of elite interviews. However, there is much confusion about the definition of "elites", and a universal definition of the term is even more difficult across different corporations, sectors and national boundaries (Harvey 2010, pp.195-196). Some suggest numerical minorities at the top of the employment and income pyramid (Woods, 1998); some stress the strategic positions within a social network that bridges between social structures (Burt, 1992). A flexible definition for elites that may broadly be accepted would be people who "carried out predominantly occupied senior management positions and were influential decision makers for their companies" (Harvey 2010, p.196).

While being a professional itself may not be a sufficient criterion for one to be defined as a member of elites (Harvey 2011, p.433), the targeted subjects in this study, hospital managers who were also medical professionals, undoubtedly fall into this category. As discussed in the previous chapters, the hospital sector in Hong Kong is medical-led. Those who hold management positions in clinical departments and at hospital-level will be influential decision makers. They are also mandated by both their professional authority and organizational authority to supervise clinical work, playing an indispensable negotiating role

in decision making as we will discuss in detail in the following chapters. In 2016, the annual income of Senior Medical Officer Grade (Associate Consultants) starts at £ 130,000 (Social Welfare Department, 2016) or the 95th percentile of the working population in Hong Kong (Census and Statistics Department, 2016).

Access to this privileged group was crucial for me in conducting elite interviews in this study. It is suggested researchers of elite interview should attempt to pursue various avenues in a persistent and opportunistic manner (Yeung, 1995). In addition to open access routes such as potential respondents' office email addresses and telephone numbers as aforementioned, key informants and snowball strategy were helpful in the recruitment of interviewees. At the beginning stage of recruitment, my university affiliation was of high importance in terms of gaining access to the elite networks of doctor managers in the HA. Both key informants and myself graduated from the same university. Most interviewees nominated by the key informants were also graduates from that university.

Yet, it is also suggested that researcher's affiliation may be received differently, which in turn will have negative impacts on gaining access to elites group (Herod, 1999). At the later stage of snowball recruitment, where interviews might be graduates from another university providing medical training in Hong Kong, I did not emphasize my local university affiliation as I would have when inviting those who were my fellow alumni. Instead, I stressed my researcher role and the University of York affiliation. Also, one key informant was previously a doctors' trade union leader and the doctors' representative in the Legislative Council of Hong Kong. To avoid giving any negative impression to the interviewees regarding my past political affiliation (I used to work for his Legislative Councilor's Office as a policy researcher), my past working relation with that key informants was only disclosed when asked. In fact, there were no interviewees who asked about that affiliation except those who were personally referred by that key informant. In that case, that affiliation helped in gaining access or trust rather than hampering access.

Another source of difficulty in gaining access that has been discussed in research ethics literature may be the restrictions set by university ethics boards (Harvey 2010, p. 196): it has been more common in recent years that researchers are requested to receive a complete written consent form from respondents before the they take part in the research; transparency

requirements for researchers, such as disclosing the research goals, expected results and interview questions may also restrict the ability of scholars to adopt critical research interrogating the social, economic and political power within organizations. While these types of conditions may make it even more difficult for scholars to gain access to elite members, relevant requirements as set in my submission to the Department Ethics (see Appendix Fifteen) seemed to have no impacts on my recruitment of interviewees. Firstly, in most cases paper work was actually handled by interviewees' assistants so it did not affect their willingness to take part in the study. More importantly, as Harvey suggests (ibid), proper procedure of prior consent and discourse of information may help to build trust. The research's value and relevance to interviewees was an important concern for them in deciding whether to contribute their precious time. In addition, my request for prior consent from the interviewees' organization, or confirming that no further approval from their organization would be needed, seemed to be not a concern for interviewees (though it is not clear whether approval from the organization was a concern for those who rejected or ignored my invitation).

5.3.2. The "insider/ outsider" issue

As aforementioned, access to elite networks that are relatively closed may require some sort of insider identity for building rapport. Yet, the advantages and disadvantages of being an "insider" or "outsider" have been a longstanding debate in the social sciences. While Abu-Lughod (1988) and Hill-Collins (1990) suggest that "insiders" have an advantage in using their knowledge of the group to gain more intimate insights into their opinions, Fonow and Cook (1991) argue that "outsiders" have more objectivity and ability to interpret behaviors or narratives without bias arising from the "insider" status; also, "outsiders" are more likely to be perceived as neutral and gain access to information that is sensitive for an insider.

In the real world, researchers may find that the "insider/outsider" binary oversimplifies "insider" or "outsider" as a fixed attribute, ignoring the dynamism of positionalities in time and through space, and that "no individual can consistently remain an insider and few ever remain complete outsiders" (Mullings 1999, p.340). Researchers often have to seek "positional spaces" where "the situated knowledges of both parties in the interview encounter, engender a level of trust and co-operation", shift between an insider and outsider

identities, or silence some identities to avoid threatening interviewees in relation to their disclosure of sensitive information (ibid, p.341).

In this regard, a "positional space" that researchers shall actively display is a sound knowledge of the topic to win the respect and confidence of elites during interviews (ibid, p.340). By this the researchers and their subjects can forge solidarity as intellectual equals, without attaching to insider/outsider privileges based on visible attributes such as race, gender, ethnicity, class, or occupation /education that played an important role in this study.

My background as a health policy researcher working for the medical professionals' political representative granted me a "temporary insider" status (ibid). On the one hand, I could understand sub-cultures of medical professionals and daily hospital operation as a result of past working relations with the profession. On the other hand, I was not totally an insider in terms of my education and occupation. That means I could easily detach from my affiliation with the medical profession and shift to an outsider position when needed. Also, as discussed in the previous section, sometimes it might be necessary to silence some identities (e.g. university and political affiliation) in building my rapport with interviewees. Representing myself as a health policy researcher at the University of York therefore served as a common "positional space" in my recruitment and interviews. In view of frank discourse of information and discussion, I adjusted my insider/ outsider image from time to time dependent on individual interviewees' reaction.

Such flexibility was not only crucial for gaining access, but also for balancing the biases that might arise from my insider and outsider identities – I might have become sympathetic towards medical professionals after years working for them, and less objective in interpreting the interviewees' narratives; but if I had no insider insights it would be doubtful whether I could accurately interpret the interviewees' narratives, which were sometimes embedded in their sub-culture. The ability to see through both an insider and outsider lens therefore was necessary for me to balance my potential biases, without losing my connection to the research subjects.

The positionality of elite respondents themselves within an organizational setting could also have critical implications for a frank discussion in the interviews – elite interviewees usually hold senior management positions in their organizations, therefore more likely to represent

the position of the organization rather than their own individual viewpoint, especially those opposed to the organization's line-. It is suggested that an elite member's power and autonomy within the organization is a determinant factor of the researchers' ability to gain access to their personal views (Harvey 2010, p.199).

In this study, two groups of physician managers were interviewed, organizationally-oriented physician managers who were losing affiliation to clinical work, and a professionally-oriented group whose management work was mainly at a departmental-level. It is reasonable to expect that the former group had more pressure on them to align to the organization's policy stand. But as discussed in the previous chapters, reporting organizationally-oriented identity or narratives itself was not regarded in this study as a distortion of interviewees' personal views, but a result of the internalization of their manager role at the expense of their clinician identity. For instance, when answering interview questions that asked whether interviewees would stand behind the HA regarding unpopular policies, many from the latter group of physician managers at a departmental-level did express resistant attitudes towards those policies they thought unreasonable. Overall, physician managers in the HA enjoyed considerable autonomy and cultural authority in hospital operation. Whether they expressed opinion opposed to organization policies was largely an identity issue, that is, the extent they had internalized a manager role or retained a clinician role in the first place.

5.3.3. Interpretation of narratives

While the positionality of physician managers seemed to have no significant impacts on the reliability of their narratives in this study, in the research ethics literature   there are still some wider issues set around the interpretation of narratives in interviews on whether they can be regarded as "authentic accounts" of the social world (Miller and Glassner, 2004).

Positivists strive for "pure" interviews enacted in a sterilized context through standardized interviewing, in view of a "mirror reflection" of the reality that exists in the social world; emotionalists propose unstructured, open-ended interviewing as "authentic accounts of subjective experience"; radical social constructionists question whether those "authentic accounts" are just repetition of familiar cultural tales, and suggest that no knowledge about a reality that is "out there" in the social world - but just constructed narrative versions as one

could obtain from interviewing. These views all point to the risks that interviewees' narratives may be context specific, invented, and subject to demands of the interactive context of the interview (ibid, p. 125).

Yet, Miller and Glassner (2004) reject the assertion that interviews are meaningless beyond the context in which they occur, as it provides "a means for exploring the points of view of our research subjects, while granting these points of view the culturally honored status of reality" (p.127). For them, knowledge of social worlds is achievable through in-depth interviewing as the positivist view ignores important interactive components in the achievement of that knowledge, such as "inter-subjective depth" and "deep mutual understanding" (ibid). Instead of denying that knowledge, what researchers should do is to be skeptical of a romanticized view of seamless authenticity emerging from narrative accounts and carefully examine the grounds upon which these claims are founded (p.126).

Miller and Glassner pay special attention to two types of narratives suggested by Richardson (1990) by which "people organize their personal biographies and understand them through the stories they create to explain and justify their life experiences" (p.23). The first one is "cultural stories" that are typically "told from the point of view of the ruling interests and the normative order" (p.25). The second one is "collective stories" that take the point of view of the interview subjects, and "give voice to those who are silenced or marginalized in the cultural story", challenging popular stereotypes (ibid).

As Miller and Glassner (2004) note, both cultural and collective stories provide important insights - an interviewee who is too deeply committed to the ruling interests and that order, or as clearly outside of them, may restrict the reliability of his or her narratives (p.130). For them, the strength of qualitative interviewing is not only eliciting mainstream narratives but to access the self-reflexivity among interview subjects, leading to the greater likelihood of the telling of collective stories as to "discover the anxiety, ambivalence, and uncertainty that lie behind respondents' conformity" (ibid). Such "ambivalence" and "uncertainty" arising from contradictory accounts among interviewees are of high importance in understanding the whole picture of the social world. In addition, interviewees may also offer facets incongruous with their own narratives (p.137).

Therefore, it is possible to find realities within interviews – by juxtaposing an interviewee's narratives to that which is given by others and other inconsistent narratives given by him/herself. In this study, two types of narratives were expected from physician managers interviewed, one more organizationally-oriented and one more professionally-oriented. As we discussed earlier in this chapter, some physician managers in the HA were not taking the organization's line in policy disputes with their professional peers while some reported that they were. The contrasting ways of understanding or enacting their manager role imply certain forms of "collective stories" were told by the interviewees. More importantly, it was also found that some interviewees were giving narratives contradictory to our expectation – organizationally-oriented narratives for some managers in departmental management posts, and professionally-oriented narratives for some managers at a higher level of the management hierarchy. To a certain extent, those narratives different to the HA policy and norms in their stereotypical subgroups were not "socially desirable". The impacts of positionality seemed to be very minimal on this study's capacity to obtain interviewees' authentic personal view points.

Interestingly, interviewees themselves might also have varied in how they define the "cultural" (mainstream) or "collective" (alternative) narratives in the first place. For instance, one interviewee stressed to me "as the theories you study may suggest, a physician will be loyal to their profession' before going on the organizationally-oriented narratives. Obviously, for that interviewee mainstream narratives would have been the professionally-oriented one and he/she was telling me something alternative. Yet, it was not the case for some other interviewees who were also giving organizationally-oriented narratives – they were more like giving a norm shared by all physician managers.

In conclusion, to assume interviewees would mislead or distort their narratives for certain social norms or positionalities as fixed attributes is as equally assertive as the romanticized view that assumes they would not do so. The critical point is whether the research design is open to alternative narratives. In the coming chapters, we will discuss how the analytical approach in this study attempted to obtain alternative narratives by comparing the different narratives as given by two groups of interviewees, and as explored by different interview questions (examining different dimensions of their manager/ clinician identity). We will

explain how physician managers are "ambivalent" and "uncertain" as a group (Chapter 6), as a subgroup, and as individuals (Chapter 7).

5.3.4. The problem of data analysis

Although reliable data can be obtained from interviewees, there could also be problems regarding the process that researchers analyse those data. Many qualitative researchers have faced the dilemma of whether they should adopt a structured or less structured approach to data collection – on the one hand, relying on interview transcripts may generate a huge amount of information, leaving researchers overwhelmed by data if there are no proper prior conceptual frameworks; on the other hand, to prevent a premature closure of potential themes, researchers should adopt a Grounded Theory approach delimiting the areas they are investigating to wait for interesting themes to emerge (Bryman 2005, p.138).

Indeed, Grounded Theory suggests that researchers do not approach reality as a "tabula rasa". Rather, they "must have a perspective that will help [they] see relevant data and abstract significant categories from [their] scrutiny of the data" (Glaser and Strauss 2007, p.3). While theory is grounded in data it involves constant moving backwards and forwards between data and emerging theoretical notions - researchers first elaborate "categories" or "themes" with hypothetical links between them, then redefine them empirically during further data collection with new themes and recategorizing. Also, when there is a semblance of structure within which the data can be organized and tentatively conceptualized, it will be more possible to elaborate themes with a conceptual coherence while postponing theoretical reflection to a later stage of data gathering (Bryman 2005, pp.139-140).

In an ideal situation, researchers should first establish rough theoretical frameworks and compare them to new evidence, allowing room for adjusting them and planning for a new round of data collection. Yet, such back-and-forth movement may be an endless process. Redefining research questions may also involve resubmission to ethics committee and longer recruitment processes with some elite interviewees being used as pilot cases. Due to difficulties in recruiting enough elite interviewees and time constraints, this study did not move backward to theory but adopted a flexible framework that expected two types of possible narratives of physician managers – one representing the internalization of

managerialism and one representing the resilience of professionalism – as apprehended by current theories, and allowed a third type of narrative to emerge in the data as independent to those existing institutional forces.

The following chapters will examine how the new themes that emerged in the data can be analysed and feedback to the theoretical debates at the later stage of the study. This approach balances Miles's (1979) emphasis on prior framework as to avoid difficulties at analysis stage and Glaser and Strauss's (2007) preference to postpone theoretical reflection. With the guidance of current theories on the medical power and governmentalization, working theoretical frameworks or themes had been pre-established yet they were open to the challenges when the new themes emerged as something outside that dichotomized structure. The generation of knowledge in this study therefore was also grounded in data rather than purely a "hypothetico-deductive practice" (Haig, 1995).

5.3.5. *Transferability of western research protocols*

In a non-western setting, the indigenization of qualitative method, which is largely a western invention and embedded in the western context, may add further methodological complexity to this study.

As Hsuing (2012, p.3) suggests, researchers from a non-western setting tend to simply retrieve, modify research protocols presumably created by the western core, with local context being ignored. In this connection, Park and Lunt (2015) have explored issues that researchers in countries with a Confucian heritage may encounter. For example, the importance of seniority, collectivism and personal ties may risk encouraging researchers to hand pick respondents, and that subordinates would have felt obliged to participate if asked, resulting in a sampling bias (p.4); interviewees' sense of "face" and "honour" may deduce socially or organizationally desirable answers (p.9); some western social research practices of ethics may be ill-fitting, i.e. formal ethics approvals are not valued as promoting transparency but seen as strange, and the giving of a customary gift at meeting or visit is seen as ethical and expected as a sign of respect (ibid). While these issues may be common ones facing all qualitative research in general, researchers in a Confucian setting should pay special attention to them as they are particularly central to Confucian cultures.

In fact, the Confucian setting seemed not to be predominately an obstacle to applying western qualitative research standards to the fieldwork of this study in Hong Kong – consent forms and other formal ethical approval procedures were well accepted as protecting interviewees' privacy and a sign of my professionalism; the seniority of nominators did not create pressures for participation in this study, e.g. one Hospital Chief Executive invited physician managers in his/her hospital to participate in this study, but there was only one of them showed an interest and he/she finally rejected being interviewed; while my personal ties were used at the initial stage of recruitment as to get the key informants' nomination for the first group of interviewees, as discussed in previous sections, the common "positional space" by which I won the respect and confidence of elite interviewees was being equal intellectually with a sound knowledge of the topic, rather than personal ties. Instead of feeling obligated to entertain the request from the nominators who were seniors or closely tied, interviewees decided whether to participate in this study mainly based on their own interest in the topic.

It is not surprising as a number of studies have suggested Hong Kong may be the least collectivist society among those that share the Confucian heritage, such as China, Taiwan, Singapore and Korea (Hofstede and Hofstede, 2005; Tu, Liu and Ting, 2009); the recent tendency of Hong Kong society to increasingly promote independence, self, and mobility may also have narrowed cultural differences between Hong Kong and western countries (Danon-Leva, Cavico and Mujtaba, 2010). It is especially true when the focus of this study was medical elites whose education was largely in western style aiming at training highly self-processed and autonomous practitioners. Indeed, the Confucian notions of hierarchical order and harmony (avoidance of conflicts) found little support from the findings of this study: as will be shown in the following chapters, in the power dynamics among physician managers the authority mandate of the management hierarchy did not overpower clinical autonomy, and the resistance from the frontline was as significant as cooperation. Another key Confucian notion of collectivism was contentious as well – in the case of physician managers' identity, the emphasis on individuals' ties to groups and the priority of collective interest over individuals could refer to either their profession or organization. The concept of collectivism may therefore help little in explaining the interviewees' narratives.

More importantly, researchers are able to close the gap between locality and the global academic practices and interests. For example, Confucian influences in deducing socially or organizationally desirable answers from interviewees, if any, could be handled with the openness of method and reflexivity to the contested meanings. As Hsuing (2012) proposes, while criticising the dominance of western standards in social research, a "globally informed, locally situated" analytical framework is achievable by a bottom-down approach that is open to local narratives and "plural and multiethnic histories" (p.7):

> Methodologically, the inductive logic of QR encourages bottom-up, locally-grounded research as researchers raise new questions, call upon different types of data, and employ alternative perspectives in data analysis…Pursuing QR in the periphery therefore promises the possibility of a new school of thought that questions the status quo, disturbs taken-for-granted norms and practices…. (pp.7-8)

As the following chapters will unpack, quite different to mainstream western studies in the field of physician managers, it is common for physician managers in Hong Kong, from both the "pure" or "frontline" categories, to give alternative different to the HA policies or the expected image as advocates of doctors by their professional peers. In this open approach of analysis, local data of physician managers in Hong Kong, while locally grounded, was able to inform the globally interested issues of professional-led governance in healthcare by modifying current theories based on the dichotomy of professionalism and managerialism.

5.3.6. Other research ethics issues

In practice, there were also some research ethics issues raised by the Department Ethics Committee before the fieldwork was launched. Among others, protecting interviewees' privacy was the major concern discussed in length in my submission.

Firstly, I was asked about the procedure of how informed consent to participate will be elicited from participants. This information was contained within an Information Sheet (see Appendix Eleven) for potential participants at the first point of contact, with a Consent Form (see Appendix Twelve) asking them to read and complete before their interview commences. They were given the opportunity to decide if they would like to participate, and provided with clear information of: the purpose of the research; what would happen to the results and

how they would be disseminated; what their participation in the research would involve; what the potential risks and benefits of their involvement might be; how issues of anonymity and confidentiality would be managed; and the fact that they were not obliged to take part and that they could withdraw from the study if they later changed their mind.

Secondly, I was asked to state the promise I would make to participants about how their data would be used, including in publications and dissemination, for example whether names, job titles, or direct quotations would be used, and to state what protection of anonymity I were offering.

In relation to outputs of this study, participants were informed via the Information Sheet (see Appendix Eleven) that their words might be quoted in my PhD thesis and associated research outputs such as articles, conference papers and web pages. And they were given the option to request me to send them a copy of publications that quoted their words. Yet, they were not invited to give comments about my analysis before publication. Although that might offer a chance of "respondent validation" as to increase reliability of interview data, in view of avoiding censorship some research ethics literature regard this method as undesirable (Bryman 2005, p.137).

In relation to anonymity, all research participants were given three options concerning how their words would be quoted within research outputs in the Consent Form (see Appendix Twelve): A) "You may use my name and my job title"; B) "You may use my job title only"; and C) "You may not use my name or my job title" (only their rank and specialty would be discoursed). If a participant preferred option B they would be allocated a pseudonym (Dr X, Y, Z etc.). Yet, absolute anonymity could not be guaranteed to participants even if they opted for option B or C, i.e. participants might still be possible to identify for their distinctive insights and the relatively small sample size. At the end, to promote the highest anonymity I unified all the anonymity forms as C, hiding all their personal information except their rank and specialty, despite that some interviewees agreed to the disclosure.

In relation to the storage of data and personal information, the anonymised interview data, the documentary evidence, my research notes, Consent Forms, other paper-based data/ personal information and the keys to those archives were kept securely by me and were only

accessible to me and the supervisor of this study. After 3 years of my graduation these items will be destroyed.

In general, all information collected form interviewed during this study was kept confidential in line with the Data Protection Act (1998) in the UK and Personal Data (Privacy) Ordinance (Cap. 486) in Hong Kong, as stated in the submission.

Thirdly, I was also asked to disclose whether this research would involve payments, reimbursement of expenses or other incentives for interviewees to taking part in the research, and specific ethical challenges to deal with "vulnerable people". As stated in my submission, these were not relevant situations to my fieldwork. Concerning the case that the research information disclosed to me might legally require my further action (e.g. the participant disclosed the potential for harm to themselves or others), I stated I would contact with my supervisor. My Consent Form stated that I might be legally required to inform someone who may well act on such information.

5.4. Limitations and future research suggestions

Although this study is pioneering research of physician managers in Hong Kong, there were several limitations regarding its data collection. Firstly, our data sample was only 15 physician managers in the HA. Secondly, they were recruited by the referral of two important informants and snowball strategy instead of via systematic access. Thirdly, our sample was male-dominated with only one female. Finally, this study relied heavily on first person narratives and lacks cross-validation by archive or other data sources.

Regarding the first and second points about sample, considerable efforts was made to avoid bias by emailing and telephoning all the Cluster Chief Executives and Hospital Chief Executives, as well as the HA Head Office for its assistance in sampling, although no successful invitations were made through such open access route (a few of them were recruited eventually with personal referral by our informants or interviewees). As an alternative, we adopted a purposive/ snowball sample which is a common strategy of previous empirical studies when a statistically representative sample is unavailable for elite interviews. The narrow origin of our sample has caused a geographical bias that half of the

interviewees are from the same Hospital Cluster, but we did not observe specific differences between their transcripts and those of interviewees from other Clusters. Using questionnaire as a supplement, we had also benchmarked our interviewees against a random sample in the US (Hoff, 1999).

Regarding the third point, we particularly invited the three female Hospital Chief Executives in the HA but our requests were rejected. While such bias may perhaps reflect the tradition of a male-dominated community of physician managers, the cradle of future physician managers, medical schools in Hong Kong, have had a more balanced gender ratio in recent years. In the coming decades, female physician managers may take a more prominent role in the HA. While gender cannot be captured fully in this study, future researches should pay attention to it in terms of how female managers enact and reconcile their manager and clinician roles compared to their male counterparts, as well as its impacts on healthcare governance in Hong Kong.

Finally, the lack of archive data or field observation limits the cross-reference of our data as well as the scope of the research. While I planned access to potential internal documents, such as minutes of meetings, organization charts, strategic plan, management consultant reports and project documentation as stated in the submission to Ethics Committee, the HA rejected such a request to assist in the research project.

This has narrowed the capacity to only a snapshot for the current order of healthcare governance in the HA. Institutional changes are another important academic issue in healthcare studies (Scott et al., 2000) and they cannot be effectively examined without historical archive data. Researchers who see New Public Management in public service as an "identity project" (Du Gay, 1996; Goodrick and Reay, 2001; Meyer and Hollerer, 2010) have employed longitudinal data such as media articles, annual reports of public service organizations / professional associations to display how old orientations are interacting with a new managerial logic. Future studies on the constellation of managerialism and professionalism in Hong Kong public healthcare governance may source huge potential from archive data in view of a comprehensive understanding of its past, present, future with the overall tendency of developments.

Considering that the uncertainty in the access to internal documents may also arise in the future studies, researchers working on this topic should also undertake a comprehensive search for a wide range of published documents to crosscheck the content of interviews: national policy documents, newsletters of medical associations, and curriculum of medical education etc.

Chapter 6

Empirical findings: the re-stratification within medicine and physician managers' identity

6.1. Introduction

With the rise of the physician managers as elites in the profession and the partner of the state under the re-stratification of medicine, the discussion of hybrid identity has drawn researchers' attention as it may affect how the manager role is actually enacted, i.e. as the proxies of state authorities or medicine. In the previous chapters, we have discussed such theoretical relevance of physician managers (hybrids) to healthcare governance and examined systematic methods to research identity issues as developed by precedent studies. In this connection, we have outlined our research design and data collection on physician managers in the Hong Kong Hospital Authority. In this chapter, we will report the empirical findings of 15 interviews in Hong Kong during the first half of 2016.

The findings confirm the Re-Stratification Thesis of medicine suggesting that the collective medical autonomy is preserved by medicine elites who exercise tighter monitoring on front-line doctors. In brief, physician managers interviewed overall hold a strong belief in the physicians' rights to collective self-regulation but not physician's individual autonomy in clinical work.

As will be shown, our findings also echo recent researches in the NHS context arguing that physician managers are not a homogenous group as stronger managerial identities are associated with more senior management roles (McGivern et al., 2015, p.276). Specifically, two groups of physician managers are found to be occupying respective levels of healthcare management: "Organization-Compatible" or "Willing' Hybrid" managers are often in directorial positions (*pure managers*; Cluster/ Hospital Chief Executives or Chief / Senior Managers at Head Office in the HA). On the other hand, "Profession-Compatible" or "Incidental Hybrid" managers are often in frontline management (*frontline managers*; Heads of Department, Chiefs of Service, or Clinical Directors/ Co-ordinators). Given that the spilt in medicine under "re-stratification" appears not only between medicine elites and rank-and-

files but also among the elites as two groups of physician managers, the interaction between two groups of managers can be seen as the frontline of the professional-organizational conflicts.

6.2. Characteristics of the sample

Before we go into detail of our findings we first have an overview on the characteristics of our 15 interviewees. We asked the interviewees to fill in a questionnaire before the interview to collect their personal information such as age, level of management training, and the amount of time they still spend in clinical work. For privacy considerations, we hide interviewees' gender, speciality and medical school in the table below. Our interviewees will be allocated a pseudonym from A to O according to the sequence of their interview.

Table 8   Characteristics of physician managers interviewed

Level	Management Post	Training	Clinical work (%)	Age	Year(s) as manager
Pure	HCE	Degree	5	50-54	7
Pure	Manager at HAHO	Degree	0	45-49	10
Pure	CCE	Degree	0	50-54	25
Pure	Manager at HAHO	Course	0	40-44	2.5
Pure	HCE	Degree	0	50-54	10
Pure	HCE	Degree	0	50-54	14
Pure	HCE	Degree	5	50-54	13
Frontline	Consultant; CSC	Degree	20	55 <	23
Frontline	COS; CSC	Course	60	55 <	10
Frontline	Consultant; Deputy CSC	Degree	70	45-49	5
Frontline	COS	Course	50	55 <	19
Frontline	COS; CSC	Course	50	50-54	8
Frontline	COS	No	60	50-54	18
Frontline	COS; CCC	Course	40	55 <	10
Frontline	Consultant; CCC	Course	50	45-49	4

HCE: Hospital Chief Executive; HAHO: Hospital Authority Head Office; COS: Chief of Service; CCC: Chairman of the HA Co-ordinating Committee on a specialty; CSC: Clinical Service Co-ordinator/ Director; CCE: Cluster Chief Executive

Management post, training and time spent on clinical work: Seven interviews are at the "pure management" level, including one Hospital Cluster Chief Executive, four Hospital

Chief Executives and two senior managers at the HA Head Office. All pure managers have received management training at degree level except one who holds a Master Degree in public health. They are detached from clinical work spending between 0% and 5% of their time in clinical work. The other eight interviewers are at the "frontline management" level, including five Chiefs of Service who are the leader of a clinical department, and three Consultants who are Clinical Service Co-coordinators/ Directors responsible for cross-hospital or specialty management duties. Only two of them received their training at a degree level and most of them (6 out of 8) received management course training only. They spend a significantly larger amount of time in clinical work than pure managers, ranging from 20% to 70%. In our sample, the manager roles are closely related to their formal management training and attachment to clinical work, which are good predictors of physician managers' identification with the manager role as we will discuss later in this chapter.

Age and length of service in the management: Almost half (7 out of 15) of our interviewees are in their early 50s. Three interviewees are over 55 years old and they are all frontline managers in the post of Chief of Service, which typically goes to a senior physician in the department. There are also four interviewees under 50 including two pure managers at the Hospital Authority Head Office and two frontline managers. The average length of management tenure of the interviewees is 12 years and they commonly moved to the management in their early to mid-40s. Regarding this pattern, no significant difference is found between two groups of physician managers although those managers who are now in COS posts tend to be older.

Specialty and medical school: almost all our interviewees are specialist doctors except two pure managers who are GPs. In addition to General Practice, pure managers are mainly from a general postgraduate training background of Medicine (2) and Emergency Medicine (2). As one pure manager explained in the interview, in a specialist-led hospital care setting, a general training background may be a barrier to physicians' promotion in the mainstream specialist departments. General management may then open up a mid-career opportunity for them. In contrast, frontline managers are mainly from Surgery (3), Psychiatry (2), and Obstetrics & Gynaecology (1) Medicine & Therapeutics (1) and Paediatrics (1) and Emergency Medicine (1). For the latter case, the interviewee noted that it was their

Emergency Medicine background which drove them to move to management. We will discuss it in depth in the analysis of interview transcripts.

Medical school background Gender: we have a balanced representation in our sample of the two medical schools in Hong Kong (eight from the University of Hong Kong and seven from the Chinese University of Hong Kong). For the gender distribution, our sample however is male-dominated with only one female interviewee. Although the gender ratio of Hong Kong medical students has been approximating 1:1 in recent years, the gender imbalance in the cohort of late 40s or 50s is determined by the situation three decades ago. For instance, in all the forty-one public hospitals in Hong Kong, there are only three female Chief Executives. Unfortunately, we did not manage to interview those three female HCEs through recruitment strategy by our invitation emails or snowballing. Yet we could see that gender bias as reflecting the reality of a male-dominated community of physician managers.

6.3. Evidence for the Re-Stratification Thesis from the questionnaire

6.3.1. *Professional beliefs as measured by 7-point scale statements*

To supplement in-depth interviews, in addition to the interviewee's personal information, the questionnaire also includes 14 statements that reflect their identity in three dimensions, namely "professional commitment", "belief in individual physician autonomy" and "belief in collective self-regulation" based on the template study by Hoff (2000). Interviewees were asked to rate the statements at a 7-point scale from strongly *disagree* (1), *disagree* (2), *somewhat disagree* (3), *neither agree nor disagree* (4), *somewhat agree* (5), *agree* (6) to *strongly agree* (7).

Professional commitment refers to the extent to which physician executives identified with and were attached to the medical profession: "I talk up the medical profession to my friends as a great career"; "I feel very loyal to the medical profession"; "I am willing to put in a great deal of effort beyond that normally expected in order to help my profession be successful"; "For me, medicine is the best of all possible professions in which to work"; "I am proud to tell others that I am part of this profession"; and "I really care about the fate of the medical profession".

Belief in collective self-regulation refers to the extent to which physician executives believed in the exclusive right of the medical profession, as opposed to an external entity, to regulate collective norms and behaviors: "Physicians' work is something only those trained in the field can evaluate"; "Only physicians can make judgements about how well other physicians practice medicine"; "Only a physician can fully evaluate another's medical judgement"; and "Non-physicians are able to evaluate a physician's competence in practicing medicine" (reversely scored).

Belief in individual physician autonomy refers to the extent to which physician executives believed that individual physicians shall have a high degree of discretion in their clinical work: "Individual physicians should make their own decisions in regard to what is to be done in their work"; "Individual physicians should be left alone to exercise their own judgement in their work"; "Individual physicians should be their own boss in almost every work situation"; and "Individual physicians' decisions should be subject to reviews by others" (reversely scored).

6.3.2. Self-regulation at a collective level

The results in the sample are basically in line with Hoff's (ibid) study which is based on random sampling survey of 293 physician managers in the US. "Professional commitment" is the strongest belief held by the respondents in both studies interviewees (5.7 in this study and 5.1 in Hoff's study), followed by "belief in collective self-regulation" (5.3 in this study and 4.6 in Hoff's study) and "belief in individual physician autonomy" (3.7 in this study and 3.2 in Hoff's study).

While our interviewees are scoring higher than Hoff's, they score consistently higher by 0.6 in all the three sets of statements so the pattern of divergence is maintained in our sample. In both studies, physician managers still hold a strong belief (somewhat agree or agree) in collective self-regulation (e.g., only physicians can evaluate clinical work) and at the same time a relatively weak belief (somewhat disagree) in the traditional ideas of individual physician's autonomy (e.g., individual physicians should be their own boss). These findings suggest that physician managers have accepted the managerial idea of accountability in medical work but insisted their control over its process to preserve self-regulation in a

collective form. Our sample is basically in line with the pattern as shown in the randomly sampled American study while the comparison here does not deduce any statistically significant conclusion due to the small size of our sample (15).

Table 9 Professional beliefs measured by Hoff's (2000) 7-point scale statements

	Professional commitment	Collective self-regulation	Individual autonomy
Hoff's original study	5.1	4.6	3.2
This study	5.7	5.3	3.7
Pure managers	*5.5*	*4.6*	*3.4*
Frontline managers	*5.9*	*5.7*	*3.9*

With our sample, the difference between two groups of physician managers can be further observed. First of all, both pure and frontline managers hold a strong commitment to the medical profession itself, scoring 5.5 and 5.9 respectively. The both groups also have a divergence in their beliefs in collective and individual autonomy. So we could say physician managers as a whole have a line to take on the fundamental structure of healthcare governance positioning themselves as central, the state as outer and frontline physicians as subordinate. Yet, pure managers show relatively less enthusiasm in protecting their collective rights scoring only 4.6. In contrast, frontline managers score 5.7 for collective self-regulation as high as they do in the score for professional commitment. Does such difference imply two different types of hybrid identity in terms of their reaction to managerialism in healthcare, more than merely different levels or degrees of managerial influence? In the analysis of our in-depth interviews we will attempt to examine how qualitatively different the two kinds of physician managers could be.

6.4. Two types of identity as revealed by semi-structured interviews

6.4.1. Coding of transcripts and typology

To further examine those two types of physician managers' identity in different dimensions, we created a set of questions following Hoff's (1999) and Forbes and Hallier (2006) on the interviewees': 1a) reasons and paths of moving into management, 1b) experiences or struggles in the management role, 2a) views on and interaction with non-medical managers,

2b) views on and interaction with medical professionals, 2c) Views on the fairness of the HA's treatment of physicians, and 3) attitudes and actions towards the organization's management measures or policies. Based on Hoff (1999), the interviewees' answers to those questions can be classified into two types, namely "organization-compatible" and "profession-compatible". To cover possible answers that are not exhausted by Hoff's codification and those questions originated from Forbes and Hallier (2006), we add the codification used by McGivern et al. (2015) which is based on the comparable data of 3 studies using semi-structured interviews. During the codification of our own interviewee's transcripts, we found that those two codifications are still not exhaustive enough so we add two minor sub-items to Hoff's (see Tables 10 and 11). In this chapter, we will have an overview of the ideal typical answers given by pure and frontline managers based on the dichotomy of "organization-compatible" and "profession-compatible" identities. With the codification schemes we set out here, in the following sections we will further attempt to analyse the codified transcripts records of individual interviewees, and give a more sophisticated analysis on physician managers' identity work, its pattern if any, and its implication for healthcare governance.

Table 10	Codifying identities of physician managers in Hoff (1999) *	
	Profession-compatible (P)	Organization-compatible (O)
Attitude towards	1. Physician managers: a) "advocate and protector"; b) 'communicators and doctors' lobbyist	1. Physician managers: a) supervisor, leader; b) educator, salesman, decision maker
	2. Management: a) should help practicing doctors but not dictate; b) boring; c) not what "real" doctors do with their time; **d) non-professional or inferior to medicine**	2. Management: a) legitimate means of control over other doctors; b) challenging **or worth learning**; c) an alternative to practicing medicine; **d) professional or necessary**
	3. Practicing doctors: doing best they can, need to be left alone to do jobs	3. Practicing doctors: "coddled, insulated, need to 'wake up'"
Common verbiage	4. a) Squeezed, b) Remaining loyal, c) Enduring headaches	4. a) Buying in, b) Credibility, c) Being accountable
Goal/value alignment	5. "The doc in the trenches"	5. "The organization mostly"
Belief and orientation	6. "Those in full-time management positions are non-doctors"	6. "Going from medicine into management full-time is like crossing a point of no return"
	7. "The only people who understand and can comment on my work are colleagues in the trenches with me everyday"	7. "I am committed to my management job"
	8. "I am committed to my fellow clinicians"	8. "I am committed to the organization"
Strategies of resistance	9. "Tuning Out"	9. "Participatory Rituals"
	10. "Undermining the Data"	10. "Rationality Strategies"
	11. "Work Group Empathy"	11. "No-choice Appeals"

* Underlined items are added after first round of coding

Table 11 Codifying identities of physician managers in McGivern et al. (2015, p.420)

	Incidental hybrids (I)	Willing hybrids (W)
Roles	Clinical Director; PEC Chair.	(Associate) Medical Director; Public; Health Director; Network Director.
Identity (relational)	10. A professional temporarily in a hybrid role, engaging with management by necessity	9. Permanent hybrid manager–professional identity, interested in managing and organizing healthcare services
	11. Seen by professionals as a professional	10. Seen by professionals as a hybrid or sometimes a manager
Institutional work	12. Endogenous maintenance of professionalism.	11. Professional hybridization aligning professionalism with managerial organizational and policy contexts
Role claim	1. Passive professional obligation to take a "turn" in a hybrid role at professional colleagues' request	1. The fruition of formative identity work, a) involving early hybrid role models, b) positive experience of management, and c) inter-professional working
	2. Reactive professional obligation to take a hybrid role to address departmental or wider organizational or managerial problems	2. A mid-career opportunity providing a permanent career or autonomy to organize services
	3. A senior professional representative (not a substantively managerial role)	
Role use	4. Representing and protecting professionals, professionalism and good patient care (constructed individually) from managerialism	3. Transcending/disrupting professional boundaries to improve patient care (constructed collectively)
	5. Using habitual interpretive agency to valorize professionalism and demonize managerialism.	4. Using practical/evaluative and projective interpretive agency to influence and challenge unrealistic and outdated professional mentalities and practices
	6. Co-opting and loose-coupling managerialism to conceal and buffer ongoing professionalism	5. Using/integrating professionalism and managerialism.
	7. Influence maintenance of professionalism using institutionalized modes of professional communication	6. Regulating and auditing professionalism, challenging indeterminacy and poor professional practice.
	8. Validation of hybrid role use and professional identity from professional colleagues	7. Experiences in hybrid roles validate a permanent hybrid identity
	9. Maintaining flat intra-professional relations	8. Positioning hybrid as an elite within their profession

6.4.2. Reasons and paths of moving into the management (Q1a)

Pure managers and frontline managers were driven by different incentives on their path to management. With early role models of physician managers and positive experiences in management and inter-professional working, pure managers tended to see management as something meaningful in itself and as another way to practice medicine that benefits patients by system improvement. Alienated from the clinician role, some of them had a clear vision to modernize healthcare or to challenge outdated traditional professional mentalities, and some might see that as a mid-career opportunity for individual mobility asides being a senior specialist and moving up to the management in a clinical department. In contrast, frontline managers were somewhat "reluctant managers" (Forbes and Hallier, 2006). They tended to see their manager role as a professional obligation or incidental to their senior clinician role. For them, management is not what a doctor should do with their time or something uninteresting. Some of them might have a more proactive motivation seeing management as a way they can protect their own department or make policies in the hospital more reasonable for clinicians. After all, frontline managers still see themselves first a doctor and a manager, instead of a more permanent manager role as developed by pure managers.

There are three common "role claim" narratives given by frontline managers for why they went into the management in the first place.

I (1)   *Passive professional obligation to* take a "turn" in a hybrid role at professional colleagues' request

Because I was the Consultant, I eventually became the COS. Naturally it was my responsibility to do so. (Doctor C, COS; CCC)

I (2)   *Reactive professional obligation* to take a hybrid role to address departmental or wider organizational or managerial problems

- I think it is important to have administrators in the department because it affects the department in a great deal, protecting the development of the department in terms of getting resources; my mind is always with my department. That's why when the department needed somebody to be the COS, I thought I'm the best person. So I came back to the position. (Doctor C, COS; CCC)

183

- I felt that the hospital was actually unable to find some good solutions to the management problem it faced. You can say it "lacks the means" to deal with frontline's clinical problems…. Some management initiated by the HA were unreasonable…I mean the projects and the implementation was problematic as they don't take into account the frontline's needs. (Doctor K, COS; original transcript was in Cantonese)

I (3)   A senior professional representative (not a substantively managerial role)

- People do not choose to become a physician manager. When you want to get promoted yourself, automatically you become one…As a doctor you will move on to a senior position, and then be a consultant. Automatically you become a physician manager already. It's not a matter of choice. (Doctor G, Consultant; CSC)

- In the HA, usually you get promoted because of your good clinical work; and when you get promoted you become increasingly loaded with administrative duties. (Doctor C, COS; CCC)

Doing a manager job on a part-time basis without formal management training, most frontline managers actually did not undertake the management post purposely but as an obligation for a senior professional. The first frontline narrative that sees the management duties as a passive obligation was commonly found among physician managers in the COS post. Many senior Consultants actually declined the opportunity to be COS. They did not choose to be a manager but were asked by colleagues to take a "hot potato". A common situation is that HCE finally picked one senior Consultant who was less reluctant. As Doctor C (COS; CCC) noted:

At that time, I was pretty young and I was promoted to the COS. The situation dictated…When I was put to be the COS, it was a special occasion - not because I was fully competent or qualified; just because the chairman of the department became the HCE…It's not by election and actually some of the Consultants chose not to be the COS. At the end the appointment came from the HCE. After few years, I decided not to be the COS. I went back to the clinical work; it was really above me; I am not interested in management.

The second frontline narrative is a relatively reactive professional obligation. A good example is Doctor C. He/she returned to the management in a few years ago in a crisis

situation that many physicians left the department as "the department needed somebody to be the COS" in order to "protect the department". Similarly, Doctor K (COS) addressed some management problems in the department. Helping the department to solve management problems, he/she earned more opportunities to take up management duties:

> In face of the frontline's opposition the HCE was looking for someone who may have some ideas that can contribute to the committee's discussion. Then I was invited to the committee as a department rep. So I had some initiations from the department level. Somehow why they got me involved in the hospital-level management is that my ability was recognized and some influential committees got me involved. So I was gradually promoted to the higher levels. (Original transcript was in Cantonese)

The third frontline narrative of manager role is "senior professional representative". It does not emphasize the manager role as something "reactive" or "passive", but "natural" as senior physicians in a clinical department will automatically become a symbolic head in the management post. As Doctor G (Consultant; CSC) remarked, when one is promoted to the Consultant grade "automatically" he or she has become a physician manager already. Management duties are gradually attached to frontline managers along his or her career path without a clear-cut transition. Also, frontline management was not a pure management job for physicians but primarily was a requirement to be a clinical leader. As Doctor C noted, frontline managers usually get promoted "because of their good clinical work" and "become increasingly loaded with management duties". The manager role sometimes was not seen as an essential part for frontline management job, but something attached to the clinical leader role or as recognition to the seniority of the most experienced doctors in the department.

In contrast, there are two common "role claim" narratives of pure managers on why they went into management.

W (1)   The fruition of formative identity work, involving

    a) Early hybrid role models

- By luck, the College wanted to involve some young fellows to help their discussion in the Council. I was really young at that time, so I just did what the President told me. So I was picked by the College as a Young Fellow Council Member and had

got the chance to know many Service Directors at the Head Office before I went to the management. (Doctor N, HCE)

- My predecessor…he got me involved in it and I became a Cluster Coordinator. So I worked with him, part-time actually. I was then still COS director in clinical service but part of the time I worked with him as Cluster Coordinator for almost 10 years before I moved on this job 4, 5 years ago. (Doctor F, Manager at HAHO; original transcript was in Cantonese)

b) Positive experience of management

- It's just lucky...it's quite good and it is suitable for me to stay. (Doctor B, Senior Manager at HAHO)

- I don't consider it as suffering, otherwise I would have left. Because I found the meaning in doing this; somehow once I have got the job, I found the meanings and my interests. That's why I stayed. (Doctor E, CCE)

c) Inter-professional working

- My experience is very fulfilling with colleagues from finance, human resources administration background. (Doctor J, HCE; original transcript was in Cantonese)

- I can say my relation with other colleagues is good and we are willing to communicate with each other. (Doctor B, Manager at HAHO)

W (2)   *A mid-career opportunity* providing a permanent career or autonomy to organize services

- At that time, I was working in the clinical field, where I did not have much interest. That's the problem and I decided to try something else. (Doctor E, CCE)

- Somehow my career was in Emergency Medicine where you will easily reach the apex of the ladder. After 5 or 10 years you will have learnt everything. There are only a few things that are really fresh and how can you pursue excellence and creativity? It is because the authority or expertise in any subspecialty of A&E will finally belong to another specialty. (Doctor J, HCE; original transcript was in Cantonese)

Pure managers in the sample were more motivated to take up the manager role. They mentioned some of their positive early experiences in management, including their early role model and their sense of gratification or achievement gained from management work and interaction with non-medical administrators. Those early experiences offered a quite different picture of what management work is and drove pure managers to move up the management hierarchy. In addition to "pull" factors, there were also "push" factors for pure managers to leave the clinical path of promotion. Some of them expressed losing their interest in clinical work and looking for a mid-career opportunity.

> It's something unplanned actually. My original intention was to be a general practitioner in the private market but I considered that it is a bit risky to venture to the private sector. At that time, it was a civil service, so I decided to stay and so I discussed with my boss that I did not wish to stay at that particular portfolio. Somehow he considered me to be suitable to try taking up somebody's management responsibilities, and he introduced me to the head quarter of the Hospital Services Department. It was a post in planning. And after a couple of years, I was promoted to another layer, and then I decided to stay on. (Doctor E, CCE)

While frontline managers were using the manager role to achieve professional aims, such as the "the frontline's needs" (Doctor K, COS) and "to protect the department" (Doctor C, COS; CCC), some pure managers saw it as an "individual mobility strategy" (Forbes and Hallier, 2006). Individual mobility strategy was associated with physician managers' training background. In our sample, 5 out of 7 pure managers were from a General Practice or general postgraduate training background (Medicine and Emergency Medicine). As Doctor J (HCE) explained, "the authority or expertise in any subspecialty of A&E will finally belong to another specialty" and one will easily reach "the apex of the ladder" in the mid-age after 5 to 10 years of promotion in one's own speciality (physicians in the HA typically obtain fellowship at the age of 30 after 6 years of residency). The mid-career opportunity opened by general management might then be very attractive to some of physicians who have a little chance to get promoted via a clinical path, or uninterested in specialist training in the first place (e.g. Doctor E).

Besides individual mobility, a clear managerial vision to reform medicine was found among some pure managers at HAHO.

W (3)   *Transcending/disrupting professional boundaries* to improve patient care (constructed collectively)

- For a large-scale institute, good organization and service planning will be the very determinant for good outcomes of patient, in terms of quality and quantity': When doctors graduated they will find that how to manage the patients is just part of the service…. Public health care system is very much a kind of organization and also the delivery of service. These are the questions to professionals. So I tried to explore how those services are organized, why and how the funding comes from, what is the purpose of delivering services to the elderly, what is the final target you want to achieve. (Doctor B, Manager at HAHO)

- It's out of my interest in public health because public health is very important. People have been having stronger awareness of it, especially after SARS (Severe Acute Respiratory Syndrome). Before that people had long accepted our system as a specialist-led or clinical-oriented one, but I thought if we want the system to perform well we need public health. We are not only facing individual patients but the whole Hong Kong as a group of patients…I think people working on public health would not be pure clinical as you are talking about population health rather than individual clinical heath management. (Doctor F, Manager at HAHO; original transcript was in Cantonese)

W (4)   *Influence and challenge* unrealistic and outdated professional mentalities and practices

- As the world is going on, public expectation is higher, technology is improved, and also the doctor-patient relationship has changed…when those things changed, how can the whole organization change in the same way, right? If you look at the other professions, medicine is one not that closely packed with those changes. It's already left behind'. (Doctor B, Manager at HAHO)

- For the patients, there's nothing wrong to have a specialist to look after them. Given that money is not a concern, this is the optimal option and everyone is inclined to do that. This is what I want to change in a public healthcare system. In the private market you can do whatever you want, while in the public system resources allocation is an issue, especially when medicine is coming up with new evidences

and findings in each passing day that are going to have impacts on healthcare system. Its impact on Hong Kong is that public health becomes more important. (Doctor F, Manager at HAHO; original transcript was in Cantonese)

The meanings given by those pure managers to their role were inspired by a bigger vision of modernizing the specialist-led public healthcare system. For them, the bio-medical model that primarily sees medicine as treating individual patents' diseases had been proven outdated, and the public health model was called for in view of rationalizing the specialist-led system. In this connection, physician managers were the rationalizers in the profession challenging their peers who were coddled in a traditional professional culture. Also, management work was not something incidental for pure managers but the key to deliver good service to patients at a population level. Organization and evaluation of service therefore was as necessary as, if not more important than, clinical expertise in healthcare.

Those positive purposes for physician managers to go into management were closely linked to their attitudes towards management recognizing it as an alternative to practicing medicine. As Doctor J (HCE) delineated:

> As everyone in the management would say, you treat individual patients by practicing medicine whereas management is talking about to treat the whole system. You want to contribute by helping the systemization. (Original transcript was in Cantonese)

Similarly, Doctor E (CCE) justified his move to the management as "for the benefits of the six or seven million population rather than a limited number of individuals under my care". Equalizing the significance of management to clinical work for patients was a core part of pure managers' identity work as to legitimatize their detachment from clinical work in a more permanent manager role.

The personal histories of some pure managers were also related to the rise of general management in the HA as a consequence of SARs (Severe Acute Respiratory Syndrome), which took place in 2003 in Hong Kong and killed 300 citizens. As Doctor F (Manager at HAHO) suggested, the specialist-led system of the HA was heavily blamed for its inadequate handling of the crisis, and reforms were urged in response to the deficiency in management. As a result, general management was expanded with more permanent management positions being created, and some pure managers made their debuts in management. Illustrating

examples of how some physicians were drawn to the management post in the crisis are as follows.

- That was after SARS I got promoted to the consultant post. At that time there was a problem of the hospital beds in the department. I was asked by the Chief Executive and I thought it was a challenge. I think that's how I got in management duties in the hospital. And after that I was given more tasks by the Chief Executive and I took up those tasks. I thought I did it quite well. When there was a vacancy of the Chief Executive in my former hospital, I was asked to apply then I got the job.   (Doctor A, HCE)

- In 2003, the SARS took place in Hong Kong. The Head Office needed someone in the Legal Service Department to handle law suits related to the epidemic. So the HA picked me as Executive Partner offering support to the Legislative Council. And I spent a whole year in the Legislative Council and Law firms. I stayed on in the position after that as long as they created a permanent post for it. I did not expect anything as I had no idea about management at that times. (Doctor N, HCE)

Pure managers were not necessarily going into to management with a clear vision but did have a relatively formative identity work of the manager role. Enrollment in formal management training at the degree level can be seen as an acknowledgement to one's permanent manager role. All pure managers finally obtain a formal qualification although they might not have it before entering management. In contrast, most frontline managers do not hold a formal qualification. Doctor J (HCE) expressed how they feel pressured to meet that implicit requirement for pure managers:

When you are doing management on a full-time basis, you better have a qualification to backup yourself. Actually I was quite ambiguous about the requisite for the master course. Since I had the time and the opportunity…and because sometimes people will challenge you…even in just an interview you could ask me if I have got any management training. Also, you have to manage something other than medical, such as HR, finance, procurement, and administrative things. Then you will be not assured or confident enough as you may doubt whether you can handle something that they know well and you know very little. Although you can learn those things on job, it would be very difficult for you to manage. So I went for the master course. (Original transcript was in Cantonese)

Instead of stepping down as Doctor C (COS; CCC) once did, pure managers decided to stay on and tried to back up themselves as a qualified manager. As McGivern et al. (2015, p.426) argue, cultivating a manager-self or identity is a cause rather than a result of a manager role. Given that one could choose to advance as a physician manager or preserving their professional identity, the underlying driver for claiming senior hybrid roles is therefore the identity work itself. As abovementioned, pure managers were generally more positive about their early experience in management and interaction with non-medical administrators. They also had a clearer vision and mission for their management work. Such identify work was reinforcing and reinforced by their different experience in the transition from a clinician to a manager role as we will discuss in the next section.

6.4.3. Experiences and struggles in the transition from a clinician to manager role (Q1b)

Most physician managers expressed that clinical work did mean something to them and there was a sense of loss associated with their detachment from the clinical field. However, pure managers tended to emphasize the bigger picture of overall benefits they could bring to patients in the management position, and their sense of satisfaction or achievement associated with management work. Quite differently, frontline managers tended to see clinical and management work as conflicting and therefore stuck to the traditional way of defining a professional self with their attachment to clinical work.

As Doctor F (Manager at HAHO) illustrated:

> Facing patients is something gratifying. We can say doctors love to face patients. That is your profession itself, something you are supposed to do...It is very satisfying when you can see something you can help the patients...There are many gratifying stories about the everyday clinical work.

> After all, you are one step back from the frontline. Then what you are seeing is different. You can't just do it in the way like "it is good because I think it is good." For example, I have 10 apples, shall I equally give one to each person, or I give two to those who are hungrier, or even more? Most of the management is actually for the patients' good. When moving to a higher position, you have to start considering those factors. There may be different service models alongside the one you are using. So how can you integrate them?

Such things cannot be done in individual patient's management, but you can do it in this direction'. (Original transcript was in Cantonese)

Seeing management as *an alternative to practicing medicine (O2c)*, pure managers were more likely to replace their sense of loss with a sense of achievement on something "cannot be done in individual patient's management". As Doctor F went on to conclude:

I have achieved something...We can progressively change the things in our positions. We can steer something and wait and see them to move slowly...Those are what I need to think about how to help the whole the HA. (Original transcript was in Cantonese)

Doctor L (HCE) mentioned other sources of frustration and challenges a pure manager could perceive, such as "different opinions", "objections", "hurdles", "resistance to change", "lack of resources", as well as "losing clinical authority". Yet, most pure managers found that their expectations for their manager post were met and felt rewarded. As Doctor L noted:

I've been participating in numbers of projects that can help our staff and patients, and some of the projects have had certain impact to the health care system as well.

The transition to a manager role might actually be a very gratifying experience for some pure managers. For some of them, their early experiences in management were seen as a preparation for their further promotion as physician managers. As Doctor N (HCE) noted:

I didn't feel that's too difficult for me. Before I moved to the Head Office, I was Associate Consultant. So I had been taking some duties that are most "annoying" to the others - duty arrangement.

Some pure managers might even see that *management is "worth learning" and "challenging" (O2b)*. For Doctor J (HCE), who deemed him/herself as "a person who hungers for new knowledge", "the opportunity to do management job sounded quite attractive". He/she also thought that "management is funny as there will always be new things for you to learn" and "it is quite funny and right for my personality". For Doctor J, the transition was "a very a short period of time":

It was a gradual change. Sometimes I would remember the satisfaction from doing particular cases. But there would not be much time for me to think so much as every day you feel you are learning something new. (Original transcript was in Cantonese)

For those who had lost their interest in clinical work like Doctor E (CCE), the transition could be an escape. For Doctor E, clinical work was "simple and far too relaxing":

I would say I didn't like that department…to the extent that it has ruined my interest in clinical practice because of the lack of the supervision and lack of training…the atmosphere was so laissez-faire there. I did not have much to do. Every morning I did ward-round before 10 or 10:30 and basically I finished the morning duty. And it was far too relaxing…in general, once I was off, and it's off. And then you go to cinema, you go to dating, and so.

Management however was more "challenging" and "meaningful" for Doctor E in a sense that looking after the entire population required greater efforts and intelligence from physicians:

For management, one's mind never stops. Even when I was sleeping, watching a movie, having dinner with my parents, I kept on thinking about work-related issues, thinking about maybe tomorrow's meeting, how to write certain paper, what to do when I meet my director tomorrow, things like that. So it is pretty different…I found the meaning in doing this…As a clinician, my mission was supposed to look after patients under my personal care. So is quite simple. I have 10 patients, 20 patients, that's it. But as a manager or as an executive, I don't have a single patient to look after, and many a time what I do was to look after the entire population.

For frontline managers, the transition to a manager role was a rather painful experience. Doctor O (COS), who didn't think management as a "fulfilling job" and "don't like administrative work personally", explained to in the interview:

I do see the point but still there are conflicts between what you want to help patients best and what actually your duty as an administrator to look at the big picture to contain the costs, like you cannot use expensive drugs although there are some marginal benefits. I would say the administrative role is not actually very gratifying.

The big picture of productivity gains was not valued by frontline managers as something beneficial to more patients but as conflicting with the professional idea to "help patients in the best way". Instead of seeing management as something meaningful, they saw it as *not what "real" doctors do with their time (P2c)*. For example, Doctor C (COS; CCC) defined a clinician with his or her clinical attachment:

> I did not switch to the management. I just took up administrative duties; I still see myself as a doctor but part of my duty is to manage the department; I don't consider myself in the management as a whole. I'm still a clinician; I still do the ward round…I still operate when I'm the (team) leader. So that's why I don't see myself as a manager.

Time allocation was another issue raised by frontline managers on the conflict between their professional and manager roles. As Doctor K (COS) noted:

> Somehow your management duties clash with clinical duties and that may affect clinical works…Sometimes it is difficult because some special patients may need an expert care. You may need to change your timetable from clinical duties to management duties. (Original transcript was in Cantonese)

In sum, pure managers and frontline managers demonstrated two different types of identity work and the associated outcomes in their transition to a manager role. Generally speaking, pure managers had a clearer vision and positive attitudes towards management work as something meaningful, and this was accompanied by encouraging experiences of entering the manager role. Sometimes their manager-self was developed at the expense of their clinician-self, justifying their detachment from actual clinical work. For frontline managers, the clinician role was rather a permanent identity for them. Their manager role might only be a temporary one based on an obligation to their profession or department, instead of a robust motivation or meanings attached to the management work itself. As a result, they were always in a struggle to reconcile their clinician role to their manager role, unlike pure managers whose pains in their transition from their clinician role were compensated by gratifying experiences and a sense of achievement in the manager role. In the next section we will turn to another dimension of their identity work as revealed by their interaction with non-medical administrators.

6.4.4. Interaction with non-medical administrators in the manager role (Q2a)

An indirect depiction of physician managers' attitudes towards management work and their manager role perhaps is their attitudes towards other management personnel. It is also related to how the medical power is interacting with other actors in healthcare governance. In the management of the HA which is a professional-led system, non-medical administrators may probably be seen as an extraneous part by medical professionals. Interestingly, while our findings confirm that generally pure managers were more welcoming and frontline managers are relatively antagonistic, the overall domination of physician managers as a group was still intact and their explicit confrontation with or subordination to general management rarely happened.

Two common narratives that recognize non-medical administrators as the integral part of healthcare governance were given by pure managers:

O (2d)   Management is professional or necessary in medicine

- Is it that everything in the healthcare system is related to clinical? Not necessarily. For instance, for something related to law, a doctor won't help...The fact is that it is something you don't have in your training, especially now things are becoming more and more specialized and compartmented. (Doctor B, Manager at HAHO)

- The benefit of having a doctor like me who took on a managerial position is we can understand a bit more how doctors think and act. But that's not an absolute necessity. Someone else can do that if they spend enough time in the system. (Doctor E, CCE)

O (2b)   Management is worth-learning

- I think the most important point is how to use others' expertise. Never feel yourself like sitting up high here, superior to anyone else, or I can do everything…when you have contacts with various people, such as finance, statistics, and the auditor units, you will have a different way of planning a service model or handling works. (Doctor F, Manager at HAHO; original transcript was in Cantonese)

- There are so many things you can learn from them as they have their own specialisms and perspectives. The most important thing is to have a teachable heart. It is easy for

doctors to see themselves as superior to everyone else in the healthcare system, of which we know is not real. Management tells you that it is all about team work and you need different perspectives. (Doctor J, HCE; original transcript was in Cantonese)

- Medical profession is actually the easier one. Being a doctor, you just need to think about the best interest of the patients. It is very comfortable to act on that moral high ground, while in finance and legal service the most difficult bit is the prioritization of conflicting needs...The difference in our backgrounds actually means that we can learn from each other. (Doctor N, HCE)

Pure managers tended to see management as an equally important profession or expertise alongside medicine in healthcare governance that requires for specialized training in finance, statistics and auditing. Their enrolment in formal management training spoke for itself. They also denied the necessity of medical qualification for managing healthcare. For them, devotion to management and management skills, rather than clinical knowledge, defined a competent manager. This was also associated with pure managers' positive perception of management work as something worth-learning. They showed a "teachable heart" to see things differently and work with non-medical administrators as a team, as well as the willingness to learn the latter's management skills such as prioritization of conflicting needs and planning of service.

Contrary narratives that some frontline managers gave on non-medical administrators however were:

P (2d)   Management is unprofessional or inferior to medicine

I think obviously when people work in the health care area, a strong background in healthcare is really very important, simply because there are so many different types of work for all going on in the hospital. So if you have not been involved in this, it will be very difficult to understand those things. If you do not understand, that will lead to conflicts because..."Wow, why do these people lead like that? "

To be honest the doctors are always at the top level. The other people they are more looking upon as supporting.... So if you're not a doctor, say for example, it would be quite difficult to imagine somebody else say administrators or nurse to be in my position.... they always

need a doctor in a lead role. Otherwise, you can't drive order changes. (Doctor G, Consultant; CSC)

P (2c)   *Management is not what "real" doctors do*

You can see the lack of passion...not compassionate…because they have not really seen their patients and felt the hardships of both the healthcare workers and the patients. They have other competing demands on their side, say for example control budget, all the political pressures. If they do not have other things to check and balance on the other side, decisions may not always be in the best interest of the patients.   (Doctor G, Consultant; CSC)

Frontline managers expressed an obviously different sentiment regarding the role of non-medical administrators in healthcare governance. For them, clinical background was a pre-requisite for one to be a fit manager in a sense that a non-medical manager was seen as unable to drive changes or lead medical professionals. Interestingly, while both groups of managers were taking about the complexity of healthcare system, frontline managers tended to refer to clinical activities instead of management issues. They also defined physician managers as those who had commitment and passion to patients in contrast to non-medical managers who they saw were compromising those values for budget, cost-efficiency and political pressures. In short, the introduction of general management was seen as contesting with traditional professional values and professionalism of medicine shall be upheld against it.

Regarding the potential conflicts between physician managers and non-medical managers, Doctor F (Manager at HAHO) described how the conflicts with non-medical managers could be settled by pure managers' communication efforts:

We have goals in common to make things better while we may be out of steps or for some difficulties we have different views on the matter. It's not right or wrong but I have my own views and you have your own views. So doing management, you have to spend a lot of time in communicating with different people. (Original transcript was in Cantonese)

Instead of consensus, communication or a collaborative relation, "social creativity strategy" was adopted by some frontline managers to settle conflicts with non-medical managers. According to Forbes and Hallier (2006), in contrast to "social competition strategy" that is

explicit confrontation to challenge the legitimacy of management's authority by acts of open hostility, "[i]n the situation where the status of doctors in relation to management is seen as both high and stable, doctors are likely to pursue social creativity by using their managing role to engage in covert undermining of managers in order to continue management's perceived inferior status" (p.38). As Doctor H (COS) remarked, when different opinions arose in the hospital, it didn't concern him/her much as final decisions were usually made by Hospital Chief Executives. The unspoken words were that physician managers' rights to speak on policy were well protected as Hospital Chief Executives was usually also a physician. In this respect, Doctor O (COS) suggested that administrators were only playing a supporting role in healthcare governance, far from a substantial challenge to physician managers:

> I would say in Hong Kong administrators are still clinician-led. So it is slightly different on the American system or the UK system, and the conflict is not that sharp.

While some frontline managers might recognize that non-medical managers were necessary for healthcare management, this didn't imply an equal status obtained by the latter. For Doctor D (Consultant; CCC) who emphasized that management was something that cannot be done without non-medical managers, management work was actually something rather clerical or ancillary. At the end, non-medical managers' role was seen as supporting the frontline clinician as they lacked the necessary clinical background:

> We learn from each other...it is not just doctors and nurses working for the patients, but basically you need someone paying the electricity bills, the water bills, make sure we have fire safety…They also learn from us in terms of, like the clinical flow, the environment of like in the ward or outpatient, which they know what they need to help providing to the staff.

> Compared to those who don't have a medical background…I understand more about the patients, and the clinical staff's needs...I will say the management role as well as the administrative role will be sort of like a supporting role for the clinicians to carry out the duties more efficiently.

Doctor K (COS), who admitted that even a senior clinician could have no idea of what's happening in management, also concluded that physicians actually had a huge competitive advantage over non-medical managers:

> If you don't have the management background you are really in a huge disadvantage in the beginning. Yet, if one keeps going with the management for years, a manager who has a clinician background will be superior to those who haven't. They know what the problem is. When they also dabble in other areas of techniques, such as engineering and IT, they will know the both ways and become very powerful. (Original transcript was in Cantonese)

Noticeably, while pure managers did not have such a strong sense of privilege of being a physician compared to frontline managers, they did not lose their superiority over non-medical managers:

- When you are seeing deeper from others' perspective, doctors are always advantaged - after all, doctors are respected in the healthcare industry. If you are more modest, you will easily gain trust and be accepted by colleagues. (Doctor J, HCE; original transcript was in Cantonese)

- Doctor's background would definitely be useful - because I have worked in the hospital, I understand what's the working pattern; If you don't have this knowledge, you will spend a lot of time to talk with so many people; This saves a lot of efforts. (Doctor B, Manager at HAHO)

Although pure managers recognized that the non-medical administrators could be qualified for a manager job in theory, in reality the latter can rarely compete with physicians who know both the clinical and management expertise. This echoes the questionnaire results that pure managers still hold a strong commitment to the medical profession itself and beliefs in collective rights of physicians to self-regulation, which emphasizes that non-physicians are unable to evaluate a physician's work. Taken together, a flat and collaborative relation between pure managers and non-medical managers implies no more than higher acceptance to managerial ideas by the former. It is far from evident that the balance of power between physicians and general management personnel has undergone substantial changes.

6.4.5. Interaction with medical professionals in the manager role (Q2b)

The Re-Stratification Thesis suggests that physician managers are alienated from the rank-and-file doctors as a group of elites in the profession. In this connection, the extent to which they maintain a goal or value alignment to the frontline doctors will be crucial to the question of whether the medical professionals and clinical work can be shielded from managerialism in the daily operation. In our interviews, physician managers then were asked directly on their views on frontline doctors and how they enacted their role towards the latter.

Pure managers, who *aligned their values mostly to the organization (O5)*, tended to deny or tone down their role in representing frontline doctors or protecting their interest. Their responsibility to the organization and a "global picture" of things were preventing them from identifying themselves solely as doctors' advocates, whose views were limited to the needs of the frontline or individual patients. On the contrary, frontline managers, who generally *aligned their values to the doctors in the frontline (P5)*, showed a stronger commitment to the frontline doctors and claimed to be their "protectors" as well as "lobbyists". They also tried to avoid being seen as a manager by close connection to clinical work or a flat relation with professional peers.

Reservations about being an advocate for frontline doctors were commonly found among pure managers. Doctor A (HCE), who claimed that he/she disliked using the word "management" or "manage" frontline doctors, on the one hand felt some sympathy for the "extremely heavy workload" they were having and pledged to "make them feel supported", on the other hand remarked that "I'm not just an advocate for doctors but all colleagues". A similar stand taken by Doctor E (CCE), who identified themselves as "representing the management", and they did not see themselves to have "an additional duty as an executive":

> From an angle of employer-employee relationship, of course I represent the management, I represent the employer. So there are basic things which I need to do…And I'm also a doctor; I'm also a part of the profession. Of course it will also be my role to do something. But I'm just one of many, just one of the 13,000 medical doctors in Hong Kong. So I don't know how much of additional duty as an executive as far as the interest of the medical professionals is concerned.

For Doctor B (Manager at HAHO), ambiguity of roles between a clinician and manager was something a physician manager has to avoid in order to protect the manager role:

> I think we should clearly identify our stand – I am coming down to the front-line as a manager. You must be acting in a certain role in the communication and it should not be ambiguous. You also have to know their role. They are those who are doing the clinical work; you are doing the management. Our roles are clearly defined.

The explanation given by physician managers for their detachment from a clinician role was that clinicians' views are sometimes "narrow" and limited to their immediate environment at the department-level. For them, *practicing doctors are "coddled, insulated, need to wake up" (O3)* and *physician managers are elites within their profession (W8).* As Doctor B went on with their "difficulties in communicating with doctors" arose from the latter's ignorance of the responsibility of the healthcare system as whole:

> At that time the doctor patient relationship has not yet established, for executives like us, we have a duty to look after patients before they can see our doctors. But for the doctors, since the doctor patient relationship has not been established yet, at least you can see a lot of doctors saying that it is none of my business. So if we monitor waiting time, if we introduce some initiative to reduce the waiting time, and so on, sometimes we have difficulty communicating with doctors at this point.

In this respect, Doctor J (HCE) suggested that "management is another language that you have to consider' while "for clinician, that may not concern them at all". Therefore, physician managers "have to be more detached when doing management" because "if you are still too clinical, thinking like a doctor, it's easy for you to be narrow". Talking about "the advantage of a doctor in doing management", Doctor J actually referred it as being "easier for you to put yourself in doctors' shoes", and remarked that skillful physician managers "don't fully take their point of view thinking totally like a doctor" (original transcript was in Cantonese). Put positively, a wider view is what distinguishes physician managers from rank-and-file doctors:

> What you can offer to doctors is that you have a wider view than theirs. For instance, they know less about HR, financing, they know less about the government's perspective, they know less about the Bureau and Ministry's perspective, they know less about the Head

Office's perspective, they know less about the general public's perspective, as well as other departments' perspective. This is the value I can offer them. (Original transcript was in Cantonese)

Or put it negatively as Doctor E (CCE):

Most of the doctors don't understand what the management system is about...There are many other components of the management system which will improve the standard of care; all the forms, all the checking, all the protocols… if they can achieve the benefits of reducing medical errors, then I see no reason why there's a dichotomy.

In this sense, frontline doctors' resistance to managerialism in healthcare was seen by pure managers as hindering its improvement because management is something good for the standard of care delivered to patients; and they were "coddled, insulated, need to wake up" rather than the guardians of patients' interest. "Privilege of physicians" was understood by pure mangers as offering an advantage to managers over clinicians in the frontline, instead of the other way round:

The main point of your interview is that, as the theories you study may suggest, a physician will be loyal to their profession. To a certain extent I agree to that, but the most important thing for being a physician manager is to realize that you have a privilege. You have the clinical knowledge. So when someone is telling you how to treat a disease, you won't be overawed as you have the ability to analyze whether the treatment is in line with the current international standard or it is only your personal idea, or whether a new theory is evidenced. If you have the ability to read a journal, I can say you will at least know the general picture. This is a really crucial privilege of physicians. (Doctor B, Manager at HAHO)

On the one hand, pure managers saw their exploration beyond the clinical field as an advantage over their professional peers in the frontline. On the other hand, clinical background was valued an asset, especially when they needed to manage the latter.

Other than positioning physician managers as the elites in the profession, pure managers downplayed the potential conflicts between the manager and clinician role by justifying their detachment to clinical work as the division of labor between doctors and managers. As Doctor B (Manager at HAHO) put it:

Nowadays doctors have more knowledge about public admin in public healthcare system. They know their role is to treat the patients, and they know that I'm trying to run the system for them. If nowadays you are performing your functions well, doctors will appreciate it.

Frontline managers, on the contrary, developed a different kind of identity seeing themselves as *frontline doctors' advocates, protectors and doctor's lobbyists (P1)* and *practicing doctors as "doing the best they can, need to be left along to do their work" (P3)*. For example, Doctor C (COS; CCC) who claimed to be "the final leader" of frontline doctors, suggested that physician managers and frontline doctors were in a relation that "settled on resources", rather than managers and workers:

They always need to come to me for resources. As far as possible, I will try to support them unless something doesn't make sense…I don't tell people what to do. Because they are more than an adult; they are professionals; I believe everyone should do what they believe. If they are the team heads in an area, I think that area belongs to them.

Frontline managers also expressed strong sympathy for frontline doctors as the victims of managerialism in healthcare, and more importantly, saw physician managers as one of them:

I think to be a clinician is always not easy. In Hong Kong, we are using a minimum GDP to cater whole healthcare system. It is one of the most efficient healthcare systems in the world...but at the expense of over-utilization I would say, over-drafting of lots of things, sometimes the communication with the front-line staff. Sometimes the relationship with the front-line staff is jeopardized. As a clinician, I think listening more to clinician's thoughts is important. The Hong Kong system sometimes is over-efficient. (Doctor O, COS)

Maintaining a flat intra-professional relationship (I9), frontline managers held clinical freedom as a core value.

I do not influence how they manage the patients…I mean by exerting any administrative influence. They still have the freedom to practice as long as they follow the Code of Practice, and for the benefits of patients follow the practice that we have to follow in our profession. Otherwise I don't interfere with them too much. They do have their autonomy. They just have to follow the house rules. (Doctor M, COS)

Also based on trust and public service ethos, some frontline managers saw a manager mindset or management itself as incompatible with the medical workplace where the accepted mode of interaction were engagement and reasoning processes.

- I prefer not to have a very strong mindset of managers. We actually may not be able to manage many things. So I think respect is the most important thing…. within the public setting, I would be quite comfortable to have an assumption that people working here are wanting to help other people.   (Doctor I, Consultant; CSC)

- I do think first of all we don't use the word quality control. We use the word quality improvement. It will be better because quality control is a concept more useful in the manufacturing industry: get product, check, throw away right? That is more like quality control. And I believe in quality management we are talking more about engagement…we have to understand that you can never be successful unless you change their mind, and they want to improve. (Doctor G, Consultant; CSC)

Behind the motivation of entering into a manager role, many frontline managers were actually driven by their commitment to frontline professional peers.

- I still think I am a clinician more than a manager. So why I still work as a manager is because I want to have voices of the clinician at the management level so that they won't be like left out...' (Doctor D, Consultant; CCC)

- We just bring the clinicians' perspective into the decisions. It is a reasoning process. (Doctor H, COS; original transcript was in Cantonese)

As well as "lobbyists", the role claim as "protectors" was found among frontline managers. For example, Doctor I (Consultant; CSC) demonstrated a sense of responsibility to protect frontline physicians from long working hours:

Most of our colleagues are working so hard, and the working hours are so long and they are so exhausted. At the end this is perhaps one of the most common reason why people may make mistakes. And it is actually the responsibility of the manager that how we can make sure you have sufficient rest.

In this connection, Doctor M (COS) mentioned some issues whereon frontline managers should fight for frontline doctors, such as training opportunities, promotion opportunities, to

ensure sufficient staffing for the department, as well as re-engineering work, rearrangement of duties and restructuring of the team to lessen the frontline doctors' workload or make it less stressful for them.

Frontline managers' resilience to their clinician role was also reflected by their sentiments of being distrusted by peers. Rather than complaining about the frontline doctors' narrow vision and their ignorance of management, frontline managers complained about the alienation from their professional peers.

- I think the most difficult bit is to deal with my own peer doctors…They just think you are trying to do something very superior and then leaving the duties to the others. So that's why you have to spend some time to explain or to make them understand that you are actually doing something for them. (Doctor I, Consultant; CSC)

- Some clinical colleagues will doubt about whether you are…the worst scenario is not trusting… the common scenario is having a doubt about what you are actually representing…They will see you as a manager, no longer a doctor. They will position you as a management position rather than a clinical one. (Doctor K, COS; original transcript was in Cantonese)

As discussed in previous sections, frontline managers' clinician-self was actually built up with their role as clinician leaders. In this regard, some frontline managers emphasized their clinical connection as "the clinician hat" that helps them to avoid being seen as a manager by their professional peers.

- As a supervisor of the clinical duties, I still work to a certain extent to instruct what they do....my background as a clinician will help a lot, when I say to them as a clinician rather than a manager purely. I will try to use the hat as a clinician slightly more rather than putting on the hat as "I'm purely a manager". (Doctor D, Consultant; CCC)

- Back to my own department…people more view you as a clinician as you are doing clinical things again. Being part of my team and with me for many years, many of them still receive clinical supervision from me. That's why they see me as a clinician and see me doing clinical work as well. So they will see me differently. (Doctor K, COS original transcript was in Cantonese)

205

In summary, while frontline managers, who positioned themselves as also clinicians, tended to be more attached to the clinical role and acted as a manager to protect or represent frontline doctors, pure managers, who positioned themselves more as elites in the profession with a wide view and scope of knowledge, tended to be relatively detached from the clinical role and acted as a manager to improve patient care at the population level.

6.4.6. Views on the fairness of the HA's treatment of physicians (Q2c)

In this section, we will turn to more sensitive questions on whether the interviewees accept the status quo of the HA's governance. We first asked the interviewees whether they think physicians as group are treated fairly in the HA, followed by a more specific question on whether they think the senior management communicates enough and seeks input regarding decisions that affect physicians. Incongruously, while physician managers were divided by two types of identity, one relatively organization-compatible and another one relatively profession-compatible, they demonstrated a general acceptance to the HA management.

Pure managers took a relatively unified stand affirming the fairness of the HA's treatment of physicians, with none of them denying that. Although two of them refused to answer directly, they suggested that "physicians are treated equally" in the sense that "there is no perception of favoritism" (Doctor A, HCE) and "physicians are having same working hours and salary level across specialties" (Doctor L, HCE). Such kind of answer can be considered as perceiving no unfairness *de facto*. In contrast, frontline manager's answers were more diverse, with only two of them perceiving the treatment as unfair, three of them affirming it as fair, and two of them giving a mixed answer. One frontline manager denied the question as a meaningful question as "there is no fairness" (Doctor C, COS; CCC). We can consider this answer as "Yes" for it is *de facto* suggesting that there are no unfairness issues in the HA.

Taken together, two-third of physician managers in the interview positively commented on the HA's treatment of physicians, including over half of the frontline managers. A similar pattern was also found in physician managers' answers to whether the communication and input from the frontline is enough. 9 out 13 of interviewees whom we managed to ask about

this question answered "Yes", including half of the frontline managers and most of the pure managers.

Table 12   Physician managers' attitudes toward the HA management (whether physicians are treated fairly in the HA)

Type	Answer	Remarks
Pure	Treated equally	No perception of favouritism
Pure	Yes	Public service should not be compared to the private sector
Pure	Yes	Same pay scale for all; people can choose to leave
Pure	Yes	Public service should not be compared to the private sector
Pure	Mixed	Well paid; but work is demanding, long working hours
Pure	Treated equally	Same working hours and salary level across specialties
Pure	Yes	Same pay scale; inequalities in payroll have been redressed
Frontline	Yes	No definition for fairness
Frontline	Mixed	Clinical autonomy; inequalities in payroll
Frontline	Yes	We have gone through the hardship
Frontline	No	Not protecting doctors in complaints against clinical accidents
Frontline	No	Doctors are not paid for extra workload.
Frontline	Yes	Given the resources in the HA, it is fair
Frontline	Yes	We have some people to represent us
Frontline	Mixed	Efficiency is at the expense of quality; due to resources problem

Table 13   Physician manager's attitudes toward the HA management (whether the senior management communicates enough and seeks input regarding decisions that affect physicians)

Type	Answer	Remarks
Pure	Yes	Both parties have the chance to express their views
Pure	NA	Question was not asked in the interview
Pure	Yes	
Pure	Yes	There is the mechanism
Pure	Yes	There are transparent channels
Pure	No	Frontline doctors are not keen
Pure	Yes	They have every intention
Frontline	Yes	Channel is always open
Frontline	Mixed	There are channels but not effective/ They have tried hard
Frontline	No	Not scientific or structural
Frontline	NA	Question was not asked in the interview
Frontline	Yes	Channel is more and more open
Frontline	No	No enough channel
Frontline	Yes	Frontline doctors are not keen
Frontline	Yes	There are Opportunities. They start to learn

The focal point of disputes between physicians and the HA in recent years is undoubtedly working hours and remuneration issue. Following the government deficits in the early 2000s, the HA introduced tight productive gains programs and pay cut to its frontline staff while the senior management personnel were rewarded with performance bonus (Yeung, 2005). A backlash was doctor trade union's ten-year long lawsuit against the HA's policy of depriving frontline doctors of overtime payment. The only thing the HA could do was to attain the 65-hour/week cap for all frontline doctors, and the disputes continued. In our interviews, however, pure managers tended to justifying the HA's treatment of physicians as acceptable. Some frontline managers did mention about working time and remuneration issues as an example of the HA's unfair treatment of physicians, but they generally at the same time expressed an understanding attitude towards the HA's senior management seeing it as system level problems arising from resources limitation or the complexity of a large organization.

A common justification given by pure managers for their positive perception of the HA's treatment of physicians was the public service ethos. They suggested that unfairness only arose when physicians were comparing their benefits to those in private practice which is unreasonably good, and that is not an appropriate reference for comparison for those who are serving in the public sector.

- Doctors they have the job that can't make them rich...when you're working in the public, what gives you satisfaction is that you are helping people in that way. When you raise salary to the double, the private would be triple; when you raise it to the triple the private would be five times or six times. You won't catch them. (Doctor B, Manager at HAHO)

- For those who want to make more money, they would have already left. Be true in private practice there are higher autonomy and better material rewards. In the public sector, I believe that our colleagues appreciate that we are serving the patients who are needier. This is the ideal we share in public hospitals in Hong Kong. (Doctor F, Manager at HAHO; original transcript was in Cantonese)

- If you mean their living standard, they are not bad compared to ordinary people. Another issue is that they are comparing the public sector to the private sector, which

I think is an unusually high standard. (Doctor J, HCE; original transcript was in Cantonese)

For pure managers like Doctor L (HCE), "the problem is that workload is something difficult to accurately measure and longer working hours are not equal to more workload". In this sense, overtime payment is not necessarily a fair policy as the trade union leaders would see.

The explanations given by frontline managers who had a negative perception included working time and remuneration issue complaining that doctors are not paid for their extra work (Doctor D, Consultant; CCC; Doctor I, Consultant; CSC), as well as the HA's too-soft attitude towards patients' complaints against doctors:

> I don't think the HA is protecting the medical profession well enough. In handling medical accidents, the HA tends to treat doctors as scapegoats. Whenever there is an accident the HA will ask the doctors to apologize to the patients and the public, including those who might not be guilty. (Doctor H, COS; original transcript was in Cantonese)

However, frontline managers who gave such an ideal-typically negative answer were only a minority. A little bit surprising, half of the frontline managers were actually satisfied with the HA's treatment of physicians. They demonstrated an understanding attitude towards the HA's senior management, justifying the management problems that led to physicians' unfair treatment as "undeliberated" or due to some inevitable system level constraints, such as limited resource and complexity of a large organization.

- I think that is a resource problem. I think it is because of the lack of resources in the public healthcare system. I think the HA is trying to do lots of things to help the front-line to understand, but I can see no matter how they try to communicate with the front-line, there is still the structural problem. Basically it is an overdrawn healthcare system. (Doctor O, COS)

- Given the resources in the Hospital Authority, I think it is very, very reasonable. In many ways it is fair. While some may think it is unfair, I think some unfairness is inevitable, in some way at least it is not a deliberate unfairness, but unfairness due to history or management difficulties, rather than the results of a deliberate act. (Doctor K, COS; original transcript was in Cantonese)

- I think when the senior management in the head office make policy, they must have consulted somebody...they cannot come every time to go around hospital to talk to different people. So they have to get the options from representatives. There are different levels so there may be some communication breakdown…Original ideas maybe somehow distorted. (Doctor M, COS)

Frontline managers' acceptance of the status quo was not only based on their understanding attitude towards the management, but also on another kind of positive perception of clinical autonomy they enjoyed in daily operation and that they are well-represented in the management.

- I would say on the whole it's fair as they can still use their clinical autonomy. They can manage the patients as much as they would need to and like to. Although they are resources-constrained, on the whole the line managers are still supportive in the sense that the doctors can exercise their clinical autonomy in managing the patients. (Doctor D, Consultant; CCC)

- I think so. We can express our opinions. We have some people to represent us, I mean at the HA level, trade union. (Doctor M, COS)

Some frontline managers also justified harsh junior doctors training with long working hours and low remuneration as a test for newcomers to the medical community. It was not related to their manager-self but rather the subculture of the medical profession.

So if you ask me about my personal evaluation. I think it is ok. But if you ask them, maybe…because their expectation is not the same...Because all your bosses they have gone through their time as housemen. They always think that when they worked as a houseman they work harder than you, they worked better than you! Ha-ha...it's like that! I may have the same mentality that I have gone through days - when I went through the days, I worked harder than you, I worked better than you.

The general acceptance of the HA's treatment of physicians as expressed by both groups of physician managers can be seen as the result of the HA's efforts to get their buy-in. While it is not surprising to see pure mangers justifying the status quo, one may be puzzled by the frontline managers' attitude. Yet, from a frontline manager's point of view, does it necessarily imply the deterioration of the frontline doctors' autonomy or rights to speak on

policy, giving that they also claimed to be protecting those values in the daily operation? So how well are those perceptions reflecting the reality? To further clarify about the physician managers' influence in mediating the impacts of managerialism on healthcare governance, we finally touched on the most sensitive issue of how they will act when conflicts arise between the management and the medical professionals.

6.4.7. Attitudes and actions towards management measures or policies (Q3)

Generally speaking, pure managers and frontline managers expressed two different types of attitudes and actions towards the HA's management measures or policies. Pure managers saw management work as a legitimate means of control over doctors stressing accountability and regulation of clinical activities. They tended to tone down the resentment of frontline doctors to those management measures and justified them with quantitative performance data. Frontline managers however ridiculed management measures as impractical in the clinical field. They held the idea of good patient care that was constructed individually (quality) against the idea of serving more patients (quantity). Also, they rejected those requests from the senior management that were deemed unreasonable for clinicians, and fine-tuned policies in the clinical field for the clinicians' needs.

The typical negative sentiments expressed by frontline managers on the organization's management measures or policies were that they are "impractical", "useless", or even "ridiculous". Seeing performance data as distorting the reality, Doctor C (COS, CCC) criticized that it is creating extra workloads for clinicians. Doctor H (COS) further argued that "the problem actually is that the HA is doing something not cost-effective" as "ninety-nine percent of those guidelines are pointless but create extra workload for us":

> They try everything to prevent one single error, maybe out of 1,000 cases, by issuing many guidelines that create extra procedures for all cases. As our resources are not unlimited our hospitals are finally packed out. The HA has even issued a guideline on health safety for the doctors on how to protect themselves when carrying heavy items! How often would you see a doctor carrying heavy items in the workplace? It's only for the HA to avoid potential blame. (Original transcript was in Cantonese)

In addition to impractical guidelines, the Patient Charter which aims to modernize the doctor-patient relationship was also deemed by Doctor H to be a dead letter, and even harmful to clinical work as "it goes too far" making patients "like kings and queens":

> Patient Charter is ridiculous. It asks doctors to explain to patients their rights every time seeing them. It is totally impractical. So it ends up with nothing. I think the HA wants to change the physician-dominated culture but it goes too far. The patients are now like kings and queens. They yell at doctors and hospital staff for anything they are unhappy with. (Original transcript was in Cantonese)

For some frontline managers, measures to promote cost-efficiency were having two conflicting aims of having less input and more output. Taking the unrealistic policy of "zero waiting time" as an example, Doctor O (COS) suggested:

> If you push the front-line clinicians to achieve zero waiting time, or push them crazily, the system will burn out. This is the point administrators don't understand…To me, limited resources are not necessarily a problem, but they have to accept that there must be long waiting time.

In response to management policies that frontline managers disagreed with, some of them might take an overt resistant strategy rejecting those policies, and some would try to fine-tune those policies in implementation.

Seniority and experience in the clinical field offered frontline managers, especially COS, the authority to overtly reject the management's request to implement some measures that they saw unreasonable, even in front of the very senior personnel in the HAHO:

- I will say no! For example, increasingly they want to have a unified system of waiting time, which is impossible for me. Less urgent patients need to wait and you have a streaming system so that you can afford to see more urgent patients, rather than squeezing front-line clinicians. So I will say no we cannot change the current waiting time system. (Doctor O, COS)

- Actually I challenged the (HA) CEO at the time, E.K. Yeoh. I said it is wrong because whatever data you collect it is not informative at all. Because you say one

hospital get 10 patients died, and another hospital get 100 patients died…which one is better? You have the data, but you cannot judge. (Doctor C, COS; CCC)

- We are always in this dilemma - We want to do more in terms of number, or wants to do more in terms of quality of service? …It has long been a philosophy in this department to not lower the standard, not to lower the quality of service to exchange for a larger output. That's why we limit the number of cases we do in a session, which is lower than our peers. We are facing some pressures because the head office administrators are looking at numbers - "why do we see so little patients?", "why the output is so low? (Doctor M, COS)

They adopted the strategy of *undermining the data (P10)* and use their role as to *representing and protecting professionals, professionalism and good patient care (constructed individually) from managerialism (I4)*. Performance data, which are powerful tools of the management to make clinical work more measurable and comparable, were undermined by frontline managers as imprecise and therefore meaningless. Protecting professionals from external scrutiny, they upheld the idea of good patient care that was based on individual patients (quality) instead of the population-level factors of standards, access and waiting time (quantity). In regard of the long working hours of the frontline clinicians, as discussed in the previous section, pure managers tended to justify it as an altruistic sacrifice a public servant should do for the public interest. Frontline managers, however, rejected such idea of shortening the waiting time by squeezing physicians.

Withstanding pressures from the HAHO, frontline managers were to a certain extent autonomous from the management agenda of running or reforming healthcare. For those frontline managers who were not in a COS post and less confident in overt resistance, fine-tuning policy to cater for the frontline's needs served as another way of being doctors' advocates. As Doctor D (Consultant; CCC) explained:

As a manager, I would say I still act as an advocate for the clinicians. That's why I work in a management position. On the whole I would say I still take sides slightly more on the clinician side; I will still view myself as a clinician. So if I have to take sides, I will still take the clinician side. Most of the decisions are actually being done when you are doing the ward round with the frontline. And you say "is it okay for you?" They will actually at

that time also give you the feedback. Therefore you continuously adjust your policy, or your decisions, or your plan on how to make particular programs ongoing.

In contrast, talking about the management as "we" instead of "they", pure managers tended to see *management work as legitimate means of control over doctors (O2a)* and use their role as *regulating and auditing professionalism, challenging indeterminacy and poor professional practice (W6).*

For instance, Doctor E (CCE) was assured about the necessity of the management measures to promote cost-efficiency or productivity for healthcare system as to be accountable for public money, and saw it as part of a physician manager's life:

> Of course we need to measure productivity, mind you we are spending public money; you need to know how your doctors are performing. It is part of our life.

Doctor L (HCE) was one of the pure managers who were proud of the high efficiency in the Hong Kong healthcare system. For them, the HA was seen as contributing to this achievement, rather than part of unrealistic system squeezing frontline doctors.

> The whole of Hong Kong only consumes 5% of our GDP on health care, and then we have a very what we call a very enviable index which WHO uses to measure the health outcomes. So in terms of efficiency, Hong Kong is definitely one of the cities. Contributing to that efficiency, the Hospital Authority is actually the major contributor. ….in recent years we have set up a lot of systems to measure their performance…So a lot of these formations have become transparent, and we can measure productivity.

Pure managers might tone down those productivity measures as "gradual alignment of our services" or "energy saving measures" which will not impact the frontline working conditions substantially. They also undermined the resentment of frontline doctors to management measures as a normal labor issue or even something frontline doctors would support.

> - What we are doing on cost-efficiency is just some gradual alignment of our services. The objective has never been cutting your manpower. For those energy-saving measures like switching off the light in non-office hours, I don't think anyone will dispute it. (Doctor F, Manager at HAHO; original transcript was in Cantonese)

- There are no conflicts at all! Doctors themselves love efficiency and hate to be seen as inefficient. Confrontation arises only when they have resistance mentality, but the majority of doctors are excellent people. They love to win. While they have to achieve certain level of quality they don't want to lose in terms of quantity. (Doctor J, HCE; original transcript was in Cantonese)

- These are some labour relationship issues that happens everywhere. Trade unions of course they would like to get paid more, and the employer may not afford to do. So that is something not particularly relevant to the medical profession as such. (Doctor E, CCE)

To handle challenge from frontline doctors, pure managers used *Participatory Rituals (O9)* and *Rationality Strategies (O10)*:

- When they asked for additional manpower, I always advised them to look at those data. Sometimes they realized that they're not the worst one off. And if their efficiency or productivity was not good as other hospitals or clusters, they would improve a bit. So actually nowadays with information available, it is easier to have a dialogue with front-line clinicians about their pressure areas and the ways to improve their pressure areas. (Doctor L, HCE)

- They all know whatever the solution you tell them it is not going to be perfect. So if you just go to tell them about your policy actually they are not going to listen. What they need is that you listen to them on their dissatisfaction. When you give them the chance to express those discontents, things will be much better. But we don't want that to be a lip service. If their demands are reasonable, we will strike to fine-tune the policies. (Doctor N, HCE)

Unlike frontline managers who challenged the use of data in measuring clinical activities, pure managers valued data as something offering an objective basis for managers to compare performance or justify decisions. Given that pure managers had more data, the "dialogue with front-line clinicians about their pressure areas" became "easier" in a sense they could counter challenge their perceptions on management policies. Talking about "fine-tuning the policies", pure managers also tended to accept the status quo and downplayed the improvements consultation can bring about. They suggested that frontline doctors did not care about the details of policies and they just needed a chance to voice their discontent.

Compared to frontline managers who saw their contact to the frontline as an effective way to seek feedbacks as above-mentioned, pure managers might rather take it as a ritual of communication in view of easing frontline doctors' discontent.

6.5. Concluding remarks

6.5.1. Two types of physician managers

With the six dimensions of identity work discussed in this chapter, we now compare the two ideal types of physician in terms of how they act as the proxies of the medical profession and the state, and discuss the implication for the re-stratification of medicine and power dynamics in healthcare governance.

The two types of physician managers underwent sharply different processes of building up their identification with the manager role. Frontline managers were likely be unprepared when going into management. They usually were asked by their professional colleagues to fill the management post when there was a vacancy. Some might see it as a professional obligation to address management problems in the department or hospital in order to facilitate clinicians' work. For them, the manager role might also be something that naturally goes to a physician who becomes a senior Consultant, or incidental to their clinician role. As a result, they would step down from the management post once they perceived obligation is discharged. For such a temporary role they thought unnecessary to equip themselves with a formal qualification in management. In the transition to a manager role, they had a challenge of seeing themselves as doing something not what a doctor should do with their time, as well as a sense of loss for their detachment from clinical work and earning distrust of professional peers. Therefore, frontline managers were "incidental hybrids" who took the manager role as a temporary position and struggled to reconcile it to their clinician-self.

Pure managers, however, generally went into management with a clearer vision of system improvement or individual mobility purpose, taking the management position as their permanent role. Some of them were inspired by the idea of public health, stressing system factors that may have impacts on patients' well-being at a population level, such as standards, access and waiting time; some pure managers might simply lose their interest in clinical

216

work or look for a mid-career opportunity in general management as their General Practice or Emergency Medicine background had hindered their promotion in a specialist-led hospital setting. Valuing management as an equally important expertise as medicine, they thought necessary to obtain a formal qualification in management. For them, the manager role should not be compromised for their clinician role but was a better way to practice medicine in order to help more patients by system improvement. In the transition to a manager role, they had a sense of achievement as well as positive experiences seeing themselves as doing something meaningful and challenging. Therefore, pure managers were "willing hybrids" who took the manager role as a permanent position at the expense of their clinician-self.

The differences in values and beliefs dimensions were followed by the "role use" dimensions. In the interaction with non-medical managers, frontline managers used "social creativity strategy" to undermine the non-medical managers' status as a supporting role. They also saw themselves as one of the clinicians and acted as the clinicians "protectors" and "lobbyists", rejecting unreasonable policies and representing clinicians in the management post, or fine-tuning policy at the implementation stage in view of safeguarding the quality of care. In addition, they avoided being seen as a manager by their professional peers with a flat relation among professionals or attachment to the clinical field. In short, frontline managers were acting first as a doctor and then a manager.

Pure managers, in contrast, saw non-medical management personnel as necessary stressing the importance of team work and learning from other management professionals, if not seeing management expertise as equally important as medicine. They tended to tone down the HA's unfair treatment of physicians under managerialistic policies, and saw management as a legitimate means of controlling physicians in view of accountability and reducing variations or errors in clinical activities. Identifying themselves as elites in the profession with a wider view of the big picture of the system and a broader scope of knowledge, they use "rationality strategy" to justify management policies by performance data and counter challenge frontline doctors' rejection. In short, pure managers were acting first as a manager and then a doctor.

Table 14　　Common answers given by physician managers in the same manager role

Dimension/ role	Frontline	Pure
Reasons and paths	• Unprepared • Professional obligation • Incidental manager role	• Clear vision (rationalizers) • Individual mobility • Permeant manager role
Experiences/ struggles	• A sense of loss • Earning distrust of professional peers	• Management is challenging and meaningful • A sense of achievement and positive experience
Interaction with non-medical managers	• Undermined non-medical administrators as a supporting role	• Respected management expertise
Interaction with medical professionals	• Identified themselves as clinicians • Undermining the data	• Identified themselves as elites • Rationality strategy
Handling of professional-organizational disputes	• Sympathy for frontline doctors • Management as impractical, useless, or even ridiculous • Acted as the clinicians' protectors and lobbyists	• Saw management as a legitimate means of controlling physicians • Toned down the resentment of frontline doctors • Reservations about being doctors' advocate

6.5.2. The power dynamics of re-stratification

With the prevalence of "willing hybrids" in senior management roles, McGivern et al. (2015, p.426) conclude that medical management is increasingly considered as a legitimate sub-specialty within the medical professional, who "challenged the indeterminacy of poor professional practices, which they judged to undermine professionalism, but maintained the need for professionals to judge professional practice". As a result, there is an "intra-professional battles for jurisdiction over professional work" (ibid) beneath the surface of overall dominance of the medical professionals in healthcare governance. Our interviews support this line of argument.

While "willing hybrids" or "organization-compatible" physician managers are occupying senior pure management posts, those "incidental hybrids" or "profession-compatible" are setting their back against them on frontline management posts. So what is the implication of

such a split in medicine for healthcare governance? Will the balance of power tilt towards the state or general management because of "willing hybrids"? McGivern et al. do not offer a definite answer but suggest that "the maintenance of institutionalized professionalism remains powerful" (ibid).

Indeed, interviews in this study reveal that frontline physician managers, based on their close connection to everyday clinical work and experience in specialties, played an important role in mediating management policies at the implementation stage by overt rejection or fine-tuning. Noticeably, such an intact power base of institutionalized professionalism in the frontline was *inter-subjectively* perceived by both frontline managers and pure managers.

As Doctor C (COS; CCC) explained on why he/she chaired the HA Coordinating Committee in his/her specialty:

> I perceived COC as very powerful because when all the COSs in a specialty say it is very important, who can say it is not?

And also on the COS's power over the clinical academics from the university:

> We are very powerful. If we do not allow the HA doctors to help them, to allow them to teach, to allow them to do the research, they are in trouble. They can't do any research without our help.

Frontline managers had the cultural authority in agenda setting regarding the HA's policies as well as a solid power base in terms of their control of clinical departments' human resources and budget. In addition to COS, frontline managers might also exercise their influence in the macro-level decision making as Clinical Service Coordinator/ Director at the hospital cluster- level and the Chairman of the HA Coordinating Committee on their specialty service. In response to this, pure managers might always need to compromise on policy implementation with the frontline. As Doctor B (Manager at HAHO) commented on the importance of communication and engaging frontline clinicians:

> Just like a restaurant - How can the manager always fight with the kitchen? If the chef always says no to whatever the manager asks, how can you run the restaurant? ...If you are talking down to people of how things should be done, people will probably say "it is actually not how it should but if you ask so, well, it may do…" Finally your policy will

only be a dead letter. That's why engagement is so important. Also, each locale has its own characteristics. You may need to reach some consensus or common ground. (Original transcript was in Cantonese)

In reality, how do pure managers communicate with and engage frontline clinicians? Given that they see themselves as rationalizers who regulate or modernize medicine, how do they reconcile those conflicting demands? This is a question we may need to think outside the dichotomized framework of the "manager vs. clinicians" stereotype.

Perhaps the major limitation of the dichotomy is that it may ignore the outliers. On the one hand, both groups of physician managers were generally in line with their ideal types reacting to conflicts between the organization and profession. One the other hand, it is found that there are still some outliers in our interviewees who did not fall into their respective ideal types in one or more, if not all dimensions of their identity work. In the light of all these limitations of the dichotomy framework, in the next chapter we will discuss those outliers in detail arguing that outliers from the two ideal types were undergoing two different forms of hybridization - "satisficing pure managers" were under pressure to adopting the strategy of wearing a "clinician hat", while "satisficing frontline managers" were also exposed to managerial ideas. By those two moves, "satisificers" were aligned to the middle from the two ends, bridging the two groups of physician managers and the institutional forces of professionalism and managerialism that they represent. The power dynamics in the re-stratification of medicine therefore involve not only confrontation in a dichotomy framework but also integration, which is a relatively untouched area in the Re-Stratification Thesis regarding how the equilibrium is maintained.

Chapter 7

Empirical findings: mixed identity work and negotiating strategies

7.1. Introduction

The discussion on physician managers' mixed identity work in the last chapter is based on a theoretical dichotomy seeing it as a reflection of competing institutional logics of professionalism and managerialism. These were strong ideal types but were physician managers' possible identities limited to either one? Also, while the corporatist setting in healthcare was a contested arena of professional and managerial powers, how was the equilibrium achieved so both the state and sectoral interests could be represented?

As will be discussed in this chapter, physician managers in our sample faced inconsistences in their identity work, thereby not fully conforms with the dichotomy in one or more dimensions of their identity work. More importantly, it is found that such there were underlying patterns of such inconsistences, creating two different forms of hybridization. On the one hand, some frontline managers were exposed to certain managerial influence and bought into a minimum level of management of clinical work. On the other hand, some pure managers were constrained by the subculture of medical professionals, such as seniority, respect for colleagues' autonomy, and the pressure on them to wear a "clinician's hat" by symbolic contact with clinical work. Instead of maximizing professional or organizational values, as discussed in Chapter 4, these outliers were "satisficing" (Simon, 1956) with attempts to achieve at least some minimum level of both goals.

We argue that, an uneasy balance between the managerial and professional agenda in healthcare governance is maintained by those two quite different forms of hybridization - for "satisficing frontline managers", who had a stronger clinical attachment the department level, their professional beliefs were blurred by their manager role; for "satisficing pure managers", who had more power in resource allocation at the organization level but lacked contact with daily clinical work, they were bounded by a professionally defined mode of communication or management strategy in exchange for the authority to align clinical activities at the frontline. This may also help explain why the medical power as a whole

could still function well as the partner cum challenger of the state in a corporatist setting of healthcare, rather than turning into overt internal confrontations. With the proposed concept of "satisficers" whose identity work is mixed with professionalism, and managerialism, in this chapter we will attempt to understand the waves that lie between the two ends of the power continuum in healthcare governance, arguing that it is not merely a dichotomy but a spectrum where there is room for the two groups of physician managers to be integrated through satisficing.

Theoretically, "satificers" who identify themselves as "first a doctor then a manager" or "first a manager then a doctor" are not the only possible outcomes of mixed identity work. We will further explore whether physician managers seek to avoid identity conflicts by escaping from that dichotomy in the absence of a dominant institutional logic.

7.2. Limitations of a dichotomized framework and mixed identity work

Following empirical studies that employ a typology of identity (Forbes and Hallier, 2006; Hoff 1999; McGivern et al., 2015), in the last chapter we have analysed how the two types of physician managers were contesting in healthcare governance on behalf of the institutional forces of professionalism and managerialism. Yet, in those precedent studies relatively little is discussed about how we can analyse outliers who are not typical pure or frontline managers.

In reality, a physician manager could have both types of values or beliefs at the same time. Therefore, inconsistency in physician managers' identity work might arise in two forms: first, holding contradictory views within a single dimension (e.g. a frontline manager could have a headache of earning distrust of professional peers and at the same time a sense of achievement and positive experience in the management post); second, holding contradictory views across different dimensions (e.g. a pure manager could have a self-identification as rationalizer of medicine while feeling pressured to adopt a professional mode of communication and symbolic participation in clinical work). In the six dimensions where we have examined the identity work in the last chapter, it is found that some interviewees were giving managerial as well as professional types of answers in the same

dimension, and some could be classified as contradictory types across the different dimensions. So to what extent is the dichotomy still valid? How we can systematically classify physician managers taking that fuzziness into consideration?

With the codification scheme we have used in the last chapter (Tables 10 and 11), the managerial and professional types of codes are allotted to the interviewees for further comparison (Tables 17 to 21). In every dimension of identity work, interviewees are first classified as "organizational" or "professional" by their overall tendency in terms of the number of the two types of codes (Table 15). Where there are contradictions or no decisive results in an interview, the transcript will be further analyzed. If no strong tendency is found eventually, the interviewee will then be classified as "mixed" as both institutional logic operated in the identity work and neither one could dominate. Combing all six dimensions, the overall identity of an interviewee will be generated.

Table 15   Identity type of physician managers by the six dimensions

	1a	1b	2a	2b	2c	3a	Identity	Remarks
Pure	M	O	O	M	O	M	Mixed	Negotiating strategy
	O	O	X	O	O	X	Organizational	
	O	O	O	O	O	O	Organizational	
	O	O	O	M	O	M	Organizational	Negotiating strategy
	O	O	O	M	O	M	Organizational	Negotiating strategy
	M	O	M	M	O	O	Mixed	Negotiating strategy
	O	O	O	M	O	M	Organizational	Negotiating strategy
Frontline	P	P	O	P	O	P	Professional	
	O	O	P	P	M	P	Professional	
	O	M	P	M	O	M	Mixed	Negotiating strategy
	P	M	P	P	P	P	Professional	
	O	O	O	M	P	M	Mixed	Negotiating strategy
	P	M	P	O	O	O	Mixed	
	M	P	O	M	O	M	Mixed	
	P	M	P	P	M	P	Professional	

Strikingly, the elaborated mode of analysis including the "mixed" identity does not reject that the institutional logics of professionalism and managerialism are contesting in physician managers' identity work. Rather, it offers a more sophisticated understanding of how it worked. Firstly, the association between manager role (pure vs. frontline) and identity

(organizational vs. professional) is still valid. Taking all the six dimensions together, no pure or frontline managers eventually fall into the opposite type of identity. Most pure managers are still classified as "organizational" and no frontline managers fall into that type. It is also noticed that many frontline managers developed a "mixed" identity, but those inconsistences were restricted to the beliefs and values dimensions. In the action dimension of how they took sides between their professional peers and the organization in conflicts, as well as whether they saw themselves or acted as doctors' advocate, professional identity was still intact among frontline managers. So was there any pattern of conflicting identity work among pure managers as well? That leads us to the second point.

The second noticeable finding of the elaborated mode of analysis is that "mixed" identity developed in certain patterns in two respective forms among pure and frontline managers. As aforementioned, hybrid identity mainly worked to blur frontline managers' professional beliefs in individual clinicians' autonomy but not their self-identification as doctors' advocates. At the same time, a converse pattern of hybridization was found among pure managers with a professional mode of interactions such as symbolic contact with clinical work or flat relations among professional peers, together with their strong beliefs in managerialism in healthcare. Such pattern of "doctor vs. manager" role conflicts among two types of physician managers sheds some light on our understanding of power dynamics in healthcare governance - the mainstream of physician managers reached some consensus on the necessity of management as well as clan governance of professionals (Ouchi, 1979), so that both the state and the medical profession can fulfill their agendas.

Thirdly, to reconcile the contradictory clinician and manager roles, some physician managers in the interviews adopted a "negotiating" strategy' to circumvent direct conflict in view of protecting the dual role. Instead of aligning fully to one side, they played a brokering role when conflicts arose between the organization and profession.

Taken together, between the two ends of the power continuum in healthcare, "satisficers" were driven from the polar positions by the contradictory institutional forces, with some pure managers being aligned to professionalism and some frontline managers being aligned to managerialism. We argue that it is not an arbitrary fuzziness shared by the outliers of the two groups as they were undergoing two different types of hybridization that focused on

different dimensions of their identity work. After all, "satisficing" pure managers still acted as "rationalizers of medicine" while "satisficing" frontline managers still acted as "advocates of doctors". It is also found that some physician managers developed a brokering role and negotiating strategies to buffer themselves from potential identity conflicts in their dual role. Instead of acting for one side, they repositioned themselves as neither representing the profession nor organization, and tried to get decisions making in the organization closer to the expectations of both parties or avoid being embraced by disputes as a merely a middleman.

Table 16 Power continuum in healthcare governance by elaborated identity types

Power centre	Organization				Profession
Identity	Manager (controlled)	First a manager (mixed)	Doctor and manager	First a doctor (mixed)	Doctor (purified)
Role	Pure physician manager	Satisficer	Broker	Satisficer	Frontline physician manager
Action/attitude	Hegemony	Co-optation (soft bureaucracy)	Negotiation	Strategic Adaptation (soft autonomy)	Resistance

In the following sections, we will examine identity conflicts in each dimension and explore how different values worked together to create two forms of hybridity among pure and frontline managers.

7.2.1. Reasons and paths of moving into the management (Q1a)

Mixed identity work does not influence two groups of physician managers uniformly. Regarding their motivation for moving into management, pure managers were a relatively homogenous group with organizational beliefs that saw the move as something meaningful, while frontline managers were less exposed to the influence of managerialism, with roughly half of them preserving a professional identity undermining that move and another half turning into the opposite type (see Table 17; please refer to Tables 10 and 11 for the coding schemes we are using in Tables 17 to 22).

Table 17 Codified transcripts: reasons and paths of moving into management

Post	Identity	Professional	Organizational
Pure	M	I (1), (2)	W (4); O (2b)
	O		W (1b), (3), (4), (6); O (2c)
	O		W (2); O (2c)
	O		W (3), (4)
	O	I (1), (3)	W (2); O (2b), (2c), (6)
	M	I (2)	W (1b); O (2c)
	O	I (1), (2)	W (1a), (1b); O (2b), (2c)
Frontline	P	I (1), (2), (3); P (2b)	
	O		W (1b), (1c)
	O	I (3)	W (1a), (1b), (1c), (2), (3), (4)
	P	I (3)	
	O		W (1a), (1b), (3); O (2c)
	P	I (2)	
	M	I (3)	W (4)
	P	I (3)	

Those organizational values held by frontline managers in the interviews include:

W (1b)   Positive experience in management work

- Initially it was just a taste of management as a clinician to work on some of the areas which are related to my own specialty. Gradually with the building up of the relation and the experience in building infrastructure of various issues related to service provision, I become interested in the whole area of the hospital administration as well. (Doctor D, Consultant; CCC)

- By chance I was involved in the work and I find it quite interesting. So I carried on. (Doctor G, Consultant; CSC)

W (4)   Influence and challenge unrealistic and outdated professional mentalities and practices

- It's actually at that time the department was also facing a manpower shortage problem. And there were some senior clinical staff did not do much clinical work.

So after I took up the management role, I had to put the things right again. (Doctor M, COS)

- I saw quite a lot of things that need to be improved. When I talked to people, they would say that "you bother about your own area. We don't want you to get into ours". But this job in quality and safety it gives me the responsibility - not the rights but the responsibility - to look after these things. (Doctor G, Consultant; CSC)

O (2c)   Management as an alternative to practicing medicine

- That will be more meaningful….by your own pair of hands you can only do a little, but you can let people do it equally well or even better…Apart from providing the critical service we have also to organize or to formulate some of the system to make sure that our services are being provided efficiently and being evaluated. (Doctor I, Consultant; CSC)

While taking management as an incidental part of a senior physician's role, some frontline managers were encouraged by their early positive experience in management work or inter-professional working and decided to stay in the management post. Becoming "interested" is their common verbiage. They showed much less reluctance to the manager role than those frontline managers who thought management as uninteresting or not what a doctor should do with their time. Some frontline managers might find the meaning in the management post as an alternative way to serve patients with system improvement such as better evaluation and efficiency. They did not see the manager role as merely a passive obligation or a burden.

Similar to pure managers, some frontline managers became somewhat sceptical towards unrealistic and outdated professional beliefs and practices. Still motivated by kind of sense of responsibility to their immediate clinical units, they saw the need to "put the things right again". Yet, for them the management problems in the department or hospital arose from the professionals themselves instead of unreasonable policies in the organization, such as "senior clinical staff did not do much clinical work" and the territorialism that protected professionals from scrutiny by peers on what needed to be improved. Such kind of motivation as a proactive obligation is combined with the managerial idea to regulate medicine, and should be considered as "co-optation" by the state rather than "strategic adaptation" that aims to protect professionalism (Numerato et al., 2012).

7.2.2. Experiences and struggles in the transition from a clinician to manager role (Q1b)

Associated with the positive motivations, some frontline managers also experienced a relatively gratifying transition to a manager role. Those organization-compatible narratives include:

O (2b)   Management as something challenging

- I think it is a challenge and it's quite a lot of work to move from a more or less a pure clinician to somebody who has to manage a department. But I think it's quite unique for me...yea not everybody could go for that. (Doctor G, Consultant; CSC)

- I will see that as a challenge. There are gains and losses. You gain exposures to different kinds of roles and skills that you can learn from, but you also give up your family time. (Doctor H, COS; Original transcript was in Cantonese)

W (1c)   Positive experience in inter-professional working

- In medical school we had never been taught about what management is. It was really eye-opening in the sense that when you met various people and saw things you would never see if you were in ward. (Doctor D, Consultant; CCC)

- So with the exposure I understand it's not just like having meetings and things like that...If you want to deliver the service, actually you understand it is not just clinicians, not only to clinical staff, but you also need to build up the whole infrastructure for that therefore you have to meet various people and management…basically is to liaise all these together and manage things well. (Doctor I; Consultant; CSC)

O (3)   Frontline doctors are insulated

- At the end we management see the big picture…I know it is very harsh to you (frontline doctors), but I cannot inject additional resources to your team. It can't be done because we know the whole story is not that simple...as I know the constraints. (Doctor K, COS; original transcript was in Cantonese)

- So you start to have a macro picture of the healthcare system - clinicians look after patients as individuals, get the patients back to recovery, to work and the society. However, the manager role focuses on the bigger picture, for example, to utilize resources, to make decision looking at the macro picture, the waiting list, waiting time, cost effectiveness… (Doctor O, COS)

They saw the management role as an empowerment process conferring them unique experience and skills, as well as the chance to venture to the wider world outside the clinical field. "Challenging" and "meeting various people" were common positive comments they gave on their experience in the transition to a manager role. Some of them noted about the management perspective of healthcare in "the whole story" or "bigger picture" that frontline doctors do not know. Mentioning also the negative experience in the transition as being "squeezed" by meetings and administrative duties, they might not be fully aligning themselves to the manager role, while they showed a consciousness about managerial concepts such as waiting list, waiting time, cost effectiveness, and a more understanding attitude towards management seeing it as necessary.

Noticeably, while pure managers were generally more organization-compatible and struggled less when moving into the manager role, some of them felt the need to maintain clinician work. As two pure managers reported in their questionnaire, between 0 to 5% of their time was preserved for clinical work although they were in full-time management posts:

- I don't see patients in the sense of consultation. I see patients, greeting them, just to say hello to them. I think if your colleagues see you in the frontline or wards walking around, they will appreciate that…I have to be seen to be in the frontline, not just hiding in the office doing administrative paperwork… (Doctor A, HCE)

- I usually participate in the handover sessions where doctors handover the ward and the patients to another team between the shifts… This is to deliver a message to the front-line: I would like to know about the clinical field and I actually know about it.' (Doctor N, HCE)

Certainly, maintaining clinical contact is a kind of *Participatory Ritual (O9)* as the amount of time pure managers spend is too small to be seen as clinical practice in any real sense,

and it was intentionally used as a strategy to maintain their authority over frontline doctors. Yet, such practice was also due to their clinician-self:

- I enjoy very much the clinical work actually even now; because I had been working in the frontline seeing patients for 20 years before moving to management. I went down to give them a hand; I came down to see some of my friends, if they wanted to see me and get my medical professional advices. (Doctor A, HCE)

- It is somewhere I can know about what's actually happing in the hospital as a clinician…I see it as part of my advance incident reporting system. In the medical circle, you will easily know about one's reputation of his or her clinical competence if you are in the field...if you know who constantly underperforms or makes some mistakes, you may be able to prevent medical incidents. (Doctor N, HCE)

Attachment to the clinical field was a way that pure managers maintained symbolic assurance of their membership in the medicine community, i.e. being seen as a clinician by clinicians, as well as their contact with their professional peers who might also be closely connected in their social circle. In addition, those pure managers saw true understanding of frontline doctors' clinical competence in the field as a prerequisite for a competent physician manager to manage doctors. Influencing professional activities through inter-personal contact and informal discussion and in daily clinical unit meetings, pure managers used *institutionalized modes of professional communication (I7)* based on peer reviews instead of formal management procedures. Although pure managers finally gave up clinical work for their manager role seeing management work as more meaningful or an alternative way to practice medicine, they were still constrained by their clinician role or the norms in the professional circle. We will discuss this dimension of pure managers' identity work in detail in the section on their interaction with medical professionals (Q2b).

In summary, conflicts in pure managers' and frontline managers' identity work created two quite different forms of hybridization. Although still aligned with their professional peers in their beliefs and values, some frontline managers were bought into managerial ideas of the necessity for management in clinical activities; some pure managers, on the other hand were constrained by the clan model of professional governance based on informal communication in the clinical field. They also felt the need to reconcile their manager clinician role by

attachment to the clinical field, as well as to be seen as a clinician by clinicians in order to maintain authority. By those two moves, frontline managers were aligning with the management and pure managers were aligning with the frontline.

Table 18   Codified transcripts: the transition to management

Post	Identity	Professional	Organizational
Pure	O	I (7)	O (2c), (7), (9); W (1b), (4)
	O		W (1c), (3); O (6)
	O		O (2b); W (1b)
	O		W (3), (8); O (2c)
	O		O (2b)
	O	P (4a)	O (2c)
	O	I (7)	W (1b); O (9)
Frontline	P	P (6); I (4)	
	O		W (1b), (1c)
	M	P (6); I (4), (7)	W (4), (6); O (2b)
	M	P (2b)	O (2b)
	O	P (2c)	W (3); O (2c)
	M	P (2c)	O (1b); O (3)
	P	I (2)	
	M	P (2b); I (5)	O (3)

7.2.3. Interaction with non-medical administrators in the manager role (Q2a)

Although frontline managers were generally less welcome to non-medical administrators, some of them expressed a managerial attitude recognizing management as an integral part of hospital activities or expertise as valid as medicine. Examples of those organization-compatible narratives given by frontline managers are:

O (4a)   Buying in

> People would perceive the Head Office as a controller...actually they do have a process before they are deliberated, before they come out… Because I am the chairman of the COC, I can have some influences… (Doctor C, COS; CCC)

O (2b)   Management is worth-learning

So you can have more chances to talk to other people. It helps you to know more and learn more. In terms of the manager or administrative role, I would consider myself as very junior - junior means not only the rank but also about the knowledge level. I think I'm just like a kindergarten or a student level, so I really love to learn from all of them. (Doctor I, Consultant; CSC)

O (2d)   Management is professional or necessary in medicine

I don't think that doctors are the most important people in the hospital… different people are actually taking different responsibilities.…for example, operating theatre - it's not something that a doctor can know; everything is actually beyond what a doctor can do. (Doctor D, Consultant; CCC)

W (1c)   Formative identity work involving inter-professional working

- I used to have a good working relationship with them. I learnt the experience of how to package my ideas in administrative terms, something convincing, to be more likely to get the support. So after I took up the present position, I got a lot of support from them. (Doctor M, COS)

- You're very frustrated, and you thought your colleagues (同事) with non-medical background were antagonistic, which at the end are some misunderstandings. When years go by, when you get into the system and understand how the system runs, you will know their constraints and you can give them very good advices. (Doctor K, COS; original transcript was in Cantonese)

Being engaged in the decision making process, some frontline managers thought that they could exercise their influence. As a result, they were being more aligned to the management's policy and did not perceive the HA Head Office as a "controller" as many frontline professional peers would do. They also rethought the perception they once had of non-medical administrators as antagonistic outsiders. Being within the system for years, they established a collaborative relation with their "colleagues" from a non-medical background. In such a collaborative relation, a manager mind-set was not seen as what a physician manager should avoid. Rather, it should be acquired by physician managers in order to gain

support from non-medical administrators for their work. Some of them even admitted that doctors themselves might not be the most important people as management expertise was beyond the scope of knowledge a doctor would have. With those organization-compatible beliefs being combined with the clinician-self, some frontline managers' professional identity was blurred.

While physician managers' buy-in for management in healthcare does not imply the decline of medical power as management duties still go to the medical professionals themselves, internalizing management values could run them a risk of being "governmentalized" (Flynn, 2002). If frontline managers, as shown in our sample, were becoming less resistant to management in clinical activities as pure managers, the rank-and-file doctors' defence against pure managers' efforts to rationalize their labour process would be softened up, leaving it further exposed to monitoring regimes under managerialism. In this connection, management policies in the HA were expected to be implemented more smoothly with some satisficing frontline managers being more co-operative and understanding, if not giving up their obligation for frontline professional peers fully. We will discuss those impacts in detail later in the section of physician managers' handling of management policies in the organization (Q3).

In summary, in the interaction with non-medical administrators, satisficing frontline managers demonstrated significant managerial influences in their identity work aligning them to the senior management. Taken together with their overall positive comments on the status quo of the HA's governance as shown in the last chapter (fairness of its treatment of physician and communication in policy making in Q2c), the HA has successfully co-opted frontline managers into the establishment in view of softening resistance from the frontline. Yet, one should also notice that the most common organization-compatible value that some frontline managers shared with pure managers was a *formative identity work involving inter-professional working (W1c)* that mainly referred to the awareness of other actors or the management perspective in healthcare governance. Explicit support for the idea of challenging doctors' indeterminacy however was rarely found among frontline managers. Compared to pure managers' tight embrace, frontline managers' acceptance of management in healthcare, if any, was rather passive and moderate.

Table 19   Codified transcripts: interaction with mon-medical managers

Post	Identity	Professional	Organizational
Pure	O		W (1b), (1c)
	O		
	O		O (2d)
	O		W (1b), (1c); O (2c), (2d), (12)
	O	P (1d)	W(1b), (1c); O (2b), (2d)
	O	P (2c)	O (2d)
	O		W (1c); O (2d), (2b)
Frontline	O	P (4)	W (1b), (1c); O (2a), (4a)
	P	P (2d)	
	P	I (5); P (2d), (2c)	W (1c)
	P	I (4); P (2d)	W (1c)
	O		O (2b), (2d)
	P	P (2d)	W (1c)
	O		W (1c)
	P	P (8), (2d), (2c)	

7.2.4. Interaction with medical professionals in the manager role (Q2b)

While frontline managers' clinician-self was shadowed by the cloud of managerial influences, it was still intact in their interaction with professional peers in terms of acting as doctors' advocates and lobbyists. Being more engaged with the management, they could also use their manager role to represent their professional peers in decision making and protect professionalism. As shown in the last chapter, they general did so. Therefore, one could also argue that management policies in the HA was justified with professionals' participation in the decision making process. After all, frontline managers as a whole did not identify themselves as rationalizers of medicine but some of them expressed a higher acceptance of management work in the clinical field.

On the other hand, most pure managers were also undergoing another form of hybridization curtailing their manager role and aligning them to professionalism. While pure managers generally expressed the organization-compatible belief in the necessity for tighter regulation of medical professionals, most of them were not totally free from the influence of professionalism but constrained by the collective professional identity and culture, such as

flat relations between professional peers, "wearing a clinician hat" with clinician language and informal professional network, as well as respect for individual clinician's autonomy and indeterminacy. Those profession-compatible beliefs or actions found among some pure managers include:

I (9)   *Maintaining a flat intra-professional relation*

- We should be able to partner together… the basic component is number one, mutual respect…second…trust. You need to look from my angle, and vice versa…achieve a situation where we agree to disagree. (Doctor E, CCE)

- You have to cautiously avoid using your authority even though you have it…If you are imposing your authority over others, you lose the chance to learn, and you lose the chance to do an open and fair deliberation for the decision…In general, doctors are all intelligent people. All their arguments are reasonable in some sense...So if you are top-down they won't be convinced and you can't manage at all. (Doctor J, HCE; original transcript was in Cantonese)

P (3b)   *Frontline doctors should be left alone to do their jobs*

- Health care providers are intelligent people with specialized expertise. They don't need people to guide them. What they need is a facilitating environment to do what they consider as professionally appropriate. (Doctor E, CCE)

- I always tell them (frontline doctors) if the statistics doesn't look good, it doesn't matter as long as they can explain to me. Rather, the most important thing is that every patient is getting a good care. Sometimes they should even forget about the protocols and use their discretion to cater for the patients' special needs. (Doctor N, HCE)

I (7)   *Using institutionalized modes of professional communication*

- Actually I have a lot of clinical experiences, and also in my clinical days I can proudly say I was not a bad clinician. They have some respect for my clinical background and knowledge...So when we deal with difficult situations, I will speak in their languages and then I will discuss some clinical scenarios that they have also experienced...So I will say "we" – we experienced these conditions. So you will see

me as very compassionate or understanding the situation. They will see me as one of them. (Doctor L, HCE)

- In the daily hospital operation, do you think doctors are taking orders from HCE? They aren't! If you are a surgeon, you listen to the head of Surgery Department...If you are not good at working with your hands, how will they listen to you? So if you have to get doctors in line with the whole hospital's operation, department heads are the key. So it won't work at all if you are top-down but you always have to discuss and manage, delivering you message through the department heads. (Doctor J, HCE, original transcript was in Cantonese)

While pure managers saw themselves as the representatives of the organization as shown in the last chapter, they stressed in the interviews their flat intra-professional relations with frontline doctors. "Partnership", "mutual respect" and "communication" were their common verbiages. In the interaction with frontline medical professionals, who they saw as intelligent professionals as well, they consciously avoided "top-down" or "authority" conferred to them in the management post. Medical professionals were not seen as subordinates who only took order from their boss but respected as professional peers who pure managers had to convince before they managed.

The core of flat professional relations is the respect for individual physician's autonomy or intermediacy. Doctor E's (CCE) ambiguity in his/her comments on clinical autonomy is an interesting example. On the one hand, as discussed in the last chapter, he/she thought that doctor's productivity needed to be measured in view of the accountability for the public money they spent. On the other hand, he/she suggested that doctors did not need any guide and shall be left alone to do "what they consider as professionally appropriate". Also, for Doctor N (HCE), doctors could override protocols to cater for patients' special needs, and statistics of clinical activities could be ignored sometimes. Tolerance to frontline doctors' indeterminacy might only be given at pure managers' discretion, limited to those that can be explained to pure managers or did not have any significant impact on budget or cost-efficiency which was pure managers' major concern. Yet, in reality pure managers could hardly micro-manage in the clinical field and the technical aspect of clinical governance was often controlled by frontline managers.

As Doctor J (HCE) explained in the interview, delegating power to department heads was a common strategy employed by pure managers to manage the frontline. In the every-day governance of a hospital, HCE did not manage through the organizational hierarchy at all. A crucial point here is that COSs were not only a manager in the organizational hierarchy but also the clinical supervisor in the institutional hierarchy who could share the legal liability for individual frontline doctors' clinical decisions. Compared to pure managers who had already detached from the clinical field, they had more professional authority over and consent from frontline doctors in coordinating clinical activities. The clan mode of professional governance therefore was more prominent than the bureaucratic one in a healthcare organization (Wilkins and Ouchi, 1983) like the HA. This also explains why frontline managers were so powerful in rejecting the senior management's request in some occasions as shown in the last chapter.

As Doctor J went further to elaborate, in the early stage of decision making process in a hospital, messages were delivered through the professional network instead of a top-down mode. In such an institutionalized mode of professional communication, pure managers had to "wear a clinician hat". In addition to the participatory rituals of symbolic contact to clinical activities as shown in the previous section, pure managers like Doctor L (HCE) were also using the clinician language, such as discussing clinical scenarios "we" have experienced in view of that "they will see me as one of them". Due to frontline doctors' expectation for pure managers to be clinically competent, although in a senior management position, Doctor L was still under pressure to prove his/herself with past clinical experiences and the reputation about his/her clinical days as "not a bad clinician clinical". Being seen as a clinician by clinicians and adhering to the norms of the medicine community was still important for pure mangers to gain authority over the frontline.

As a result, pure mangers' management behaviors were also constrained to a profession-compatible mode. In the previous section, we have also discussed how pure managers managed clinical activities by informal discussion with professional peers and chairing clinical unit meetings. Those institutionalized modes of professional communication were based on peer reviews and interpersonal contact, adhering to the professional norms instead of the organizational one that based on formal procedure. Taking all these together with some pure managers' overpassing clinical protocols or performance data to accommodate

individual physicians' clinical autonomy and indeterminacy, whether managerialism in healthcare has brought substantial changes to the traditional mode of daily clinical governance is still contentious.

But was the institutional force of professionalism strong enough to further drive those pure managers to identify themselves and act as doctors' "advocates" and "lobbyists" as most frontline managers did? In our sample, we had a pure manager who clearly did so.

P (1a)   Physician managers are doctors' "advocates" and "protectors"

> You have to understand their difficulties and recognize their problems that they are facing so that you can do something for them. I think they do have an expectation for me to do something in the management. And it is also my wish to be more understanding about the doctors with the help of my medical background. (Doctor N, HCE)

P (1b)   Physician managers are doctors' "communicators" and "lobbyists"

> I helped the hospital to handle the questionings of the top management and bargain enough resources for its reconstruction…At that time I found that the data actually suggest that the hospital was not spending too much but was too effective. I showed to the accountants at the Head Office that we discharged patients much earlier than other hospital. They are quite objective numbers that explain why our unit costs is so high…This is a very telling example of how I can help the doctors in my management position. (Doctor N, HCE)

Rather than using the *Rationality Strategy (O9)* to counter-challenge doctors' objection as some other pure managers would do, Doctor N used the statistics he/she got in the management position to handle the questionings of the top management and bargained enough resources for the reconstruction of the hospital he/she served. He/she also expressed a clear stand in supporting professional peers, unlike many pure managers who identified themselves as presenting the management, or first management then the profession.

Yet, evidence from the codified transcripts suggests that most common profession-compatible values that pure managers shared with frontline managers was limited to a *flat intra-professional relation (I9)* and *institutionalized mode of professional communication (I7)*. In the absence of a resilient clinician-self, a strategic use of "the clinician hat" was used

by most pure managers to buffer resentment from the frontline to managerialism. As Doctor A (HCE) explained in the interview:

> I don't want to be seen to be pushing doctors to do something, or to stretch them too much to exceed the limits...You push them too much, you will suffer. They are very powerful now.

Compared to frontline managers' enthusiasm, pure managers' alignment to the clinician role was rather impassive and moderate. After all, pure managers as a whole identified themselves as rationalizers of medicine but most of them were taking a moderate stand as they were constrained by the institutionalized mode of collective self-governance.

Table 20   Codified transcripts: interaction with medical professionals

Post	Identity		
		Professional	*Organizational*
Pure	M	P (1a); I (9)	O (8)
	O		O (2c), (5)
	O	I (9), P (3b)	O (1b), (8), (3); W (4), (10)
	O	I (9)	W (5); O (8), (2d)
	O	I (9), (7)	O (1b), (3); W (3), (5)
	M	I (7)	W (5)
	M	I (7); P (1a), (1b)	O (3); W (5), (10)
Frontline	P	P (1a), (3); I (4), (9)	
	P	I (4), (9); P (4b), (8)	W (5), (10)
	M	I (7), (9)	O (3)
	P	I (7); P (5), (1a)	
	M	I (9); P (1a)	W (10); (O9)
	O		W (10)
	M	I (9), (7); P (3b)	O (3), O (8)
	P	I (4), (8), (9)	O (1b)

7.2.5. Attitudes and actions toward management measures or policies (Q3)

In the previous sections, we have examined the physician managers' mixed identity work in terms of how they constructed the manager-self and enacted the manager role in relation to non-medical administrators and medical professionals. As shown, some frontline and pure managers were taking a relatively moderate stand in enacting their roles of rationalizers or

advocates of medicine. At the end, what is the impact of conflicting identity work on those "satisficers" handling of the organization's management measures or policies?

In our sample, physician managers did express mixed attitudes towards the organization's management measures or policies. Many pure managers, while appreciating the high cost-efficiency in the current HA system, doubted whether it should go further to squeeze the frontline. Many frontline managers, however, were bought into some management policies and expressed their understanding towards the Head Office. Taken together, both "satisficing" frontline and pure managers were conscious of each other's interests and perspectives.

Table 21 Codified transcripts: attitudes and actions towards management and policies

Post	Identity		
		Professional	*Organizational*
Pure	M	I (9)	W (3)
	X		
	O	P (1a)	W (6), O (8)
	M	I (4)	P (2a)
	M	P (3a)	W (5)
	O	P (3a);	W (6); O (10)
	M	P (3a); I (5)	(O9)
Frontline	P	P (10), (2b), (I4)	O (4a)
	P	P (1a); (4b); I (9)	
	M	P (8)	O (2a), (2d)
	P	I (5), (6)	
	M	I (6)	O (2a)
	O		O (3), (2a); W (4)
	M	I (5), (4)	O (2a)
	P	I (4); P (7)	

Organization-compatible narratives given by frontline managers include:

O (2a)   Management is a legitimate means of control over other doctors

- The HA is actually maturing... increasingly I see more and more systems are coming out…. increasingly I can say "okay, that may not be a bad thing". Of course, I have to accept their limitations…I see myself a member in the Head Office to help

them…The HA got a lot of good intentions. It's their job to improve the system. That's why when they have a policy I will take part in the discussion of police. At the end of course I will implement the policy. (Doctor C, COS; CCC)

- At the end when what we call tracing the data, it is actually very understanding about the constraints that make clinical output not actually as expected. In fact, there are no consequences as long as the outcomes are explainable. In fact, the Hospital Authority fully understands that many of our staffs are over-working...So the HA wouldn't ask for an unreasonable productivity. (Doctor K, COS; original transcript was in Cantonese)

- Accreditation is like your home - you want to tidy up your home from time to time especially when some people are coming to visit your home. Although there could be some gaps, that's exactly why this is good to have some people telling you where your gaps are. And then you want to be improved. (Doctor I, Consultant; CSC)

O (4a) Buying in

- I always have to defend the policy from time to time. To me I think this is good for the service and for the patients. I don't want to see the patients waiting in the A&E for us while we have a good sleep in our home. I have to tell them it is a good practice, and it is good for patients and a very good experience for doctors as well. They won't have this experience if they're not working in this hospital. (Doctor M, COS)

- All these changes they must be for something good. They have to be. Why do I want to increase productivity? Because patients are out there they need the treatment and they're waiting already, isn't it? (Doctor G, Consultant; CSC)

While sticking to their clinician identity, some frontline managers were at the same time exposed to managerial influence as they were also the executors of the policies. They tried to reconcile the conflicts in their dual role by justifying some management policies with desirable goals for clinicians such as patients' interests and upholding professional standards.

Doctor C (COS; CCC), who claimed that he/she would and did "say no to the HA" on unreasonable policies as shown in the last chapter, at the same time expressed a gradual alignment with the senior management after years of engagement in management work, seeing himself as "a member of the Head Office" and systems as "may not be a bad thing".

Out of a resilient clinician-self and "social creativity strategy" (Forbes and Hallier, 2006), Doctor C's reasons for taking part in the policy formulation was still "to help them" and having influence in the policies that he/she would have to implement in the future. Yet, their manager-role as the executors of the policies had curtailed the clinician-self from objecting to the policies. To reconcile the manager role to the clinician-self, some frontline managers avoided a radical stand of opposition but justified the policies in the HA as generally reasonable. For Doctor K (COS), the frontline's complaints about long working hours were not "true" or "the general situation" as "the Hospital Authority fully understands that many of our staff are over-working" and it "wouldn't ask for an unreasonable productivity". Moreover, some frontline managers internalized the managerial values seeing management as something normal and wanted by professionals in view of improving the service. As Doctor I (Consultant; CSC) analogized, accreditation programs were not a coercive external requirement but something professionals shall follow to uphold the professional standards and goals. Similar to tidying up one's home, it should be done no matter whether someone is visiting or not.

Frontline managers did not only internalize those managerial values but also tried to influence their frontline peers. Acting as a manager, they had the responsibility to implement and thus defend an unpopular policy in the hospital to extend the department's night shift to support A&E. For example, Doctor M (COS) persuaded doctors in the department on the ground that the policy was "good for the service and the patients". As shown in the last chapter, Doctor M had also rejected the Head Office's requirement for the department to increase caseload at the expense of a shortened consultation time. So was it subject to frontline managers' own judgement on whether the policy met the professional goals? In Doctor M's own words, frontline managers had to "defend the policy from time to time". In the occasions where frontline managers had to implement unpopular policies that did not meet professional goals or interest, appeals to professional values seemed to be the only option for them to convince themselves and their professional peers. In the same way, for Doctor G (Consultant; CSC), who thought "all changes must be for something good", increasing productivity was explained as a professional goal because "patients are out there they need the treatment and they're waiting already". Noticeably, Doctor G had also claimed in the interview that he/she "usually" did not stand behind the HA.

Similar to pure managers, frontline managers used patients' interest to justify the managerial values of productivity. Yet, compared to pure managers, frontline managers were even more conflicted with justifying management policies alongside professional goals. As shown in the last chapter, for pure managers, the managerial values that saw *management work as legitimate means of control over doctors (O2a)* was combined with their role use as *regulating and auditing professionalism, challenging indeterminacy and poor professional practice (W6).* While pure managers would also justify their management work as an alternative to practice medicine, it was not necessary for them to appeal to professional goals in every part of their manager work. In pure managers' narratives, professionalism at the same time could also be a sectoral interest jeopardizing the public interest in terms of accountability for the public money or population-level performance targets, i.e. cost-efficiency, access, standards and waiting time. Management therefore in itself was legitimate as to regulate professionalism. For pure managers who frankly identified themselves as rationalizers of medicine, complementing professionalism or the clinician-self in the manager role was not a necessity, while it was a permanent headache for frontline managers.

On the other hand, pure managers were not totally free from the influence of professionalism. While pure managers felt less pressured to align themselves with their role as the doctors' advocates, when they were asked about whether they would stand behind the HA' policies that would affect frontline doctors' working conditions, a common answer was surprisingly to stress that the HK healthcare system had already been the most cost-efficient one, instead of fully standing behind the HA:

P (3a)   Doctors are doing the best they can

- The finance people tend to have a scarcity mind-set that is to use limited resources to meet unlimited demands. In relation to cost-efficiency, there was a Bloomberg's global report on the world's healthcare systems' performance and Hong Kong was ranked the first. We are only spending 5% of our GDP in healthcare while achieving almost the highest life expectancy. But you have to strike a balance as safety and quality of care is more important than those targets. So I always tell my staff it doesn't matter if you cannot meet all of them. (Doctor N, HCE)

- Before you talk about efficiency, you have to know that Hong Kong is actually the most efficient healthcare system in the world. It is always right to pursue efficiency and improvements, while you have to know that what our colleagues are doing is already the most efficient healthcare system in the world! Lacking this background knowledge, you will fail in the management work. (Doctor J, HCE; original transcript was in Cantonese)

Although no pure mangers went further to denounce the HA's policies or claimed to be not standing behind the HA, some of them did emphasize that physician managers shall be aware of the danger of over-driving frontline doctors. It is not surprising if one also appreciates the constraints they had in the clan mode of every-day clinical governance. In the face of frontline managers who had a solid power base in the clinical field, using administrative authority to implement policies would probably fail. So what did pure managers actually do in handling conflicts arose between the profession and organization over management measures or policies? As revealed in the interviews, pure managers did compromise their manager role by taking a brokering role and negotiating strategies that buffered the disputes. In the next section, we shall discuss that in detail.

7.3. Brokering role and negotiating strategies

In the previous sections, we have discussed how the two groups of physician managers were aware of and rationalizing the other half of their identity. In the handling of disputes between the profession and organization over management policies, some frontline managers did object to the senior management and stand behind the frontline, while in the common occasions they had to execute and defend those policies and justify them as meeting professional goals. For pure managers, while they were less conflicted in reconciling their manager-self and clinician-self, they were still constrained by the clan mode of professional governance and the norms or expectations for a clinician. So when the management policies and professional goals were difficult to reconcile or very unpopular with the frontline, what would be the last resort for physician managers to avoid direct confrontation?

In our interviews, to protect their dual role from direct identity conflicts, some physician managers were consciously escape from the dichotomy as "frontline vs. management" by a

brokering role and negotiating strategies. As shown in our codified transcripts, physician managers had intra- and inter- dimensional inconsistent identity work. Such inconsistency had led to contradictory attitudes and management behaviours and put physician managers in a potentially embarrassing position of failing both their professional and organizational obligations. To avoid identity conflicts, some physician managers repositioned themselves as neither representing the profession nor organization. They "satisficed" by balancing the expectations of two parties in policy making or implementation, or sought to avoid being embraced in the disputes and were merely middleman.

Those negotiating strategies that did not fall into the two types of physician managers' identity include:

Not aligning fully with one side

- It really depends…I have to understand how doctors work in a frontline setting. As a doctor you should also know where the sore points are - when they refuse and reject something, when they say no to someone, you have to really understand whether it is really a "real no" or not. If you understand how they play their tricks, you can counteract the objections…When I am dealing with non-medical professionals, I also look things from the perspective of non-medical administrators. And of course I will explain to them... I will let them see, I will put them into a clinician's shoe. (Doctor L, HCE)

- I would be just loyal to my patients and the community…but I think it's still manageable to maintain the role and try to make them understand that even the manager and the so-called front-line are not each other's enemy. They're actually trying to collaborate and trying to serve the same purpose, but just in different roles or different perspectives… (Doctor I, Consultant; CSC)

Acting as a bridge/ middleman/ messenger/ translator/ communicator

- I don't want to get involved in those direct conflicts with my colleagues! Ha-ha...When they have conflicts or differences in opinions, I will try to offer a platform for the two sides to communicate, to know each other's position, but not necessarily to convince the other party. This is the task I have to do as a communicator to let all the parties know the whole picture…not just the picture they are seeing now…

I would not say that I'm fighting for them (frontline doctors). I would try to convince the people upstairs...There are also administrators above me who want me to help them, just like the frontline doctors who want me to help them. I will try something in the middle…As a middleman, I will try to convey as a bridge. Sometimes, and actually many times, I would say the Head Office would listen. They don't really want to be in an argument with the frontline.   (Doctor A, HCE)

- Co-workers who are from a pure management background don't understand clinical department's needs because they don't have a medical background. They have no idea of what's happening. In the same way, clinical staff don't understand administrators and their considerations. They only express their thoughts in their own language and it is not going to work. Our most important role is to bridge the two parties by converting the frontline's needs into a reasonable demand in the management perspective. Yet, the final decision is the senior management's responsibility. (Doctor K, COS; original transcript was in Cantonese)

- So how can you align all the things and reach some consensus? Despite those differences, we all want to get the job done instead of giving up. So the key is alignment… If you are not a clinician, the problem is that you don't have the ability to discuss with a doctor... Yet not every doctor knows how to translate the clinical knowledge into another language. Just like you need a translator when you are speaking different languages... (Doctor F, Manager at HAHO; original transcript was in Cantonese)

Loose coupling

There must be someone in the Head Office to make the policy. So what I can do is to follow it as possible…For those policies that are very important, of course they will do some consultation. But for most guidelines or policies, you just have the documents from the Head Office. And you have to judge whether it is important and which part is relevant. For example, there is a hundred-page long guideline for injecting vaccines. Who will actually look into it? You look to your colleagues and see what the common practice is in the hospital. (Doctor H; COS; original transcript was in Cantonese)

Many physician managers refused to give a definite answer to the question of whether they would stand behind the frontline or the organization when disputes arose over management

policies. Some claimed to act as both the "rationalizer of medicine" and "protector of doctors". On the one hand, they could use their clinician role as an asset to help the management counteract frontline doctors' objections by spotting the "sore points". On the other hand, they could also use their clinician role to represent or protect professionalism by putting management into "a clinician's shoes". Therefore, they took sides based on their own judgement of a particular policy instead of their stand as a manager or a doctor. Some other physician managers claimed to devote their loyalty to patients and the community. They tried to reconcile the managers and the frontline by preaching that both parties were not each other's enemies and positioned themselves as the referees who represented the wider public interest. Such medical professional's self-positioning has been conceptualized by Sullivan (2000) as "civic professionalism", a third type opposed to the "collective mobility project in guild monopoly" and "scientific and technological rationalization" (p. 674). Other than acting as rationalizers or on behalf of sectoral interest, some physician managers did attempt to not identify themselves with the dichotomized identities of profession vs organization but instead to identify with their patients and the community.

To get rid of the conflicts between the management and frontline, a common strategy adopted by physician managers was to act as a bridge/ middleman/ messenger/ translator/ communicator between both parties. They did not claim to be the advocates of one side as they thought they had the same obligation for both parties. Instead, they claimed to "try something in the middle" and positioned physician managers as the "middleman", or even an object, a "platform", for both parties to see the whole picture from each other's perspectives. Translator was another analogy some physician managers used to define themselves as aligning both the frontline and management to each other. For those physician managers, frontline and the management were unable to understand and communicate with each other, and physician managers themselves were the key to translating one language into another. While such role could also be seen as doctors' "communicators" or "lobbyists", those physician managers did not pledge themselves to "fight for" the frontline. Rather, they suggested that the final decision shall be left to the senior management, who after all would probably listen to those physician managers in view of avoiding conflicts with the frontline. By taking a brokering role, physician managers did not act as the representatives of one side but a leverage by which both sides could influence each other.

In an Institutionalist perspective, physician managers were also using their agency to maximize healthcare organizations' legitimacy by decoupling the actual professional activities from formal organizational structures (Reay and Hinings, 2005; McGivern and Ferlie, 2007; Staniland, 2010). In the previous sections, we have discussed how deviances from clinical protocols and performance indicators were tolerated, as well as how formal procedures were replaced with informal professional networks by pure managers in managing daily professional activities. On the frontline side, as Doctor H (COS) elaborated, while physician managers were obliged to follow guidelines as possible, the lack of specific instruction left the managerial rhetoric to the frontline's interpretation in line with common professional practice. Noticeably, loose coupling behaviours were not necessarily driven by physician managers' clinician-self to circumvent managerial measures. Rather, the Institutionalist interpretation is that close alignment of actual activities to formal structure would make inefficiency and inconsistency a public record, e.g. errors or variance in injecting vaccines. This had left little choice to physician managers in healthcare governance but protecting actual clinical activities from "evaluation on the basis of technical performance" where "inspection, evaluation, and control of activities are minimized, and coordination, interdependence, and mutual adjustments among structural units are handled informally" (Meyer and Rowan, 1977, p.357), e.g. guidelines' implementation was ignored and delegated to professionals themselves.

In a relational aspect of identity work, some physician managers were also experiencing isolation from both the management and frontline. Although physician managers tried very hard to strike a balance between professionalism and managerialism in policies making in order to avoid failing any side of their identity, they could not easily fulfil both the frontline's and management's expectation at the same time. Many physician managers were indeed squeezed, rather than accepted by the both parties. As Doctor L (HCE) noted in the interview:

> I have seen a lot of physician managers when they become managers, other doctors think that they have betrayed them wearing a manager's hat; and when physician managers are facing other executives or non-medical administrators, the non-medical administrators will see he as a doctor, he's thinking for the doctors. So to a certain extent a physician manager, if you do not so-called play well, you become squeezed by both parties.

While a brokering role or negotiating strategies were adopted by "satisficers" to be distant from professional-organizational conflicts, does it mean a third type of neutral identity has emerged as an alternative to the professional or organizational one? Our codified transcripts have revealed physician managers' salient self-identification as rationalizers or protectors of medicine, and that their identity conflicts mainly arose between clinician and manager roles. When there were disagreements between frontline and management, it was common for physician managers to "fall back to see what is good for the patients" (Doctor L, HCE) as the "general principles" (Doctor N, HCE) or "common purpose" (Doctor I, Consultant; CSC). Yet, the interpretation of public or patients' interest itself was not something neutral at all eventually. Trade-off between quality (individual patients) and quantity (population level outcomes) was still the main theme of differences between frontline and pure managers. As Doctor G (Consultant; CSC) also noted in the interview:

> There are competing demands…. The demands from the patients, and the demands related to your job...I think once you have lost contact with the real everyday aspect, the other things will affect you more.

At the end, physician managers primarily swung between professionalism and managerialism based on their clinician role and manager role. The occasional adoption of a brokering role and negotiating strategies meant mainly an escape from the direct identity conflicts in their dual roles.

7.4. The division of labour and boundary between medical and managerial powers

The implication of negotiating or satisficing behaviours for healthcare governance perhaps was not that physician managers could avoid the identity conflicts fully, but the two functional sections' (frontline and pure managers) acceptance of each other. To further explore how the two groups of physician managers positioned each other in healthcare governance, our interview guide originally included a "self-perception" dimension following the core questions:

Do you see any differences between those in full-time, senior medical management positions and those in first-line supervisory positions? How do you view each role?

Although we only managed to ask roughly half of the interviewees for the limited time of interview, the findings may still shed some light on our discussion of physician managers' self-identification. When asked about their views on frontline and pure manager roles, the two groups of physician managers generally appreciated the differences between them. For pure managers, reconciling the different roles as a clinician and a manager was relatively easy as a kind of division of labour:

- As line managers, COSs tend to focus on quality control. For full-time managers like us, it is to ensure the proper allocation of resources so that adequate support can be delivered to the line-managers. We are different but we cooperate. I will see them as my friends.' (Doctor N, HCE)

- In everyone's own position we must have our own vision. The only thing in common is that we all want get the job done so we have to try our best to communicate. (Doctor F, Manager at HAHO)

Frontline managers, who were sceptical about pure managers' understanding of the frontline, also supported the idea of clinician engagement on the same ground:

- Both of us are serving the patients - but they serve patients in the policy area; we serve patients in front-line patient contacts. (Doctor M, COS)

- For senior managers who are sitting in the office, he will have an overview of everything while undoubtedly he will lose some of the contact with the very front line. (Doctor I, Consultant; CSC)

- For the full-time senior management, although they are clinicians, when they make decisions, they have a more administrative point of view of the whole system… But I buy the concept of physician administration. If you can manage the both systems well, you actually can make a much more sustainable system. But the balance is difficult. (Doctor O, COS)

While both groups of managers were sticking to their roles seeing themselves as rationalizers or protectors of medicine, they appreciated the coexistence of frontline and pure managers

as division of labour in managing healthcare at different levels. Being more aware of the management world and the external environment, frontline managers recognized the needs for someone to look after the policy area. At the same time, pure managers recognized the needs for someone to implement policies and gain support from the frontline. Rather than turning into clashes, frontline and pure managers generally expressed understanding attitudes towards each other based on the acknowledgement of different positions and functions. They actually drew the boundary of their jurisdiction in healthcare governance:

- Whoever is on the top, it doesn't matter; it's middle managers that matter: The way middle managers perform or behave has a lot of influences on the frontline. And the frontline doctors who are in direct contact with patients, yeah...what they do, what they say or what they commit will be reflected directly on the results and the outcomes of care...no matter whether you have many policies, procedures, guidelines. (Doctor L, HCE)

- Senior management does not really understand the frontline. Because they are not in direct contact with patients. If they have already made the decision, or under pressures from the government, there will be a very little room for negotiation. But if there is something not in that kind of pressures, you may be able to negotiate with them. (Doctor M, COS)

The respective jurisdictions of frontline and pure managers were mutually perceived. Yet it was not that frontline managers had the ultimate control as pure managers perceived, or pure managers had the ultimate control as frontline managers perceived on the other way round. The reality was closer to a system of "separation of powers" or "checks and balances" in its everyday operation combining the conflicting pictures offered by the two groups of physician managers. While frontline managers' power to veto policies would be very limited when the senior management insisted, equally true is that the implementation of policies would be very likely to fail when the frontline resisted. The equilibrium of power dynamics between the state and medicine therefore was achieved by the mutual recognition of both parities' jurisdictions. Mixed identity work, satisficing and negotiating here functioned as the mechanism that forged the consensus between frontline and pure managers of their relative positions in healthcare governance, and as we have discussed in the previous sections, smoothed their relations and interchanged their managerial and clinical authority.

251

7.5. Summary

In this chapter we have proposed an elaborated mode of analysis to comprehend physician managers' mixed identity work and outliers of the dichotomized typology of frontline vs. pure management. With the codified transcripts, it is found that, on top of the respective managerial and professional values/ actions as discussed in the last chapter, the two groups of managers were actually sharing some values/ actions.

Yet, there were two quite different forms of hybridization for frontline and pure managers instead of a general type of fuzziness. Firstly, physician managers did not arbitrarily combine managerial and professional values but it was in a limited scope that did not blur their self-identification as rationalizers or protectors of medicine. Secondly, with some frontline managers' acceptance of management in clinical activities and some pure managers' manager role being curtailed by a professionally defined mode of communication or management strategies, physician managers developed "satisficing" behaviours that aimed to fulfil both managerial and professional agendas at a minimum level.

Table 22　　　Common answers shared among two groups of physician managers

Dimension / role	Frontline managers	Pure managers
Motivation and experiences	• Acceptance of management work in clinical activities • Positive experience of management work	
Interaction with non-medical administrators	• Positive experience of inter-professional work	
Interaction with medical professionals		• Symbolic participation in clinical work • Flat intra-professional relationship • Institutionalized modes of professional communication
Handling of professional-organizational disputes	• Awareness of waiting list, waiting time, cost effectiveness • Negotiating strategies	• Sympathy for frontline doctors • Negotiating strategies

We have also further examined how "negotiating" behaviours were used by physician managers to buffer direct conflicts arising from their dual role. In handling professional-organizational conflicts, some physician managers adopt a brokering role and repositioned themselves as neither representing the profession nor organization. They "satisficed" by aligning policies making or implementation with both parties' expectations, or avoid being embraced by disputes as a merely middleman, i.e. not aligning fully with one side, acting as a bridge/ middleman/ messenger/ translator/ communicator, and loose coupling. Our findings in this chapter about the brokering role and negotiating strategies echo previous researches that have observed physician managers' mixed identities work (Ham at el., 2011; Sephar et al., 2015; Spyridonidis and Calnan, 2011; Spyridonidis et al., 2015). In Chapter 4, such researches are discussed in detail in the scoping review.

Yet, we hold that McGivern et al.'s (2015) notion of the association between manager role and identity is valid and add that mixed identities work are found among two types of "satisficers". While we find some evidences for physician managers' active use of their agency to negotiate between institutional forces of professionalism and managerialism, the impact of manager-self or clinician self on frontline and pure managers were tangible in terms of their resilient self-identification as rationalizers or protectors of medicine. Apart from those occasional escapes from identity conflicts, in different dimensions of their identity work, such as their transition to a manager role, interaction with medical professionals and non-medical administrators, physicians' struggle of being a manager were mainly set around the conflicting expectations for a clinician and manager. Those two types of "satisficers" are not a new identity as they still identify themselves as rationalizers and protector of medicine. With a new analysis method as proposed in this chapter, conflicting pictures offered by previous studies on the mixed identity can be synthesized.

After all, physician managers satisficed and negotiated in a way that they could act "first as a manager" or "first as a doctor" while fulfilling their secondary role. We argue that such hybridization of managerial and professional identities served to confer physician managers the managerial or clinical authority they lacked, as well as building up a mutual recognition of their respective jurisdictions in frontline operation and policy areas. With the two functional sections' (frontline and pure managers) acceptance of and integration with each other, medicine as a whole performed as both of the state's and medicine's proxies in

healthcare governance, upholding corporatist arrangements where the state and medicine colluded to maximize their interests.

Chapter 8
Discussion and Conclusion

8.1. Introduction

The intellectual quests of Hong Kong public healthcare governance in this study begins with puzzles as outlined in the end of introduction chapter: why do we have a professional-led model that is dubbed as "medical hegemony" in local political discourse, while ordinary professionals are feeling alienated from the Hospital Authority ("the HA") in New Public Management reforms? This gives rise to wider questions - who governs healthcare? The state or medicine?

Our approach to answering those questions is inspired by the Re-Stratification Thesis (Freidson,1994). It sees medicine as being divided into two groups, rank-and-file doctors and medical elites who enrol into administrative and regulatory posts, with physicians' rights to self-regulation being preserved at a collective level only alongside the state's modernization/ rationalization agendas of efficiency and transparency/accountability. Above all, the dual role of medical elites as doctors' representatives and managers is a sign of both state control and professional hegemony.

Yet, the Re-Stratification Thesis on its own may not be able to offer an adequate account of why and how the balance of power between the state and medicine is maintained. If the pivotal players, physician managers, are aligning to one side, the uneasy balance will be broken and turn into managerial hegemony or professional capture of the system. The identity issue therefore is the key to an empirical approach of investigating the power dynamics between the state and medicine. With our findings from elite interviews with physician managers in the HA, we confirm a recent notion by researchers in this field that physician managers are not a homogeneous group, but split into two roles according to their attachment to clinical work: "frontline managers" (departmental) who act as the professional's proxies and "pure managers" (directorial) who act as the state's proxies (McGivern et al., 2015); and we add that the hybridization or mixed identity work of the two groups of managers is an important mechanism to integrate the frontline and management

interests and agenda with their "satisficing" and "negotiating" efforts, while maintaining a boundary of their jurisdictions.

With a multidimensional framework, this study attempts to extend our understanding of public healthcare governance (see Table 23). In the previous chapters, we put the conflicting pictures of the triumph of state and sectorial interests in academic perspectives, from the macro- level of governance (Chapter 2), the Sociology of professions /healthcare politics (Chapter 3) to the micro- level of physician managers per se who mediate the contest between the state and sectoral interests (Chapters 4, 5 and 6). In this connection, our findings from the elite interviews with physician managers in the HA do not only help address the questions about physician managers' identity conflicts, but also the healthcare politics and welfare state governance as a whole.

In brief, we make four academic contributions in this study. First, we propose Corporatist Theory to assimilate the state-centric and society-centric governance theories, and apply it to the welfare governance of Hong Kong. Second, we confirm the insights of the Re-Stratification Thesis as well as research that applies it to the study of physician managers regarding the split between frontline and pure managers. Third, we add new findings of how the split of physician managers is related to the competitive and co-operative tensions between the state and medicine. Fourth, to deduce those new findings, we develop an analysis approach to comprehend the pattern of hybridization of professionalism and managerialism among the two groups of physician managers.

Table 23   Analysis of this study at different levels

Level / Theory	State-centric	Corporatist		Society-centric
Governance	• Asymmetric Power Model (Marsh et. al, 2001) • State-Centric Approach of Governance (Pierre and Peters, 2000)	Welfare / Neo-Corporatism (Streeck and Schmitter, 1985; Williamson, 1989)		Self-governing Networks (Rhodes, 1997)
Sociology of Profession	• De-Professionalization (Haug, 1973) • Proletarianization (Oppenheimer, 1973; McKinley and Stoeckle, 1988)	Re-Stratification (Freidson, 1994)		• Jurisdiction Wars (Abbott, 1988; Nancarrow and Borthwick, 2005) • Structural Interests (Alford, 1975)
Healthcare Politics (Numerato et al.,2012)	Managerial hegemony	Co-optation • Flexible Corporatism (Sheaff et al.,2004) • Co-option (Harrison, 2009)	Strategic adaptation • Soft Autonomy (Levay and Waks, 2009) • Adaptive Regulation (Waring 2007)	Professional Resistance
Physician Managers (Hoff, 2000; McGivern et al. 2015; Forbes and Hallier, 2006)	Compliance	Organization-compatible • Willing • Investors	Profession-compatible • Incidental • Reluctants	Resistance

8.2. Major findings and methodological contributions (Chapters 4, 5 and 6)

8.2.1. Building up methodology with scoping review

Guiding questions for Chapter 4: what can we learn from previous studies of physician managers? How can they inform the development of the Re-stratification Thesis? Drawing on them, how can we examine their social identification with or loyalty to the organization or profession?

In Chapter 4, we seek to build up the methodology for the empirical part of this study. To operationalize the concepts of "soft bureaucracy" that represents the managerial power (Courpasson, 2000) and "soft autonomy" that represents the professional power (Levay and Waks, 2009), we identify physician managers' hybrid identity as our research subjects. If physician managers identified themselves as a manager, a possible implication will be the state "colonizing' medicine by the co-optation of doctors into healthcare systems management to impose tighter self-surveillance regimes; if they identified themselves as a physician, then it will be medicine "capturing" the state by the enrolment of themselves into it to preserve their control of daily professional activities.

Using Scoping Review method (Arksey and O'Malley, 2005; Levac et al., 2010), we select 14 empirical studies from 433 academic journals relating to *hybridity* or *identity* of *physician /medical /clinician / medically qualified managers* in three data electronic bases, namely Applied Social Sciences Index and Abstracts (ProQuest), Scopus and Web of Science. The review of those 14 selected studies is based on a systematic access to empirical researches relevant to physician managers' hybrid identity from the earliest date available in the three data bases aforementioned to July 2015 (their characteristics such as year of study, data collection method, country/organization, and sampling are listed in Appendix Nine). We believe that the review of findings generated by the scoping method is exhaustive regarding studies on the same topic in that period of time and can serve as a good reference for future studies.

Following a review of their findings, those 14 selected studies are categorized into three groups: "without clear focus on typology", "with attention to mixed identity work" and "with a clear focus on typology" (see Tables 5 to 7). The findings in this study of physician managers' satisficing strategies and brokering role validate some previous researches, especially the second group that focuses on hybrid identities (Ham at el., 2011; Spehar, Frich, and Kjekshus, 2015; Spyridonidis and Calnan, 2011; Spyridonidis, Hendy and Barlow, 2015). Yet, they do not offer a template of research tools for data collection. Our interview guide and questionnaire are mainly drawn from Hoff's (1999; 2000) and McGivern et al.'s (2015) in the third group with minor revisions according to the HA setting. They classify physician managers into "Organization-/Profession- Compatible" and "Willing/ Incidental Hybrid" respectively with theoretical reference to the Re-Stratification Thesis, as well as clearly defined attributes and measurements as listed in Tables 5 to 7. Based on those typology and measurements, we have also developed an elaborated mode of analysis to take the mixed identity work into consideration and synthesize variant findings offered by previous researches.

8.2.2. Major findings

Guiding questions for Chapter 6: to what extent physician managers are developing a manager-self at the expense of their clinician role, or bringing a clinician-self to their manager role? Do their positions as frontline and pure management divide them into two different types of identity work? If so, how do they look in different dimensions?

In Chapter 6, we apply Hoff's (1999; 2000) and McGivern et al.'s (2015) analysis schemes to the sample of physician managers in the HA and find similar results. As measured by the 14 statements of professional beliefs in the questionnaire developed by Hoff (2000), physician managers in the HA hold strong views around the medical profession itself and the physicians' collective rights to self-regulation, except individual physicians' autonomy. The results are in line with Hoff's original study with a random sample in the US that supports the Re-Stratification Thesis: physician managers as a whole see that more regulation of clinical activities is warranted while it should not be done by laymen (see Table 9).

Following Hoff's (1999) interview guide, we structure our interview questions with 5 themes regarding different dimensions of physician managers' identity work, and include attributes defined by McGivern et al. (2015) to enrich our conceptualization of the contrasting managerial/ professional identities. Echoing the original studies, the two groups of interviewees in our sample are giving the same set of common answers as listed in Table 14. The findings support McGivern et al.'s (2015) notion that managerial identity is associated with manager role: physician managers with a stronger clinician-self tend to occupy frontline management positions (departmental; with half of their time doing clinical work) and those who hold a stronger managerial-self tend to be pure managers (directorial; basically detached from the frontline).

Guiding questions for Chapter 7: to what extent is the dichotomy of profession-oriented and organization-oriented identities valid? At the interface of different social forces driving healthcare reforms and the forefront of changes, how do physician managers negotiate between them? What are the implications for our understating of the power dynamics in healthcare systems and the Re-stratification Thesis?

In Chapter 7, we further question the dichotomized framework of analysis used by Hoff and McGivern et al., and propose an elaborated mode to include the outliers of frontline managers (supposed to be professional) and pure managers (supposed to be managerial). With Hoff and McGivern et al.'s detailed description of physician managers' managerial and professional values, we codify interviewees' transcripts and check whether conflicting codes exist. It is hypothesized that inconsistencies in identity work may arise in two forms: first, holding contradictory views in the same dimension; second, holding contradictory views in different dimensions. Tables 17 to 21 have listed the results of analysis regarding the first type of inconsistencies in each dimension of identity work. Based on the overall tendency combining different dimensions, the second type of intra-dimensional inconsistencies is generated and presented in Table 15.

With the codified transcripts and a systematic comparison, we find that inconsistencies of physician managers' identity work exhibit some patterns rather than an arbitrary fuzziness creating a new identity. While outliers are found among both frontline and pure managers, those inconsistencies in identity work are limited to 1) particular dimensions and 2)

particular codes that they share with the opposite type managers. As a result, all interviewees in our sample hold an overall identity that is associated with their manager role (managerial for pure and professional for frontline managers), while two different forms of hybridization are found among frontline and pure managers who try to satisfice both managerial and professional values.

Common answers shared among two groups of physician managers in different dimensions of identity work are listed in Table 22. In brief, frontline managers share some managerial values/ behaviours with pure managers, such as acceptance of management work in clinical activities, positive experience of management work and inter-professional work; pure managers share some professional values/ behaviours with frontline managers, such as a flat intra-professional relationship, clan modes of professional communication/ clinical governance. In handling professional-organizational disputes, frontline managers show some awareness of waiting list, waiting time, and cost effectiveness, while pure managers doctors express some sympathy for rank-and-file doctors. Yet, it is also found that the self-identification of frontline managers as protectors of medicine and pure managers as rationalizers are not blurred by their mixed identity work. Based on this, we hold that the typology of frontline and pure managers is still valid and add our notion of "satisficers" to make sense of the mixed identity work.

8.2.3. Methodological contributions

The proposed elaborated method therefore does not go counter to Hoff's (1999) and McGivern et al.'s (2015) but offers an innovative way to include outliers and the conflicting identity work into the analysis of physician managers. Logically speaking, a physician manager could have both types of values or behaviours at the same time. The problem of those potential conflicting answers or outliers however were not well addressed in previous studies. More importantly, the dichotomized framework offers little room for dialogues with other researchers who have observed physician managers' mixed identity work from their empirical findings (Ham at el., 2011; Spehar, Frich, and Kjekshus, 2015; Spyridonidis and Calnan, 2011; Spyridonidis, Hendy and Barlow, 2015). Yet, in synthesizing their findings with ours, we avoid simply reducing interviewees' conflicting values/ behaviours of professionism and managerialism as a general type of hybrid identity. Instead, with the

codified transcripts as systematic tools, we examine what particular attributes or dimensions those outliers share with other interviewees in their own type and the opposite type. So a more meaningful question perhaps is not "whether mixed identity work or inconsistencies exist", but how to deduce certain patterns reasonably: it is about "in what way mixed identity work or inconsistencies exist" and how they impact the power dynamics between frontline and pure managers.

With the findings generated by the proposed elaborated mode, we argue that there are two types of "satisficers" among frontline and pure managers as listed in Table 16. By means of such hybridization process, frontline and pure managers express understanding attitudes towards each other based on the acknowledgement of different positions and functions. As a result, interchange of clinical and managerial authority is possible alongside a mutual recognition of their respective jurisdictions in frontline operation and policy areas. While previous researches have offered conflicting depictions of physician manager's identity as reviewed in Chapter 4, they may mainly be a result of different methods they use. This study offers an alternative perspective to integrate all those findings into a more coherent picture. In the following sections we will discuss the implications of our findings for Corporatist Theory and the Sociology of professions, as well as the limitations of this study.

8.3. Implications for governance theories (Chapter 2)

8.3.1. Corporatism and welfare state professionals

Guiding questions for Chapter 2: what are the relative positions / autonomies of the state and welfare state professionals in welfare production and politics? To what extent can the HA's governance be defined as a state-centric, society-centric or corporatist models? Are policy networks pluralistic or asymmetric in Hong Kong? What are the characteristics of the health policy communities where medicine is co-opted? What are their implications?

In Chapter 2, we discuss the general theories of governance that predict the overall tendency of state control or professional capture, and propose Corporatist Theory to assimilate the "society-centric" and "state-centric" positions. While NPM is a global Neo-Liberal reform movement "hollowing out the state" with pluralistic networks (Rhodes, 1994), it could also

be seen as an ever- sophisticated regulation and monitoring system that strengthens the state's steering capacity (Fawcett, 2013, p.6), i.e. "associative governance" as the state's formal partnership with interest groups in the formulation and implementation of public policy (Bell and Hindmoor, 2009). In Pollitt's (2007) terminology, the HA reform in Hong Kong in 1991 was in the same way driven by the two contradicting forces of "centralization" and "decentralisation": the delegation of power was "administrative" and "non-competition" with the HA's Board of Members being appointed by the government and central planning to ensure a careful control of budget; at the same time, it was "external" and "horizontal" as the HA became a semi-autonomous public corporate independent from the civil service, and the general management was opened up to the welfare producers, medical professionals themselves. To comprehend the complexity of the developments, this study attempts to go beyond a simplified state-centric or society-centric account.

With Corporatist Theory, we argue that healthcare governance is indeed a collusion between the state and welfare producers for their functional interdependency (Williamson,1989). Physicians as welfare state professionals can always override other interest groups, service end users or the general public, while the contest is not "open and free" as a society-centric account would suggest. Health policy networks are a closed policy community working in an Asymmetric Power Model (Marsh, Richards and Smith 2001) where medical professionals are "insiders" (Grant, 1995). At the same time, the state's authority in healthcare governance is largely mediated by medicine. While the state finances, delivers and governs healthcare, medical professionals gain a "public status" or "official role" (Offe, 1981) in healthcare governance as its indispensable partner. In such political bargains, the medical profession as a whole obtains clinical autonomy and the rights to licensing/disciplining its members who are nominally state employees. In return, medical professionals respect the state's authority to set the global budget and implicitly ration scarce healthcare resources in clinical terms on behalf of the state. The entrenchment of physicians in the HA's governance structure is a telling example of such indirect rule strategy of the state.

As revealed in this study, Hong Kong public healthcare governance can be depicted effectively as "politics of the double bed" (Klein, 1990), where there is "a series of attempts to manage this mutual dependency, to find ways of accommodating the frustrations and

resentments of both sides in the partnership, and to devise organizational strategies for containing conflicting interests' in a bipartite corporatist setting" (p.700). Our findings in this study suggest that the proxies of the state, "pure managers", and the proxies of the medical profession, "frontline managers", are contesting while interdependent with each other. Identifying themselves as rationalizers or protectors of medicine, the two groups of physician managers do appreciate their differences and act differently in their manager roles, while mutual understanding as well as the interchange of clinical and managerial authority based on hybridization are taking place alongside conflicts and confrontations.

Here a unique landscape of modern welfare state governance is the dual role of welfare state professionals as members of a liberal profession as well as state employees/ agencies. In this connection, this study contributes to the discussion of welfare corporatism by bringing identity conflicts at an individual level to our analysis: physician managers are not a homogenous group affected by managerialism or professionalism uniformly. Some of them are being co-opted by the state and some others are strategically adapting for the profession. More importantly, they satisfice and negotiate in order to fulfil their roles as "first a manager/doctor" as well as their secondary roles. This study adds that such mechanism of hybridization is a key component of welfare corporatism by which frontline and pure managers can exchange their clinical and managerial authority or resources and both professional and state interests are protected.

Whereas governance literature largely set around the transformation of modern welfare states, the corporatist nature of the interplay between the state and welfare state professionals, who are the building block of welfare states, deserves more attention from researchers. With supranational integration, liberalisation and increased competition in world markets since the 1980s, as Falkner (1997) suggests, while the traditional tripartite (state; capital; labour) "public-private concertation" in policy-making has increasingly been downplayed to sectoral or even issue specific sub-polities that appears to be pluralist sub-systems, corporatist patterns may still prevail considering "the degree of integrated participation by economic interest groups in the public policy process" (p.3) in the specific sectoral settings. Although academic attention subsequently shifted from a corporatist to a pluralist approach of policy networks, scholars in governance have offered alternative concepts to capture the transformation of corporatism as "competitive corporatism" (Rhodes, 2001) and "lean/

supply-side corporatism" (Traxler, Blaschke and Kittel, 2001) where certain forms of "productivity coalitions" (Windolf, 1989) at a meso- (industry) or micro- (firm) level are built.

In this regard, our study of the Hong Kong healthcare system offers some empirical evidence for the resilience of corporatist arrangements in the specific field of welfare production, stressing that the strategic position of welfare professionals as expert producers is a key element of such organized political exchange or coalition between the state and sectoral interests. Yet, applying Corporatist Theory to other welfare production sectors such as education and social service should be case-sensitive. The coalition between the state and medicine may be an exceptional case of "expertise-based co-option" (Seward, 1990) considering the high degree of producers' control of the abstract knowledge (Abbott, 1988) and professionalization process (Nancarrow and Borthwick, 2005). In the UK context, researchers have also noticed the differences between welfare professionals from different sectors in their acceptance of new managerialism (Kirkpatrick, Ackroyd and Walker, 2005). While one could imagine the incompatibility between social workers' and school teachers' professionalism and their manager role, we may need further empirical investigation on whether other sectors are replicating the same dynamics or extent of the professional managers' identity conflicts and hybridization as we observe in this study.

8.3.2. *Corporatism and the Hong Kong polity*

A corporatist approach to our understanding of Hong Kong welfare governance, instead of a pluralist one, also pays tribute to the unique polity of Hong Kong as "liberal autocracy" (Fareed Zakaria, 1997) as discussed in the introduction chapter. Partial democracy in Hong Kong largely curtails political exchange through electoral representation but enhances the state's autonomy in building coalition with welfare state professionals. Besides, her liberal tradition prevents the state from direct or micro- management of production processes. Careful devolution of power to medical professionals in healthcare governance as we examined in this study in a corporatist approach, therefore, is unsurprisingly a desirable option for the Hong Kong Government to compromise between those conflicting principles of social management.

Indeed, from the outset, the Hong Kong polity has been characterized as corporatist (Goodstadt, 2007; Scott, 1989) for its long tradition of consultative democracy with "administrative absorption of politics" (King, 1975; the extensive use of professionals in consultation bodies to legitimize bureaucratic-led politics as a substitute for full democracy). The introduction of functional constituencies (representation for service professionals and businesses associations) in the legislature in the 1980s further institutionalized professionals' privileges in the legislature, and helped marginalize partisan politics after the introduction of direct election in 1991.

Yet, it is arguable whether functional constituencies help uphold Hong Kong welfare corporatism. Although impartial, the democratization since the 1990s has seen some challenges to the original setting of elite integration and consensus politics under consultative democracy (Lam, 2012). Scholars have noticed that welfare state professionals, including medical professionals, have been key promoters of democratization in Hong Kong, and a populist alliance between welfare state professionals and the grassroots population has been formed in election campaigns as "democrats" (So, 1999). Above all, the individual instead of corporate voting system in professional constituencies offers some hope for overturning the corporatist setting which is based on peak association's monopolized representation for their members.

The political controversies over Doctors Registration (Amendment) Bill 2016 is a telling example of the ever-widened cleavage between the professional peak associations and political representatives. Soon after the field work of this study in the second half of 2016, political debates arose in Hong Kong around the government's proposal to remove barriers to overseas doctors and increase government-appointed patient representatives in the Medical Council of Hong Kong. Under the banner of patients' interests, the HA itself and the Medical Council stood behind the government despite that the proposal had become very unpopular among medical professionals (Tsang, 2016). Claiming to safeguard professional autonomy, frontline doctors however launched a very successful internet propaganda campaign to mobilize public objection. They alleged that the Bill was actually a preparation for the secret plan to introduce Mainland Chinese doctors to Hong Kong and extend the government's power against civil society (Fung, 2016). By taking filibuster actions, the doctors' representative in the legislature backed frontline doctors but not the corporatist

establishment in health policy (the government, the HA management, and the Medical Council). Finally, the government withdrew the Bill but the division between ordinary medical professionals and their peak associations havs been further widened.

Alongside those recent developments in the medical sector that point to the resilience of Hong Kong welfare corporatism with the peak associations aligning themselves to the government in policy debates, the professionals' countervailing force through formal representation is also revealed. So will functional constituencies help uphold or turnaround welfare corporatism in the long run? In the near future, the evidence would point to welfare corporatism still being alive in Hong Kong.

Firstly, conflicts between general public interests and specific sectoral interests prevents the professional representatives from building a stable alliance with political parties. In the above-mentioned case of Medical Council reform, democratic parties elected by universal suffrage were actually wavering over whether they should back the doctors' representative, although medical professionals are generally deemed to be their supporters in direct election. On the one hand, political parties were cautious about the potential harms of the government's proposal to professional autonomy for reducing the medical professional's representatives at the Medical Council. On the other hand, they were also alerted by the potential backlash of the general public for vetoing a proposal that is beneficial to patients' interests. At the end, the mainstream democratic parties disappointed medical professionals by withdrawing their support (ibid). As professional representatives are primarily accountable to a relatively small group of people based on specific interests, maintaining independence from electoral politics will be a more realistic strategy. Instead, they tend to align themselves with the autocratic government for a partnership status in overall policy issues alongside their outlook as mouthpieces of sector perspective and guardians of sectoral interests (Kowk and Chow, 2007).

Secondly, as long as the autocratic polity in Hong Kong is preserved, it will continue to curtail the capacity of political parties in conducting political exchange between sectoral interests and class-based interests in electoral arena. The traditional corporatist concordat would still be a more effective or institutionalized way to represent sectoral interests as a whole.

The last reason perhaps is a more fundamental one questioning whether the electoral arena is the only or necessarily the most important domain of policy making. As Pierson (1998) suggests, "a focus on voters, public opinion, and party coalitions will fail to capture important political dynamics" as "the politics of the welfare state involves a complex 'two-level game'" that include both an electoral arena and a corporatist arena (p.556). In an era where pro-market right ideologies dominate, partisan politics becomes much less important as class-based differences in economic management have narrowed (Rhodes, 2001, p.178). On the other hand, corporatist arrangements create powerful interlocutors who direct reforms along consensual pathways, offering a platform of continuing dialogue and social learning to develop pragmatic solutions to micro-policy reform (Visser and Hemerijck, 1997). Those developments in contemporary Western parliamentary politics also suggest that policy making, even in a full democracy, is largely influenced by past corporatist institutions in specific sectoral settings.

Although the development of electoral politics in Hong Kong, combined with the individual voting system for professionals' functional representatives, will be a potential source of challenge to the original corporatist arrangements, it questionable whether the electoral system is the principal constituent of Hong Kong corporatism in the first place. Students in Hong Kong polity have paid close attention to her corporatist nature in relation to the political system, such as functional representatives in the legislature and consultation bodies, but we add that corporatist institutions in the production arena perhaps are the major domain where we can capture the dynamics of welfare policy making. More studies on the governance of welfare sectors themselves, especially the interplay between welfare state professionals and state actors as we have examined in this study, are of empirical importance in understanding Hong Kong corporatism.

Following a pessimistic interpretation of the political development in Hong Kong, the real threat to Hong Kong corporatism in the future however will rather be authoritarian than pluralistic electoral politics. Under the Mainland Chinese authority's encroachment and tight brace, the autonomous territory of Hong Kong Special Administrative Region has seen the tendency to mould itself in the mainland's image: while electoral politics is developing, demise of its prized autonomy and openness has been observable in terms of Beijing's control of local media and politicians that favour limiting civil liberties and containing the

civil society's capacity to challenge the government (Levin and Yung, 2016). If the liberal tradition in Hong Kong continues to decay, the notion of liberal autocracy will be problematic as social- or liberal- corporatism we refer in this study may move towards an authoritarian one where check and balance by liberal professionals in the state top-down integration is missing.

When we speak of the "liberal" autocratic polity in Hong Kong, one should not overlook that its core component is a long tradition of respect for, and extensive use of, the liberal professionals' expertise, as well as their legitimizing functions in social management. Alongside its autocratic nature, the liberal tradition has prevented the Hong Kong Government from costly direct intervention and regulation of market failure as some may observe in the authoritarian mainland. Under the communist regime of China, researchers have noticed that the lack of a widely-shared tradition of medical professionalism has complicated China's efforts in decentralization and marketization reforms, as a trustworthy healthcare workforce who can discipline themselves to put patients' interests ahead economic welfare is unavailable (Blumenthal and Hsiao, 2015). We suggest that the institution of medical professionalism is based on a liberal approach of social management conferring authority to liberal professionals as self-regulated and autonomous experts. As a kind of "public use of private organized interests" (Streeck and Schmitter, 1985), liberal professionals can in return serve as a stable partner of the state in corporatist healthcare governance endorsing social policy. This study has offered some micro aspects of how such "public-private concertation" is operating.

With a professional-led governance under corporatist arrangements in healthcare, the Hong Kong Government manages to cap healthcare spending at 5.4% of the territory's GDP, with admirable outcomes such as the highest life expectancy in the world of 84 in 2016 (Bloomberg, 2016), universal access to free healthcare, and general public support for the public healthcare system (The Harvard Team, 1999). While waiting time, support to patients with chronic diseases and the integration between community and hospital care are the main areas that require improvements in the system, its cost-effectiveness compares favourably to European advanced economies (ibid, p.51). If the "liberal autocracy" in Hong Kong is to turn into "illiberal democracy", by which Fareed Zakaria (1997) depicts a more common

type of impartial democracy as electoral authoritarian regimes, the original welfare corporatism and its effectiveness will be in doubt.

One of the major challenges for applying governance analysis to Hong Kong is the uncertainties arising from its integration with Mainland China. If the constitutional framework of "one country, two systems" was to be disregarded, a different way of life as well as social-political structure in the much smaller city-state of 7 million people from the mainland, which is the second large economy in the world with a biggest population of 1.4 billion, could be rapidly overturned. Like any other social-political analyses on Hong Kong, our study in welfare governance is not immune from these uncertainties. Cautious validation of its applicability from time to time therefore is required, although we believe that the depiction of the Hong Kong polity as social-/liberal-/neo-corporatism is basically effective and changes will tend to happen according to certain path dependency.

8.4. Implications for the Sociology of professions (Chapter 3)

8.4.1. The research tradition of the Re-Stratification Thesis

Guiding questions for Chapter 3: what are the challenges for medicine's dominance and autonomy in healthcare management from the state control and other social actors? How does medicine cope with those challenges? In particular, how do the state and medicine manage to stabilize the health policy community? What are the implications for the power dynamics in governing healthcare systems, as well as the internal changes within medicine, known as "re-stratification"?

In Chapter 3, we narrow down the scope of our discussion to the profession system itself. In the main theme of state-society interaction, the respective theories we discuss are De-Professionalization/ Proletarianization Thesis (Haug, 1973; McKinley and Stoeckle, 1988; Oppenheimer, 1973) in a "state-centric" account that sees the state has successfully deskilled professionals /medicine, and the "society-centric" account that sees the power dynamics as wars between "structural interests" (Alford, 1975) and "jurisdiction wars" (Abbott, 1988; Nancarrow and Borthwick, 2005) where the medical power prevails. As our discussion at a macro level of governance has suggested, the competition between the professional power

and other interest groups is not open and free but state-sponsored in view of building a coalition or closed policy community. At the same time, the professional power is indispensable for the state considering their functional interdependency. In such corporatist setting where the state only has influence rather than control over professionals / medicine, as its partner cum challenger, the respective theory is the Re-Stratification Thesis (Freidson, 1994) that sees the physicians' collective rights to self-regulation as being preserved by a group of elites in medicine, who enrol into the general management as the professionals' proxies while exercise a tighter monitoring over rank-and-file physicians as the state's proxies. In this study, we single out this group of pivotal actors in healthcare governance in order to examine the balance of power between the state and medicine.

According to the Re-Stratification Thesis, the professional power is far more extensive than theorists of professional decline suggest, while it is much more circumscribed than the notion of professional hegemony (Brint, 1993). One the one hand, "the economic terms and logistics conditions may be less subject to professional control than before" (Freidson, 1986, p.263). On the other hand, external oversight poses "no comprehensive or consistent threat" as "a strong system of credentialing still controls who may do practical kinds of work and how to do it" and "the basic institution employed by professionals to exercise control over training and practice conditions remain intact" (p.268). So whereas expert influence in policy making is largely maintained in purely technical areas (i.e. establishment of standards), to what extent can the professional power be maintained in organizational arena and shield daily professional activities from managerialism? That is a core question of medical sociology on the scope of the medical power.

Based on Freidson's analyses, the medical profession's knowledge monopolies are followed with subsequent organizational and legal privileges (i.e. control of case records and special treatment of expert testimony by the courts), and practicing doctors "characteristically enjoy the power to do their work as they see fit" with "considerable power over individual patients" as well as "a significant degree of institutionalized power over access to desired resources" (Brint, 1993, p.269). At the same time, the medical profession does not "control the economic and political context in which knowledge becomes usable in practical life" (ibid) as the use of engineering principles and ideas are determined by elite administrators who are

"agents of their corporations", and the professional knowledge is "developed under corporate auspices" and "proprietary and protected as trade secrets" (Freidson, 1986, p.222).

Freidson's (1994) conclusion is that professionalism is not fading but just being "reborn" in a hierarchical form where "everyday practitioners become subject to the control of professional elites who continue to exercise the considerable technical, administrative, and cultural authority that the professions have had in the past" (p.9). For Freidson, "there is little evidence that the special status of rank and file professionals will deteriorate so much that they will find themselves in the same position as other workers" as "they will still enjoy at least occupational kinship with their superiors" (p.145). In the UK context, Harrison and Ahmad (2000, p.137) also confirm that the dominance of the biomedical model at the macro-level (institutional authority of medicine as an autonomous profession and corporatist arrangements of professional-led governance in the NHS) remains largely intact, despite that the micro- aspect is under tighter monitoring. As a result, radical organizational changes or re-engineering in hospitals are rare and adjustments to services are incremental (Harrison and McDonald, 2008, p.47).

The major problem of the Re-Stratification Thesis, as researchers have noticed, is that "occupational kinship" itself may not be a guarantee for physician managers, as medicine elites, to act as protectors of their professional peers or the medical profession itself. Medical institutions could be "co-opted by external forces into constraining their own members" (Coburn, Rappaport and Bourgeault,1997, p.18) with their socialization as a manager. Put in a Foucauldian perspective, self-regulation regimes of medicine under NPM could be depicted as self-surveillance that "governmentalizes" medicine with managerial ideologies (Flynn, 2002). As Courpasson (2000, p. 157) argues, although new self-regulation regimes are flexible and decentralised in form, there are "more rigid constraints and structures of domination" in substance as "soft bureaucracy". On the contrary, Sociological Institutionalism sees reform efforts in healthcare organizations as a "loose-coupling" process that responds to coercive reform demands from the institutional environment by buffering daily activities from rigid adherence to the formal structure (DiMaggio and Powell, 1983; Meyer and Rowan 1977, p. 357). Alongside the strategic adaptation to reforms rhetoric, "soft autonomy" is preserved to uphold the professionals' rights to self-regulation in substance (Levay and Waks, 2009; Waring 2007). While there is no contention that healthcare

governance is "by" the doctors, whether it is "for" the doctors would have considerable implications for how their pivotal role is enacted, i.e. colonizing medicine for the state or capturing the state for medicine. With respect to those theoretical debates over "soft bureaucracy" or "soft autonomy" in the re-stratification of medicine, noticeable recent research efforts have been focused on the subjectivity issue regarding physician managers (Forbes and Hallier, 2006; Hoff, 1999; 2000; McGivern et al., 2015; Waring, 2014).

8.4.2. The question of the medical power

Calibrating itself in the aforementioned research tradition of physician managers, our study on the HA offers a micro-aspect of how the structure and scope of control of medicine in healthcare is being maintained or changed.

Regarding the new structure of medicine under its re-stratification, firstly, our findings echo the recent researches suggesting that the internal split of medicine does not appear between medicine elites and rank-and-file only, but also among physician managers themselves. As demonstrated in our sample of physician managers, "frontline managers", who occupy departmental management posts, tend to identify themselves as a member of the frontline doctors and their protectors; "pure managers", who occupy directorial management posts overseeing more than one clinical department, tend to identify themselves with the senior management as the rationalizers of medicine. Therefore, the interaction between the two groups of physician managers has become the frontline of conflicts between the state and medicine. In Chapter 6, we have examined the two different ways of enacting the manager role between frontline and pure managers, i.e. as the proxies of the state or medicine. Such positioning of frontline and pure managers as protectors and rationalizers also exists inter-subjectively as the interviewees are positioning each other according to that typology.

Secondly, following that advancement of the Re-Stratification Thesis, interviewees in this study, from both the frontline and senior management, further confirm Harrison and McDonald's (2008, p.47) notion that the general management can hardly control the day-to-day operation of the acute medical sector. So, how are frontline managers being engaged in a manager role so that incremental adjustments to services can be made in a pervasive way? Our proposed notion of mixed identity work in Chapter 7, by which frontline managers are

273

also influenced by managerial values and vice versa, further offers a preliminary depiction of how that engagement is working. After all, if frontline and pure managers were so conflicting, some explanation would be needed for whether medicine as whole still functions as the state's stable partner in healthcare governance, and how.

We suggest that the integration of professional and managerial values and interests consists of a two-way flow of physician managers' hybridization: one the one hand, frontline managers are exposed to the management values with some positive interpersonal working experiences and awareness of budget and the system factors; on the other hand, pure managers are also adopting a traditional mode of professional communication. Alongside formal consultation process which is deemed by the frontline largely as formality, pure managers consult and deliver messages to the frontline through their informal personal networks in the profession, wearing a clinician hat, using clinician language and by symbolic contact to the clinical field. Going beyond the current major studies applying the Re-Stratification Thesis to physician managers, this study adds that the structure of the medical power as frontline vs. pure managers may involve a more sophisticated mechanism of boundary maintenance that allows the exchange of clinical and managerial authority between the two sides, creating concertation alongside struggles in a corporatist setting.

The second question of whether the scope of the state and professional powers is limited or expanded is less directly answered by our findings in this study, which largely focus on the new structure of the profession. With the proposed notion of integration and hybridization, this study portrays "soft bureaucracy" among frontline managers for their alignment to the senior management, as well as "soft autonomy" among pure managers for their stickiness to the clan mode of professional governance. One may therefore have an impression that the balance of power between the state and medicine is achieved with the frontline and pure managers being equalized. Yet, this study has also revealed the boundary maintenance based on frontline and pure managers' mutual recognition of each other's jurisdiction in the clinical field and policy arenas. While having different self-identifications as rationalizers or protectors of medicine, the two groups of physician managers have respect for each other's differences and realize that healthcare governance cannot be done without each other. It is not that frontline mangers have acquired the same power in policy making as pure managers, or the pure managers have acquired the same power in the clinical field as frontline managers.

It is, indeed, frontline managers follow pure managers in policy arenas and pure managers follow frontline managers in the clinical field.

Here important is the distinction between institutional areas that involve technical issues and policy areas that involve high public or political interest in answering the question of the medical power (Brint, 1993, p.268). Regarding the "economic terms and logistics conditions" (Freidson, 1986, p.263) that are directly relevant to the cost containment agenda, professionals as a whole do lose some control. In the interviews of this study, both frontline and pure managers support the status quo in the HA by downplaying issues that are heavily criticized by doctor trade unions, such as long working hours and overwork payment. Also, cost-efficiency measures are generally accepted as necessary by physician managers, although those who are from the frontline are somewhat reluctant. In this sense, the professional-led governance in the HA means to engage frontline managers in management and diminish the weight of purely professional opinion in the fiscal policy area. For areas such as clinical governance, service planning and performance measurement, as Freidson (1986, p.263) at the same time suggests, the professionals' control over "training and practice conditions" remains strong. This notion also finds some support from the interviews in this study, i.e. adherence of pure managers to professionalism in the micro-management of clinical activities, such as tolerance of deviations from clinical protocols or performance data, delegation of power to frontline managers, and respect for clinical autonomy. Considering that doctors are actually the "clinical end-users" (of other health professionals' services and facilities, for example, nurses' support services and tests; Harrison, Hunter and Pollitt, 1990, Ch. 4) and their ultimate control of treatment process, frontline doctors' institutionalized power over access to desired resources is still substantial. In this regards, the professional-led governance in the HA also means to retain pure managers as a member of medicine despite that they "control the economic and political context in which knowledge becomes usable in practical life" as "agents of their corporations" (Freidson, 1986, p. 222). After all, managerialism in healthcare presents little deterioration of professional opinions in policy implementation. As a whole, the managerial and professional powers are decisive at different levels of healthcare governance with the tendency that physician managers are acting as a manager in policy arena and as a professional in daily operation.

8.4.3. An Institutionalist interpretation

Seeing through the lens of Sociological Institutionalism, such equilibrium between the medical and managerial powers can be seen as compartmentalization of daily activities and formal structure in modern institutionalized organizations. First of all, it is suggested that reforms rhetoric, as formal organizational structures ("professions, policies, and programs are created along with the products and services that they are understood to produce rationally"), is always loosely de-coupled from actual activities (Meyer and Rowan, 1977, p.340). On the one hand, under "isomorphism" or institutional peer pressures, organizations legitimize themselves by adopting standardized assessment criteria which are widely accepted by other organizations. On the other hand, if actual activities were closely conformed to formal organizational structure, inefficiency or inconsistency may be exposed and "undermines an organization's ceremonial conformity and sacrifices its support and legitimacy" (pp.340-341). Therefore, in modern organizations, "structural elements are only loosely linked to each other and to activities, rules are often violated, decisions are often unimplemented, or if implemented have uncertain consequences, technologies are of problematic efficiency, and evaluation and inspection systems are subverted or rendered so vague as to provide little coordination" (p.343). In this connection, the substantial impacts of NPM reform rhetoric on daily operations in healthcare organizations should not be overestimated.

Secondly, "organizations in search of external support and stability incorporate all sorts of incompatible structural elements" (p.356). Alongside external oversight regimes, the credential and profession system itself is a significant source of legitimization for modern organizations. It constitutes an essential part of formal organizational structures as kind of ritual conformity to standardization, creating good faith that daily activities are produced rationally. Unlike "implicit rationing" (depoliticizing the distribution of scarce healthcare resources) as scholars of healthcare politics depict (Mechanic,1978; Klein, 1990), such legitimatizing function refers to a cognitive aspect that co-ordination of activities is conceived to be adhering to certain standards accepted by the wider environment. In this connection, professionalism offers not only expertise or endorsement to government policy, but also "stabilizing effects" to institutionalized organizations avoiding direct or frequent inspection/evaluation from external constituents (p.351). If managerialist reforms go too far

to challenge the professional's performance, healthcare organizations will lose an importance source of legitimacy. Equally, if professionalism cannot be ceremonially regulated, transparency or responsible autonomy under modern management will in the same way be suspect. The implication of Institutional Theory for healthcare governance is not only limited to the resilience of professionalism but also its cooperative tension with managerialism.

Thirdly, based on the first and second institutional logics as aforementioned, "specific contexts highlight the inadequacies of the prescriptions of generalized myths, and inconsistent structural elements conflict over jurisdictional rights", thus "organization must struggle to link the requirements of ceremonial elements to technical activities and to link inconsistent ceremonial elements to each other" (p.356). While a tightly coupled system would generate conflicts between activities and formal structure and among conflicting structural elements, i.e. professionalism and managerialism, a totally de-coupled system would lose its institutional connections. A loosely coupled system therefore would be a common strategy adopted by healthcare organizations in view of maximizing their legitimacy. In the de-coupling process, the cooperation between professionals and managers is the key:

> Activities are performed beyond the purview of managers. In particular, organizations actively encourage professionalism, and activities are delegated to professionals…Human relations are made very important. The organization cannot formally coordinate activities because its formal rules, if applied, would generate inconsistencies. Therefore, individuals are left to work out technical interdependencies informally. The ability to coordinate things in violation of the rules - that is, to get along with other people - is highly valued. (p.357)

In an institutional setting, whereas activities are informally co-ordinated with the professional networks in daily operations, managers' human relations are of high importance. This also explains why professional managers are needed while they are not actually applying professional knowledge to their management work at all: human relations in the informal professional networks are what makes management of professional activities possible and can only be acquired from them. In this regard, this study contributes a micro-aspect examination to our understanding of how that complicated co-ordination take places in healthcare organizations.

Some researches applying Institutional Theory to healthcare study specific programs of managerial reform in healthcare organizations, such as quality management (Audet et al., 2005), accreditation (Pawlson and O'Kane, 2002) and guidelines (Berg et al., 2000). They stress the professionals' selective and ceremonial compliance with managerial/regulative procedures or the professionals' power in adaptively redefining them. In this study, we highlight physician managers per-se and their conflicting self-identifications as profession vs. organization, arguing that alignment of activities in healthcare organizations is a two-way-flow where the normative engagement of frontline managers in managerial practices should not be overlooked alongside their influence in mediating policy implementation. Likewise, pure managers are also aligned to professional modes of clinical governance which is based on human relations while they have been socialized into a robust manger-self. In such hybridization processes, the frontline and senior management are aligned to each other, preventing frontline managers' clinician-self from diminishing their manager-role or pure managers' manager-self from diminishing their clinician-role. We see the subsequent integration of managerialism and professionalism as a constituent stabilizer of the institutional order in healthcare organizations by ensuring that activities are aligned to potentially conflicting formal structures.

Following this, in institutionalized organizations where conflicting logics compete and coexist, "triumph of professional power" in the "inconsistency of policy" (Currie and Suhomlinova, 2006) may be an incomplete picture of the power dynamics between the professional and managerial powers. The proposed notion of "satisficing" physician managers, who attempt to achieve at least some minimum level of both professional and managerial goals, may be more coherent with the basic proposition of Institutional Theory that rejects a rational model of organizational actors as "maximizers" of particular values and interests instead of the overall legitimacy.

Indeed, recent Institutionalist researches have shifted their attention to the institutionalized accommodation of incompatible logics by which "field constituents negotiate a reciprocated, albeit uneasy, "tolerance" of multiple logics - thereby accepting that only some of their demands will be met" (Raynard, 2016, p.324). Studies on coexistence of "care and science" in medicine education (Dunn and Jones, 2010) and the "uneasy truce" between advocates of "medical professionalism" and "business-like health care" (Reay and Hinings, 2009) are

good examples. Above all, "structural hybridity" is conceptualized as a core mechanism to deconstruct complexity in institutional organizations regarding multiple institutional logics by drawing them in innovative and synergistic ways, including "blending", "compartmentalization" and "selective co-coupling" (Raynard, 2016). In the HA, it is observed that the professional hierarchy of medicine is blended with the bureaucratic one with the introduction of physician managers to integrate professionalism and managerialism, while a boundary of jurisdictions between policy and clinical arenas is maintained between frontline and pure managers in view of compartmentalization, and adherence to professionalism or managerialism is selective by physician managers. With a focus on hybrid physician managers who act as "satisficers" and the boundary maintenance between pure and frontline managers, this study has offered a tentative field-level examination of how "competitive" and "cooperative" tensions of conflicting institutional logics (Besharov and Smith, 2014; Goodrick and Reay, 2011; Jay, 2013; Meyer and Hollerer, 2010) are handled by the HA governance as structural hybridity.

In summary, regarding the question of medical power, an Institutionalist interpretation further adds that the stratified structure of healthcare, where professional and managerial powers *coexist* at different levels of policy and clinical governance, is somewhat a *compartmentalized* one or *loosely-coupled* system. Such interpretation of the new structure of medicine enriches our understanding of the scope of the medical and managerial powers (who governs) with a following question of how or in what context and conditions the scope of power is defined and maintained.

8.5. Conclusion

In addition to academic contributions to Corporatist Theory, Re-Stratification Thesis, as well as the research of physician managers as discussed in this concluding chapter, this study may also have some implications for the wider policy discussion of healthcare reforms in Hong Kong.

As the population in the territory will be aging rapidly in the near future, the sustainability of the traditional NHS-style hospital care, which is directly funded by general taxation, will

face a real test. In addition, after years of development in a specialist-led model, overemphasis on hospital care and its disintegration with primary care have become major shortcomings in Hong Kong public healthcare system. The government has proposed reform solutions of contributory financing and marketization to address those problems for almost two decades (The Harvard Team, 1999). Yet they are not well received by the general public and politicians in Hong Kong for the fear of upsetting the universal public healthcare system which has been practiced in Hong Kong since the 1970s. Above all, medical professionals' resistance is one of the major obstacles.

The political deadlock can be broken if policy makers or medicine think beyond the current statist-corporatist system. Comparative healthcare studies suggest that different models of healthcare governance, i.e. public insurance and national healthcare service, will result in different landscapes of corporatism for their different combinations of markets, hierarchies and professional networks (Giaimo, 2009). If healthcare financing, as well as the whole taxation and welfare arrangement in Hong Kong is moving from the taxation based one towards a public insurance model, the scope of the medical power as revealed in this study will be subject to considerable changes. Firstly, medical associations will further acquire a formal status in setting policy with the government and insurers/ employers regarding the parameters of insurance coverage and costs. Secondly, outside "the shadow of hierarchy" (Jessop, 1997; Scharpf, 1994), effective regulation of medical professionals who are no longer public servants will rely even more heavily on the collective self-regulation of medicine. Such moves will probably see some opportunity for the medical profession to reshape the power setting in healthcare in view of a higher professional autonomy. The sectoral interests and the wider reform agenda can therefore be complementary.

However, this may also give rise to the question of whether the government can maintain its influence over medical elites in view of protecting public interests. As Freidson (2001) suggests in his last work, *The Third Logic*, the soul of medical professionalism is "serving some transcendent value and asserting greater devotion to doing good work than to economic reward" (p.180). While a statist-corporatist system may curtail professionalism under its logic as rational-legal bureaucracy, it may also help buffer the impacts of markets on professionalism. Above all, public service ethos among welfare state professionals may be

the most valuable public good. In this respect, market forces in a public insurance system may also present a new threat to professionalism.

As Freidson also argues, professionalism, as well as free market and rational-legal bureaucracy, are just ideal types that "can but may never fully be" (p.179). In reality, the combination of professionalism with state and market logics takes place in given institutional contingencies and historical context. In this connection, which combination is optimal for public interests is a more fundamental question for policy makers. In this study on the HA, physician managers have demonstrated the medical profession's capacity to integrate those conflicting logics in a statist-corporatist setting. In the British NHS, which is the archetype of Hong Kong healthcare system, some market elements have been supplemented to the original statist-corporatist system under the banner of the "internal markets" in the past two decades to promote choice and efficiency. Policy makers may see the implications for Hong Kong from those developments on how we can modernize medicine in path dependency. After all, in all types of healthcare governance, how to circumscribe the professional interests with state and market forces while maintaining corporatism as the "public use of private interest", i.e. the professional system's capacity to check and balance other conflicting yet fundamental logics or values in social management, is the key to good governance.

Appendices

Appendix One

Share of social expenditure* in GDP and total general government expenditure, Hong Kong and selected developed countries, 1980, 2000 and 2010

Country	Share in GDP (%)			Share in total general government expenditure (%)		
	1980	2000	2015	1980	2000	2015*
France	20.2	27.5	31.7	43.9	54.3	55.2
Finland	17.7	22.6	30.6	44.4	50.1	51.4
Austria	22	25.5	28	-	52.3	54.1
Italy	17.4	22.6	28.9	-	55.4	56
Sweden	24.8	26.8	26.7	-	51.3	52.3
Germany	21.8	25.4	25	-	54.9	55.6
Norway	16.1	20.4	23.9	-	48.7	49.4
Japan	10.2	16.3	23.1	-	53.9	54.4
UK	15.6	17.7	21.5	-	47.2	49
US	12.8	14.3	19	37.2	45	48.1
Australia	10.3	18.2	18.8	30.8		45.6
Canada	13.3	15.8	17.2	-	40.9	41.8
Korea	..	4.5	10.1	-	26.7	29.4
Hong Kong	5.8	8.5	7.8	44.1	54.4	57.1

Source: Hong Kong Government Budget 2016-17 and 2001-02; Tang (1998, p.72); OECD (2016b)
* Social expenditure refers to the public spending in the policy areas of housing, education, health and social welfare as defined by Government Budget for Hong Kong; for other countries, it refers to the main social policy areas as defined by OECD as follows: old age, survivors, incapacity-related benefits, health, family, active labor market programmes, unemployment and housing.
** As all data for 2015 is unavailable for OECD countries, we use OECD figures for 2013 as comparison.

Appendix Two

Share of general government expenditure in GDP, Hong Kong and selected developed countries, 2014

Country	Government expense as % of GDP
Austria	52.8
Finland	58.1
France	57.3
Sweden	51.5
Italy	51.0
Norway	45.9
Germany	44.1
United Kingdom	43.8
Japan	42.1
United States	38.1
Australia	36.2
Korea	32.0
Hong Kong	17.8

Source: Hong Kong Government Budget 2016-17; OECD (2016c)

Appendix Three

Fees and costs of public medical services in Hong Kong (HKD 1= GBP 0.1)

Services	Fees before 2002	Fees since 2002	Unit cost in 2015
Accident and Emergency	Free	HKD 100/ attendance	HKD 1,140/attendance
In-patient	HKD 68 / day	HKD 100/ day	HKD 4,600/day
Admission fee(In-patient)	Free	HKD 50	
General out-patient	HKD 37/ attendance	HKD 45/ attendance	HKD 410/ attendance
Specialist out-patient	HKD 44/ attendance	HKD 60/ attendance (HKD 100/ first attendance) HKD 10/ drug	HKD 1,030/ attendance
Dressing and injection	HKD 15	HKD 17	

Source: Chau and Yu (2003, p.205); *Hospital Authority Annual Report 2014-15*; Hospital Authority webpage (http://www.ha.org.hk/haho/ho/cs/v3/serviceguide_feenchg-b5.htm)

Appendix Four

Public welfare provision in Hong Kong

Area	Major programme(s)	Government's role in delivery	Subsidy Level* Eligibility	Coverage**
Social assistance	Comprehensive Social Security Assistance Scheme	Indirect (payments to recipients)	100% Means-tested	7%
Social service	Subsidy to voluntary agencies	Indirect (regulation /financing)	90% Means-tested / needs assessment	-
Housing	Public rental housing Home Ownership Scheme	Direct (provision)	90% Means-tested	50%
Education	Government and subsidized primary and secondary Schools	Indirect (regulation / financing)	100% Non-means-tested	80%
Health	Hospital Authority	Indirect (regulation / financing)	95% Non-means-tested	90% (Impatient) 30% (Outpatient)

* Subsidy level refers to the share of the cost of welfare services by the government. The subsidy level of social welfare is 100% as CSSA is non-contributory. If we take CSSA as unemployment insurance or old-age pension, its replacement rate against the income level of economically active employees is 37%.
** Coverage refers to the percentage of the population covered by respective public welfare programmes for social welfare and housing; for education and health, it refers to the share of total service volume by respective public welfare programmes.

Appendix Five

Extended social benefits* per month by household income in Hong Kong

Decile Group**	Average per household (HKD)			Share of total (%)		
	2001	2006	2011	2001	2006	2011
1st (lowest)	3,500	2,960	3,040	10.6	9.50	8.6
2nd	3,500	3,580	3,850	10.6	11.6	10.8
3rd	3,850	3,760	4,210	11.7	12.1	11.8
4th	4,070	3,690	4,410	12.4	11.9	12.4
5th	4,050	3,600	4,220	12.3	11.6	11.9
6th	3,410	3,230	3,760	10.4	10.4	10.6
7th	3,110	2,990	3,290	9.5	9.6	9.2
8th	2,820	2,620	3,190	8.6	8.5	9.0
9th	2,480	2,400	2,930	7.5	7.7	8.2
10th (highest)	2,140	2,180	2,680	6.5	7.0	7.5
Overall	3,290	3,100	3,560	100	100	100

* "Extended Social benefits" refer to public housing, education and healthcare services and exclude social welfare as defined by the Census and Statistics Department.
** Each decile group contains the same number of domestic households, ranked by household income.
Source: Census and Statistics Department, Hong Kong (2012b)

Appendix Six

Pool of literature on physician managers

Inclusion criteria	
Search terms	'physician manager' OR 'clinician manager' OR 'medically qualified manager' OR 'medical manager'
Date of publication	From the earliest date available to 14th July, 2015
Language	English

Data base	No. of hits
[ProQuest] Applied Social Sciences Index and Abstracts (ASSIA)	968
Scopus	8,740
Web of Science	4,831
Total	14,593

Appendix Seven

Pool of articles for abstract screening

Research focus	Search items	No. of hits
hybrid identities	'hybrid'	217
	'identity'	216
	Total	433

Appendix Eight

Selected articles

Inclusion criteria	No. of articles
1. Empirical studies on physician managers	
2. Relating to identity work or hybridity	14
3. Relating to the theme of professionalism versus managerialism	

Appendix Nine

Characteristics of selected studies

Articles	Country/ setting	Method	Sampling	Time frame
Fitzgerald (1994)	UK / NHS providers	Two-stage interview	31 clinical/medical directors attending a management training programme	Prior and after the training programme
Hoff (1999)	US / 1 MCO (Managed Care Organization)	Semi-structured interview; observation; document analysis	22 physician managers (first line supervisors/ middle- and upper-level managers) by convenience sampling of the entire physician-manager hierarchy	Interviews and observations conducted in 15 months
Hoff (2000)	US	Close-ended questionnaire	294 respondents from a random sample of the 'Managed Care Section' of the American College of Physician Executives (ACPE)	One-off survey in 1996
Doolin (2001)	Australia / 1 public hospital	Informal interview; document analysis; observation	12 physician managers (clinical unit directors / operation managers /consultants) and 23 other personnel by an opportunistic sampling	6 months of implementing a new organization structure
Forbes and Hallier (2006)	UK / 1 NHS acute hospitals in Scotland	Semi-structured interviews	18 clinical directors in a hospital from a wide range of specialities	Interviews conducted in 5 years
Mo (2008)	Norway /1 teaching hospital	Interviews	10 department managers from a wide range of departments in terms of speciality and size assessed through the hospital Executive Director	1 year: during the first year after the management reform took place
Kippist and Fitzgerald (2009)	Australia / 1 teaching hospital	Semi-structured interviews; observation; document analysis	7 participants in a clinical leadership development program (department managers), 6 other personnel; 1 facilitator of the program	Retrospective evaluation of a 2-year programme
Russell et al. (2010)	Ireland/ 1 public hospital	Semi-structured interview	15 hospital consultants by a purposive sampling (from a range of specialities) and Snowball techniques (referred from 4 local consultants known to the researcher)	Interviews conducted in 3 months

Appendix Nine (continued)

Characteristics of selected studies

Articles	Country/ setting	Method	Sampling	Time frame
Ham at el. (2011)	UK / NHS	Semi-structured interview	22 medical chief executives identified by key informants (Strategic Health Authorities) and author's own knowledge	Interviews conducted in 6 months
Martinussen and Magnussen (2011)	Norway / hospitals	Close-ended questionnaire	1,200 respondents (asked whether or not department chiefs) in a random sample of hospital physicians drawn down from the register of medical practitioners	One-off survey in 2006
Spyridonids and Calnan (2011)	UK / NHS PCTs and hospitals	Two phases of face-to face informal interview	8 hospital consultants, 8 doctors and 23 other personnel by a *purposive sampling* (based on their potential involvement in NICE guidelines) and *snowball techniques*	6 months: first explored retrospectively the implementation of NICE guidelines and follow up how the process unfolded afterwards
McGivern et al. (2015)	UK / NHS	Open-ended interviews	43 hybrid managers from comparable data from three studies	
Spehar, Frich, and Kjekshus (2015) (2015)	Norway/ public hospitals	Face to face in-depth interview at workplace; observation of meetings	13 doctor managers (department/ first-line managers) and 17 other personnel from a master programme in management, by a maximum variation sampling of a wide range of specialities and work place	
Spyridonidis, Hendy and Barlow (2015)	UK / NHS	Two-stage semi-structured, open-ended interviews; observation; document	62 clinical unit managers from 'Collaborations for Leadership in Applied Health Research and Care' (CLAHRC) programme	5 years: before and after CLAHRC programme

Appendix Ten

Invitation email to interviewees

Dear Dr _____ ,

Research Study on Physician Managers in the Hong Kong Hospital Authority

I am writing to seek to your help in the captioned research project on 'physician managers' (managers with medical background) in the Hong Kong Hospital Authority. The research results will be a part of my PhD thesis submitted to the Department of Social Policy and Social Work at the University of York (UK).

Research background and questions

Engaging medical professionals in public healthcare system management is a common strategy of governments in the world including Hong Kong. However, literature suggests such approach of professional-led governance has mixed consequences in governance. While government's capacity to handle an ever technically complicated healthcare system has been enhanced due to physicians' expertise and connections to daily operation, physicians' professional identity/subculture and training have considerable impacts on how the manager's role is enacted.

As a pioneering research collecting data on physician managers in Hong Kong, this project aims to have their first person narratives on their management role in healthcare, with special attention to their social identification with professional colleagues and organizations. In general, the research questions are: do physician managers in Hong Kong face any conflicts between their physician and manager roles? How do they settle the conflicts? What are the impacts on management work and professional autonomy?

In addition to academic interests, the findings may also provide important information for policy makers to support physician's management work.

Proposed research method

In my research design, there are two ways to collect data on physician managers' identity and their opinion on relevant issues:

1) Questionnaire survey. A short questionnaire with 15 statements asking for respondents' opinion (agreed or disagree in 7-point-sclae) on professional identity, clinical autonomy and rights to self-regulation of physicians.

2) Personal interview. Two groups of physician managers are the targeted subjects: a) 'pure manager' - physicians who committee most of their time to management duties at the hospital / cluster/ the Head Office level, and b) 'front-line managers' - physicians who are engaged in departmental management but maintain clinical activities, such as Chief of Services and Heads of Department.

A draft of detailed interview guide and questionnaire is attached.

Assistance requested

I would like to invite you to be my interviewee. If you are happy to go ahead, please complete the consent form (copy attached). You can hide your identity by choosing options B or C. You may also find the information sheet in the attachment for more details of the research project. Your help will greatly benefit my research project so please spend just 30 -60 minutes in the interview, at anytime and anywhere convenient for you!

For any questions, please feel free to contact me at 61770920 or kwf501@york.ac.uk. Thank you very much again!

Yours sincerely,

Ken, Ka-wo Fung

Appendix Eleven

Interviewees' Information Sheet

Research Study on Physician Managers in the Hong Kong Hospital Authority

You are being invited to take part in a research study conducted by Ken, Ka-wo FUNG, a Doctoral Researcher in the Department of Social Policy and Social Work at the University of York (UK). The study is dedicated to examine medical professionals' influence in healthcare management and the impact of their medical background on their management work.

Why am I approached?

You are contacted because we appreciate that you have been involved in the management work in the Hospital Authority. Although documents will be collected as part of the research, a key objective is to hear first-hand accounts of physician managers. Your participation therefore is highly valuable. Research results may also help academics and policy makers better understand the difficulties physician managers encountered in Hong Kong. I will be very grateful if you can support this study by taking part in the interview.

What would be taking part involve?

We would like to conduct a face-to-face interview with you at a time and place convenient for you. It is anticipated that the interview will last 30 – 60 minutes.

Before the interview begins there will be further opportunity for you to raise concerns. If you are then happy to go ahead, please complete the consent form (copy attached) immediately prior to the interview. With your permission, the interview will be digitally recorded and later transcribed. If permission is not given then I will be happy to take detailed written notes instead.

During the interview you will be asked about your personal experience in healthcare management (please see the attached questions for details). A short questionnaire collecting basic information is also attached. Please fill in the questionnaire before the interview so that the researcher can collect it during the interview.

The language we use in the interview and questionnaire is English. During the interview, you may use Cantonese as supplement for particular concepts/names in Hong Kong.

What will happen after the interview?

The data collected will be analysed and used in the researchers' PhD thesis and associated research outputs such as articles, conference papers and web pages. If you so wish, the researcher will send you a copy of 1) the audio record of your interview (if permission is given), and 2) any publications that quote your words, for your own record.

You will be given three options concerning how your words will be quoted within research outputs: A) you may use my name and my job title, B) you may use my job title only (rank and department; name of hospital will be hidden), and C) you may not use my name or job title. If you select option B or C you will be allocated a pseudonym (Dr X, Y, Z etc.). However, readers of the research outputs may still be able to identify you due to your distinctive insights and association with healthcare management in Hong Kong. Absolute anonymity therefore cannot be guaranteed in relation to this study even if you request a pseudonym.

The research outputs may be freely available online in the British Library website (EThOS) as a PhD thesis submitted to the University of York.

How will my details be kept confidential?

This study has been approved by the Social Policy and Social Work Departmental Ethics Committee at the University of York.

All information that is collected form you during this study will be kept confidential in line with the Data Protection Act (1998) in the UK and Personal Data (Privacy) Ordinance (Cap. 486) in Hong Kong. Audio recordings and written transcripts will be stored securely at the University of York and will only be accessible to the researcher and the supervisor of this study if necessary.

On the University's request, if you disclose any potential for risk of harm of yourself or someone else, the researcher will consult the supervisor and may report about it to who may well act on this information. Should this rare situation happen the researcher will discuss with you first.

Do I have to take part?

No, it is entirely your decision whether you want to participate in the research. If you do decide to participate you can withdraw at any time without giving a reason.

Who can I contact for more information?

If you have any questions about the research please contact:

Ken, Ka-wo FUNG (Doctoral Researcher)	**Neil LUNT** (Supervisor)
Research Centre For Social Sciences	Department of Social Policy and Social Work
6 Innovation Close	
University of York	University of York
Heslington	Heslington
York	York
The United Kingdom	The United Kingdom
YO10 5ZF	YO10 5DD
Telephone: (852) 61770920 / (44) 0777843745	Telephone: (44) 01904 321235

Appendix Twelve

Interviewees' Consent Form

Research Study on Physician managers in the Hong Kong Hospital Authority

Please tick the appropriate boxes

	Yes	No
I have been given an information sheet about the research and have had time to consider it.		
I have had the opportunity to ask questions about the research and have had these answered satisfactorily. I feel that I understand what the study involves.		
I understand that my participation in the research is voluntary and that I can withdraw at any time without giving a reason.		
I agree to assign the copyright I hold in any materials related to this project to the researcher, Ken, Ka-wo FUNG.		
I understand that the researcher may have to speak to another person if I tell him that I or someone else is at risk of harm.		
I am happy for the interview to be digitally recorded.		
I am happy for the researcher to take detailed notes of the interview.		
I understand that the information I give to the researcher will be treated in strict confidence according to the Data Protection Act (1998) in the UK and Personal Data (Privacy) Ordinance (Cap. 486) in Hong Kong.		
I understand that data I provide in the interview and questionnaire will be used in researcher's PhD thesis and associated research outputs such as articles, conference papers and web pages.		
I understand that my words may be quoted in the research outputs of this study.		
I understand that the research outputs of this study may be openly accessed.		
Please choose one of the following options concerning how you would like your words to be quoted in research outputs. Please note that if you select option B or C you will be allocated a pseudonym (Dr X, Y, Z etc.). A) You may use my name and my job title ☐ B) You may use my job title only (rank and department; name of hospital will be hidden) ☐ C) You may not use my name or job title ☐		
I understand that even if I am allocated a pseudonym my absolute anonymity cannot be guaranteed.		
I have sought approval from the hospital/ I confirm that there is no approval needed from the hospital in relation to this study		
I wish to receive a copy of the audio record of the interview.		
I wish to receive a copy of the publications that quote my words.		
I agree to take part in the research.		

Name: _____   Signature: _____

Email Address: _____   Date:_____

Telephone no:_____

Appendix Thirteen

Interview guide

UNIVERSITY *of York*

Research Study on Physician Managers in the Hong Kong Hospital Authority

<u>Interview Guide for physician managers</u>

Administration (5 minutes)

- Introductions
- Recap the purpose of the research
- Invite interviewee to ask any questions that they may have
- Complete the Consent Form
- Collect the questionnaire
- Check how much time the interviewee is prepared to spare

Interview questions (30-50 minutes)

1) Reasons for going into management and relevant experiences
   - How did you first get involved in the physician-manager role? What were your reasons for getting involved?
   - Can you tell me about your experiences in the transition from a clinical to an emerging management role? What did you expected of the management role? Were these expectations met? Any conflicts and ambiguities associated with the move?
   - Can you tell me about the kinds of things you do in this role? Please describe your role in the hospital /HA and your job tasks, i.e., a typical work day/week.

2) Role-related attitudes and behaviours
   - How do you act in this role toward others such as administrators, other doctors, and senior management?
   - How do you think you relate to other doctors in your office in this role? Do you see yourself primarily as their advocate? Can you give me an example when you were/were not acting as an advocate? How do you personally feel about telling other physicians what to do or coordinating their work? Does the manager role interfere at all in how you get along with them?
   - Do you think physicians as a group are treated fairly in this hospital/ the HA? Can you give me an example of both fair and unfair treatment? How about other groups in this hospital/ the HA?

- Tell me about how you think decisions regarding physicians and providers get made here. Do you think senior management communicates enough and seeks input regarding decisions that affect physicians? Do you feel that you can affect decisions in this hospital/ the HA?
- How satisfied overall are you in your work here in this hospital/ the HA? How about in your role as physician-manager? What was it about this hospital/ the HA that attracted you to it in the first place? Have those things changed at all? Would you ever leave this hospital/ the HA (example)? What would be some of the costs for you in terms of leaving?

3) Feelings toward a variety of actors and entities
- How do you feel about the changes in this hospital/ the HA is going through, in terms of having to focus on things like utilization and productivity among physicians? Are you willing to stand behind it, even if it means significant changes for physicians and how they do their work as a group in this hospital/ the HA? When wouldn't you stand behind it (example)? Do you feel more loyalty to this hospital/ the HA or to your physician-colleagues? How committed are you to this hospital/ the HA and its survival?
- How loyal do you feel toward your local office and the co-workers in that office? Do you feel close to the people here? Why (example)? Can you give me some examples of things that might happen within this hospital/ the HA that would decrease any feelings of loyalty you might have to it?

4) Current concerns, anxieties, and sources of confusion or conflict on the part of individuals
- Do you see a future for yourself in management or in this hospital/ the HA? Would you like to move up in management if given the opportunity? How important is clinical work to you? Do you like to do it?
- Do you see any differences between those in full-time, senior medical management positions and those in first-line supervisory positions? How do you view each role? Would you ever want the other's job (whichever they don't have now)? Why/why not?

5) Perceptions about the position of physician managers as a group in society
- What do you think about the position of physician managers as a group in society? Do you think the general public respect physician managers? In your perceptions, what kinds of social images are associated to physician managers?

Administration (5 minutes)

- Ask the interviewee to nominate prospective interviewees
- Request potential documentary materials.
- Thank interviewee for their time and contribution.

Appendix Fourteen

Questionnaire

UNIVERSITY *of York*

Research Study on Physician Managers in the Hong Kong Hospital Authority

A.   Personal Information

1)   Name:

1)   Hospital and department:

2)   Management position:

3)   Age: under 40 ☐   40-44 ☐   45-49 ☐   50-54 ☐   55 or above ☐

4)   Gender: Male ☐ Female ☐

5)   Year(s) you have served in the HA:

6)   Year(s) you have served in the management position:

7)   Management training: Course ☐ Diploma ☐ Degree ☐ No training ☐

8)   Proportion of time spent in clinical work: %

B.   Please select <u>one</u> answer from a seven-point scale to indicate whether you agree or disagree to the following statements

1.   *'I talk up the medical profession to my friends as a great career'*

Strongly disagree ☐   Disagree ☐ Somewhat disagree ☐ Neither agree or disagree ☐ Agree ☐   Somewhat agree ☐   Strongly agree ☐

2.   *'I feel very loyal to the medical profession'*

Strongly disagree ☐   Disagree ☐ Somewhat disagree ☐ Neither agree or disagree ☐ Agree ☐   Somewhat agree ☐   Strongly agree ☐

3.   *'I am willing to put in a great deal of effort beyond that normally expected in order to help my profession be successful'*

Strongly disagree ☐   Disagree ☐ Somewhat disagree ☐ Neither agree or disagree ☐ Agree ☐   Somewhat agree ☐   Strongly agree ☐

4.   *'For me, medicine is the best of all possible professions in which to work'*

Strongly disagree ☐   Disagree ☐ Somewhat disagree ☐ Neither agree or disagree ☐ Agree ☐   Somewhat agree ☐   Strongly agree ☐

5.   *'I am proud to tell others that I am part of this profession'*

Strongly disagree ☐   Disagree ☐ Somewhat disagree ☐ Neither agree or disagree ☐ Agree ☐   Somewhat agree ☐   Strongly agree ☐

6.   *'I really care about the fate of the medical profession'*

Strongly disagree ☐   Disagree ☐ Somewhat disagree ☐ Neither agree or disagree ☐ Agree ☐   Somewhat agree ☐   Strongly agree ☐

7.   *'Individual physicians should make their own decisions in regard to what is to be done in their work'*

Strongly disagree ☐   Disagree ☐ Somewhat disagree ☐ Neither agree or disagree ☐ Agree ☐   Somewhat agree ☐   Strongly agree ☐

8.   *'Individual physicians should be left alone to exercise their own judgement in their work'*

Strongly disagree ☐   Disagree ☐ Somewhat disagree ☐ Neither agree or disagree ☐ Agree ☐   Somewhat agree ☐   Strongly agree ☐

9.   *'Individual physicians should be their own boss in almost every work situation'*

Strongly disagree ☐   Disagree ☐ Somewhat disagree ☐ Neither agree or disagree ☐ Agree ☐   Somewhat agree ☐   Strongly agree ☐

10.   *'Individual physicians' decisions should be subject to reviews by others'*

Strongly disagree ☐   Disagree ☐ Somewhat disagree ☐ Neither agree or disagree ☐ Agree ☐   Somewhat agree ☐   Strongly agree ☐

11.   *'Physicians' work is something only those trained in the field can evaluate'*

Strongly disagree ☐   Disagree ☐ Somewhat disagree ☐ Neither agree or disagree ☐ Agree ☐   Somewhat agree ☐   Strongly agree ☐

12.   *'Only physicians can make judgements about how well other physicians practice medicine'*

Strongly disagree ☐   Disagree ☐ Somewhat disagree ☐ Neither agree or disagree ☐ Agree ☐   Somewhat agree ☐   Strongly agree ☐

13.   *'Only a physician can fully evaluate another's medical judgement'*

Strongly disagree ☐   Disagree ☐ Somewhat disagree ☐ Neither agree or disagree ☐ Agree ☐   Somewhat agree ☐   Strongly agree ☐

14.   *'Non-physicians are able to evaluate a physician's competence in practicing medicine'*

Strongly disagree ☐   Disagree ☐ Somewhat disagree ☐ Neither agree or disagree ☐ Agree ☐   Somewhat agree ☐   Strongly agree ☐

Appendix Fifteen

Submission to Department Ethics Committee

UNIVERSITY *of* York

SOCIAL POLICY AND SOCIAL WORK

DEPARTMENTAL ETHICS COMMITTEE

APPLICATION FOR ETHICAL APPROVAL OF RESEARCH

This form must be used for all submissions for ethical approval to the Social Policy and Social Work Departmental Ethics Committee. Please complete all sections and sign the undertaking (on paper and electronically.

The Social Policy and Social Work Departmental Ethics Committee is intended to consider projects which students, supervisors or staff believe may raise some ethical issues but which do not need to be subject to external review or review by the University Ethics Committee.

The completed and signed form and any necessary attachments should be sent to the Departmental Ethics Committee Administrator, **Nicola Moody**, room A/B 125, for consideration by the Departmental Ethics Committee Panel. An electronic copy should be emailed to nicola.moody@york.ac.uk at the same time. A decision will normally be made within 10 working days.

Checklist (click on the box to enter a cross)

☐ *Have you decided that your project needs ethical approval and that it needs it from the Departmental Ethics Committee (not from external bodies or the University Ethics Committee)?(See "Does my project need ethical approval"* on the VLE *(under SPSW Staff Intranet/Research/Ethics) or contact Rebecca Tunstall, DEC Chair, if you are not sure.*

☐ *Have you attached copies of all additional relevant material, such as research tools (questionnaires and topic guides), information sheets and consent forms*?

☐ *Have you (and, for students, your supervisor) signed the form?*

☐ *Have you provided Nicola Moody with a hard copy and an electronic copy of the form and attachments?*

Date of submission:…………………………………………………………….

1. **Please provide details about the principal investigator (student or lead staff researcher). It is possible the ethics committee panel members may get in touch if they have queries**

Name	Ka-wo FUNG
If student, course	Doctor of Philosophy in Social Policy and Social
If student, supervisor for this research	Dr Neil LUNT
If staff, post	
Email	kwf501@york.ac.uk
Telephone	07778437455

2. For staff projects, please provide details for co-investigators (add more boxes if necessary)

Name	
Post	
Organization if not SPSW	
Email	
Telephone	

3.When does the project start??

The study commenced in October 2013. Fieldwork will begin in November 2015.

4. For staff: List any SPSW DEC member who might have a conflict of interest so should not act as reviewers for the project, such as those consulted in the development of the project, or close colleagues. A list of members can be found on the VLE (under SPSW Staff Intranet/Research/Ethics)

5. What is the full title of the research project?

Healthcare governance in Hong Kong: a study on the emergence of 'hybrid' physician managers

6. If the research is funded, who is the funder and does the funding source create any ethical concerns and/or actual or perceived conflicts of interest?

7. What are the aims and key methods of the research?

The emergence of hybrid physician managers in hospital management in western countries under New Public Management has attracted researchers' attention in the past two decades. However, it is under-explored outside the West. As a former colony of Britain, Hong Kong has a legacy of the NHS style universal public hospital system based on western medicine and a liberal profession of medicine. Similar to the U.K., the 1990s and 2000s saw rapid changes in Hong Kong that aimed to modernize the healthcare sector in terms of efficiency and transparency/accountability. The landscape of healthcare policy and politics in Hong Kong is in the same way shaped by the interplay between the state and professional powers.

Although researchers in this niche field are commonly inspired by the re-stratification thesis that sees medicine as being divided into two groups, rank-and-file doctors and medicine elites who enrol into the administration and regulation posts, only a few empirical studies focus on the identity work of hybrid physician managers as the pivotal players in healthcare reforms. Indeed, it is not only the capacity but also the loyalty of medicine elites to their peers that decides whether or not the collective control of medicine on healthcare management can be preserved.

The Hong Kong case study in this research will then aim to have the physician managers' first person narratives on their management role in healthcare, with special attention to their social identification with professional colleagues and organizations.

To collect data on the identity issue, a qualitative case study design will be employed. Two highly complementary sources of evidence will be combined to triangulate information

- Elite interviews. Individual face-to face interview with physician managers will be the main source of data collection (please see Attachment C for the interview questions). Front-line doctors may also be interviewed in focus groups to explore the validity of their narratives. All participants will also be asked to fill in a short questionnaire to collect their personal information (e.g. age, year served in the organization) and beliefs in professional values (please see Attachment D for the questionnaire).
- Documentary materials. Potential internal documents that can be accessed through informants or interviewees, if approved by the HA, include minutes of meetings, annual reports, business plans, organization charts, strategic plan, management consultant reports and project documentation. Considering the uncertainty in my access to internal documents, a comprehensive search for a wide range of published documents will be conducted to crosscheck the content of interviews: national policy documents, newsletters of medical associations, and curriculum of medical education etc.

As English is the working language of the medical sector in Hong Kong, research materials and interactions with participants will be primarily in English. Cantonese, the language commonly used in Hong Kong will be a second option for the respondents or supplement in communication.

8. What kind of research participants will be involved in the research (as interviewees, focus group participants, survey respondents etc), and how many?

Heads or Department/ Chiefs of Service (usually a senior hospital consultant) in Hong Kong public hospitals and higher-level managers (Cluster/ Hospital Chief Executives, Senior Managers) will be the targeted participants in individual face-to face interview.

I aim at interviewing at least 20 of them representing four groups of physician managers: 1) pure management at a higher level, and Heads or Department/ Chiefs of Service from three specialities: 2) Psychiatry, 3) Medicine and 4) Surgery. Each group consists of at least 5 physician managers with maximum variation in their speciality, age, gender and medical school.

Interview with policy makers and at least 6 front-line doctors will also be conducted as supplement (at least 3 from each specialty). The maximum variation sampling also applies to the interviews with front-line doctors.

9. How will research participants will be identified, approached and recruited?

Route 1: two senior doctors in HK public hospital system has agreed to serve as the key informants/gatekeepers in this research providing important background information and referral of interviewees. They are Prof Yun-kwok WING, Associate Dean of the Faculty of Medicine at the Chinese University of Hong Kong, Chief of Service in the Department of Psychiatry at Shatin Hospital and Prince of Wales Hospital, and Dr the Honourable Ka-lau LEUNG, Legislative Council Member (Medical Constituency), Council Member of the Hong Kong Medical Association, former President of Hong Kong Public Doctors Association. I was working for Dr Leung as Research Associate in his Legislative Councillor's Office from 2008 to 2013. I also had working relation with Dr Wing in the Office's research project. Practicing medicine in Hong Kong for 30 years and holding senior academic and political positions, they have personal contacts to a wide range of medical leaders which are highly valuable to this research. While the main targets of the research are physician managers, who are senior members of the medicine community, front-line doctors may feel pressured into participating by the role/status of the key informants. So the researcher will ask the key informants to clearly state to all front line doctors (especially their subordinates) that they are under no obligation to partake in the research and a decision not to take part will not have any bearing on their position. Route 2: a contact list of consultant doctors or higher-level managers may possibly be obtained from the open access hospital websites.

Route 3: Mr Chris SUN, Head of Healthcare Planning and Development Office, Food and Health Bureau, has agreed to be my informant and interviewee. He may also nominate other policy makers as my interviewees. I know him at an academic conference on Jan 22, 2016.

Physician managers: the first wave of interviews with physician managers will recruit interviewees via routes 1 and 2. Then a snowball sampling stage will commence based on the nomination of interviewees of the first wave of interview.

Front-line doctors: the first wave of interviews with front-line doctors will recruit interviewees via route 1 and the nomination of interviewed physician managers. Then a snowball sampling stage will commence based on the nomination of interviewees of the first wave of interview.

Policy makers: the first interviewee will be Mr Chris SUN. Then a snowball sampling stage will commence based on his or other informants' nomination. An information brief (please see Attachment A) will be sent to the nominated participants via the key informants.

10. How will informed consent to participate be elicited from participants? If different groups are involved in the study (e.g. parents, children, staff), please describe the consent procedures for each.

This information is contained within an Information Sheet for potential participants at the first point of contact with a Consent Form asking them to read and complete before their interview commences. They will be given the opportunity to decide if they would like to participate and will be provided with clear information of:

- The purpose of the research
- What will happen to the results and how they will be disseminated
- What their participation in the research will involve
- What the potential risks and benefits of their involvement might be
- How issues of anonymity and confidentiality will be managed
- The fact that they are not obliged to take part and that they can withdraw from the study if they later change their mind about participating

11. State any promise you will make to participants about how their data will be used, including in publications and dissemination, for example whether names, job titles, or direct quotations will be used, and state what protection of anonymity you are offering. Please attach any consent form or information sheet used.

(Note: For Research Council funded work, councils want anonymised data to be archived and made available to other researchers in addition to the research team)

Outputs

Participants will be informed via the Information Sheet that their words may be quoted in my PhD thesis and associated research outputs such as articles, conference papers and web pages.

Anonymity

All research participants will be given three options concerning how their words will be quoted within research outputs (see Attachment B):

a) You may use my name and my job title
b) You may use my job title only
c) You may not use my name or my job title

Should a participant prefer option B they will be allocated a pseudonym (Dr X, Y, Z etc.). Yet, absolute anonymity will not be guaranteed to participants even if they opt for option B or C, i.e. participants may still be possible to be identified for their distinctive insights and the relatively small sample size.

12. (Students: You are required to provide participants with a written information sheet and to obtain a signed record of consent form from participants. Please attach them.). **For staff: Please attach the information sheet and consent form. If you do not envisage providing an information sheet and/or obtaining a signed (or audio recorded) record of consent from participants, please justify and explain the measures to ensure personal data will be collected and processed fairly, citing applicable Data Protection grounds from Schedule 2 of the Data Protection Act (and schedule 3 as relevant) if necessary.**

Please see Attachments A and B

13. Does the way you will handle research data conform to the Data Protection Act?

Yes

14. What will happen to research participants once you have recruited them to be involved in the research? (e.g. invited to an interview, given a questionnaire etc). Please attach any research instruments (eg topic guides, questionnaires).

Once research participants have been recruited a face-to-face interview will be arranged. The interview will last approximately 30-60 minutes and will be audio-recorded with the participant's permission. A semi-structured Interview Guide will be sent to the participants for their reference (see Attachment C1 for physician managers,C2 for front-line doctors and C3 for policy makers).

Before the interview they (except policy makers) will also receive a short questionnaire from the researcher via email or mail (see attachment D). It will be collected by the researcher in person during the interview or via email or mail.

Telephone Interviewing (Contingency Plan)

Every effort will be made to interview participants face-to-face. However, if this is not possible telephone interview will be arranged. During the interview the participant will be asked to respond to the base list of questions that feature on the face-to-face Interview Guide.

15. If research participants are to receive any payments, reimbursement of expenses or other incentives for taking part in the research, please give details.

N/A – no payments, reimbursement, expenses or other incentives will be offered.

16. If the research may involve 'vulnerable people' explain how you plan to deal with any specific ethical challenges. Please also provide details of the relevant DBS (formerly CRB) checks and/or ISA registration that have been undertaken.

N/A – the research does not involve 'vulnerable people'.

17. What will you do if in the course of the research information is disclosed to you that legally requires further action or where further action is advisable?

Should this situation arise I will contact (email, skype or telephone if necessary) with my supervisor, and also have the research participant involved, before taking any advised action. My Consent Form states that I may be legally required to inform someone who may well act on this information if the participant discloses the potential for harm to themselves or another.

18. Are there any potential risks for participants? How have they been eliminated or minimised?

Professional Risk

As highlighted in Q11, absolute anonymity cannot be guaranteed for individuals who participate in this study. As such, the following strategies will be employed to minimise risk:

- Participants will be asked to seek any necessary approval form their organization to avoid their personal labilities.
- Where participants do not wish to be directly quoted in research outputs pseudonyms will be employed.
- Participants will keep a copy of the interview audio record to protect themselves from any misuse of the quotes of their words, if they so wish.

Emotional Distress / Psychological Harm

No risks anticipated. However, a participant's body language will be monitored for signs of distress. Should this occur I will suggest suspending the interview.

Personal Safety

No risks anticipated. I will show my University Card to participants. Interviews will be conducted in public space and according to the wishes of interviewees (e.g. in the hospital sites if allowed, or any public place interviews suggest).

19. Are there any potential benefits to participants?

There are no immediate, direct benefits to participants from taking part in the research. However, non-direct benefits include: having the opportunity to share their personal experience in medical management, feeling that their views as an expert are valued, and perhaps helping to inform future policy development.

20. Are there any potential risks for the researcher(s) involved in the project? What steps will you take to eliminate or minimise them?

(Note: these risks could include personal safety, emotional distress, risk of accusation of harm or impropriety).

Professional Risk

To protect the integrity of the study and to prevent the threat of 'veto', no opportunity for pre-publication scrutiny of outputs will be provided to research participants.

Emotional Distress / Psychological Harm

No risks anticipated. I will seek advice from supervisor for problems arise.

Personal Safety

- During the field work in my home country, Hong Kong, I will be living with my wife Janice DAO in our rented property. I will let her know who I will be going to interview (the doctor's name, hospital, department etc.) and contact her immediately after each interview. If she cannot contact me for 2 hours she will contact the interviewee, if failed, the hospital/location of interview, and local police then.
- A frequent contact (at least once for every week via email or Skype) will ensure my supervisor knows my updated satiation.
- In emergency my wife and my supervisor can contact each other.
- Interviews will be conducted in public places (e.g. in the hospital sites, or any public place the participants suggest). No interviews will be conducted in interviewee's homes or a private space.
- My mobile phone will be switched on at all times (on silent mode) during the field work in Hong Kong.
- Interviews will be abandoned immediately if any safety concerns arise.
- Equipment and valuable items will be kept out of sight.
- Public transport, reputable taxis and a private car and will be utilised as appropriate. All routes will be carefully planned in advance. I will ensure that they have access to paper and electronic maps.
- I will carry enough money for expected and unexpected expenses (i.e. taxis).

---

21. In most cases, as soon as possible during the research, and by the time research is completed, you should anonymise the data taken from your participants (data such as paper or electronic interview transcripts, notes of discussions, videos, sound recordings etc). You should do this by removing names, addresses and other identifiers, and replacing them with a number, code or pseudonym. You should prepare a key linking the code to the data from the person. (Further guidance is available from http://www.ico.org.uk/Global/~/media/documents/library/Data_Protection/Practical_application/anonymisation_code.ashx). (Note: sound and video recordings in which people may be directly or indirectly identifiable are also covered by the Data Protection Act.) **If you do not intend to anonymise data in this way, please explain why. If you do, when will you make this separation? What will you do to protect personal data in the interim? How will you keep the key safe? How long will you keep the key?**

<div style="border: 1px solid black; padding: 10px;">

Audio records of interviews

Following the completion of each interview the audio records will be transferred to my personal account on the University of York server and placed in a password protected file as soon as possible, within one day after interview. Each audio recording will be allocated a code. A data key will be prepared linking the code to the data from the participant. The data key will be stored in my google drive . Only I have the access to my personal account in the University of York server/ google drive.

Documentary evidence

The same process as outlined above will be followed:

- When electronic transcripts of the audio data are produced
- When any electronic non-published documentary evidences are obtained from interviewees or informants
- When a soft-copy or any digital record of filled-in questionnaire is collected from interviewees
- When a soft-copy or any digital record of Consent Forms is collected from interviewees

Hard copies of documentary evidence (questionnaires, my research notes or any other paper-based data /personal information) will be assigned codes and they will be separately stored in the drawer in my rented property in Hong Kong once obtained. Only I have the key to the drawer.

The data key will be kept for 3 years following my graduation.

</div>

22. Where will participant contact details, anonymised data, consent forms and data keys be kept during the research, and in what form?

(Note: The best method for contact details is to use first name only, or code, in a phone, or paper diary, and to destroy details once fieldwork is complete. The best protection for anonmysied data is to store electronic data in a single site only, on a UoY server in password protected form. If other sites are used, they should be password protected and backups should be encrypted. Commercial Dropboxes should be avoided for personal data because they are cloud-based. You can encrypt your equipment using an open source application TrueCrypt. Avoid laptops and data sticks. Please make a special note if data are likely to be stored (including on servers) or otherwise transferred outside the EU). Consent forms and data keys contain participant names and should be kept safe and separate from anonymised research data. The best protection is to store paper data in a locked filing cabinet eg in the main departmental office, and to store electronic data on a UoY server in password protected form).

<div style="border: 1px solid black; padding: 10px;">

Anonymised Electronic Data

- Audio recordings, electronic transcripts and electronic documentary evidence will be stored on the University of York server. This is regularly backed up by IT Services.
- All electronic data will be held in password protected files.
- No electronic data will be stored on hard drives or portable devices.

Paper-Based Data

</div>

- Consent Forms, questionnaires and other paper-based data or personal information (e.g., hard copies of documentary evidence, my research notes and contacts of interviewees) will be assigned codes and they will be separately stored in the drawer in my rented property in Hong Kong once obtained. Only I have the key to the drawer. After I return to York they will be separately stored in the drawer in my office in the Research Centre for the Social Sciences (ReCSS). Entry to this building is restricted to key card holders. Only I have the key to the drawer.

23. Where will anonymised data, consent forms and data keys be kept after the research in what form and for how long? If there are plans to archive data, how and where will they be kept and will there be restrictions on access and use?

(Note: Students should keep their data for a year after their mark has been finalised. For Research Council funded work, councils usually want anonymised data to be archived and made available to other researchers in addition to the research team. Councils want consent forms kept for 10 years).

Storage of data and Consent Forms

The anonymised interview data, the documentary evidence, my research notes, Consent Forms, other paper-based data/ personal information and the keys to those archives will be kept for 3 years following my graduation. Once 3 years has passed these items will be destroyed. I will first look for secure storage options in the University of York. If a secure storage system in the University of York is not available I will make arrangements for my supervisor to take responsibility for these items until they are due to be destroyed (in a box stored in my supervisor' office).

24. Who within the University will have responsibility for the anonymised data, consent forms and keys after the study? What will happen if the person responsible for the project leaves the University of York?

(Please make a special note if the data may be transferred outside the European Economic Area.)

I will remain responsible the anonymised interview data, the documentary evidence, my research notes, Consent Forms, other paper-based data/ personal information and the keys to those archives. If a secure storage option in the University of York is not available I will make arrangements for my supervisor to take responsibility for these items until they are due to be destroyed.

25. Will results will be made available to participants and the communities from which they are drawn, and if so, how?

I will send my publications to interviewees whose words are quoted for their reference.

26. Are there any other specific ethical problems likely to arise with the proposed study? If so, what steps have you taken or will you take to address them?

N/A

27. When does the project finish? Documents relating to this request for ethical approval will kept for 10 years after this end date.

I aim at submitting the project as my PhD thesis by the end of 2016.

Signature of Student/Principal
Investigator: …………………………………………………………………….......

For Supervisor (for
Students) …………………………………………………………………………………………

I have checked this form carefully and I am satisfied that the project meets the required ethical standards.

Signature of
Supervisor: …………………………………………………………………………………………

Date of
Completion: ……………………………………………………………………………………………
…

Abbreviations

CCC - Chairman of the HA Co-ordinating Committee on a specialty

CCE - Cluster Chief Executive

CCGs - Clinical Commissioning Groups

CHI - Commission for Health Improvement, UK

CHRE - Council for Healthcare Regulatory Excellence

COS - Chief of Service

CSC - Clinical Service Co-ordinator/ Director

CQC - Care Quality Commission, UK

DOH - Department of Health, UK

GMC - General Medical Council, UK

GP - General Practice/ Practitioner

HA - Hospital Authority

HAHO - Hospital Authority Head Office

HCE - Hospital Chief Executive

PCTs - Primary Care Trusts

PSA - Professional Standards Authority, UK

Bibliography

Abbott, A. (1988). *The system of professions: an essay on the division of expert labour*. Chicago, IL: University of Chicago Press.

Acker, J. (2006). Inequality regimes: Gender, class, and race in organizations. *Gender and Society*, 20(4), pp. 441–464.

Alasuutari, Pertti (2004). The globalization of qualitative research. In Gobo, G., Seale, C. Gubrium, J. and Silverman, D. (Eds.), *Qualitative Research Practice*. Thousand Oaks, CA: Sage, pp.595-608.

Alford, R. (1975). *Health care politics*. Chicago: University of Chicago Press.

Allen, A. (1995). Doctors in management or the revenge of the conquered. *Journal of Management in Medicine*, 9(4), 44-50.

Allen, D. (2009). From boundary concept to boundary object: the practice and politics of care pathway development. *Social Science & Medicine,* 69 (3), 354-61.

Allsop, J. (1999). Identity maintenance under conditions of change: the medical profession in the UK in the late twentieth century. In I. Hellberg, M. Saks, and C. Benoit, (Eds.) *Professional identities in transition: cross-cultural dimensions*. Goteborg: Almquist and Wiksell International, pp.157-73.

Allsop, J., Baggott, I. and Jones, K. (2002). Health consumer groups and the national policy process. In S., Henderson and A. Peterson, (Eds.). *Consuming health*. London: Routledge, pp. 48-65.

Allsop, J., Jones, K. and Baggott, R. (2004). Health consumer groups in the UK: a new social movement? *Sociology of Health and Illness*, 26, 737-756.

Anderson, E., Shepherd, M., and Salisbury, C. (2006). 'Taking off the suit': engaging the community in primary health care decision-making. *Health Expectations*, 9, 70-80.

Archer, M. (2003). *Structure, agency and the internal conversation*. Cambridge: Cambridge University Press.

Arksey, H. and O'Malley, L. (2005) Scoping studies: towards a methodological framework. *International Journal of Social Research Methodology*, 8 (1), 19-32.

Armstrong, D (2002). Clinical autonomy, individual and collective: the problem of changing doctors' behaviour. *Social Science & Medicine,* 55, p.1771-1777.

Arnstein, S. (1971). Eight rungs on the ladder of citizen participation. In S. Cahn, E. Cahn, and B. Passett, (Eds.). *Citizen participation: effecting community change*. New York: Praeger Publications, pp.79-91.

Askim, J., Christensen, T. and Lægreid, P. (2015). Accountability and performance management: the Norwegian hospital, welfare, and immigration administration. *International Journal of Public Administration*, 38 (13-14), 971-982.

Aspalter, C. (2006). The East Asian welfare model. *International Journal of Social Welfare*, 15, 290-301.

Audet, M., Doty, M., Shamasdin, J. and Schoenbaum, C. (2005). Measure, learn, and improve: physicians' involvement in quality improvement. *Health Affairs*, 24(3), 843-853.

Baggott, R. (2005). A funny thing happened on the way to the forum? Reforming patient and public involvement in the NHS. *Public Administration*, 83, 533-551.

Bauld, L., Judge K., Barnes, M., Benzeval, M., Mackenzie, M. and Sullivan, H. (2005). Promoting social change: the experience of Health Action Zones in England. *Journal of Social Policy*, 34, 427-445.

Beasley, B. (2013). *Elective surgery commissioning guidance - clinical engagement in high-value commissioning - Right care case book series*. [Online]. Available at: http://www.rightcare.nhs.uk/downloads/Right_Care_Casebook_High_Value_commissi oning_final_15052013.pdf [Accessed 5 July 2015].

Becker, H. (1963). *Outsider: studies in the Sociology of deviance*. New York: Free Press.

Bell, S. and Hindmoor, A. (2009). *Rethinking governance: the centrality of the state in modern Society*. Cambridge: Cambridge University Press.

Berg, M., Horstman, K., Plass, S. and van Heusden, M. (2000). Guidelines, professionals and the production of objectivity: standardisation and the professionalism of insurance medicine. *Sociology of Health and Illness*, 22(6), 765-791.

Berry, M. (2002). Validity and reliability in elite interviewing. *Political Science and Politics*, 35(4), pp. 679–682.

Besharov M. and Smith W. (2014). Multiple institutional logics in organizations: explaining their varied nature and implications. *Academy of Management Review*, 39(3), 364-381.

Bloomberg (2016). *Bloomberg Healthcare Efficiency Index*. [Online]. Available at: http://assets.bwbx.io/images/users/iqjWHBFdfxIU/iNK1THx4aD20/v3/-1x-1.png [Accessed 4 December 2016].

Blumenthal, D. and Hsiao, W. (2015). Lessons from the East - China's rapidly evolving health care system. *New England Journal of Medicine*, 372(14), 1281-1285.

Bovaird, T. (2007). Beyond engagement and participation: user and community coproduction of public services. *Public Administration Review*, 67, 846-860.

Bovaird, T. and Loeffler, E. (2012). From engagement to co-production: the contribution of users and communities to outcomes and public value. *Voluntas*, 23(4), 1119-1138.

Brint, S. (1993). Eliot Freidson's contributions to the sociology of profession. *Work and Occupations,* 20(3), 259-278.

Bryman, A. (2005). *Research Methods and Organization Studies*. Taylor & Francis e-Library.

Burt, S. (1992*). Structural holes*. Cambridge, MA: Harvard University Press.

Byrkjeflot, H. and Jespersen, K. (2014). Three conceptualizations of hybrid management in hospitals. *International Journal of Public Sector Management*, 27 (5), 441-458.

Byrne, D. (2004). Evidence-based: what constitutes valid evidence? A. Gray, and S. Harrison, (Eds.). *Governing medicine: theory and practice*. Buckingham: Open University Press, pp.81-92.

Campbell, S. McDonald, R. and Lester, H. (2008). The experience of pay for performance in English family practice: a qualitative study. *Annals of Family Medicine*, 6, 228-234.

Carroll, J. (2007). *A Concise History of Hong Kong*. Hong Kong: Hong Kong University Press.

Castro, P., Dorgan, S. and Richardson, B. (2008). A healthier health care system for the United Kingdom. *The McKinsey Quarterly*, February, 1-5.

Cawson, A. (1982). *Corporatism and welfare: social policy and state intervention in Britain.* London: Heinemann Educational Books.

Census and Statistics Department, Hong Kong (2012a). *Hong Kong monthly digest of statistics: feature article, statistics on Comprehensive Social Security Assistance Scheme, 2001 to 2011*. [Online]. Available at: http://www.statistics.gov.hk/pub/B71209FB2012XXXXB0100.pdf [Accessed 4 December 2014].

Census and Statistics Department, Hong Kong (2012b). *Hong Kong 2011 Population Census - Thematic report: household income distribution in Hong Kong*. [Online]. Available at: http://www.censtatd.gov.hk/hkstat/sub/sp170.jsp?productCode=B1120057 [Accessed 4 December 2014].

Census and Statistics Department, Hong Kong. (2016). *Population By-census - Summary Results*. [On-line] Available at: https://www.censtatd.gov.hk/hkstat/sub/sp459.jsp?productCode=B1120094 [Accessed on 22 May 2017]

Chamberlain, J. (2009). *Doctoring medical governance: medical self-regulation in transition*. New York: Nova Science Publishers, Inc.

Chan, C. (2003). Managing Welfare in Post-colonial Hong Kong. In A. Walker, and C. Wong, (Eds.). *East Asian welfare regimes in transitions*. Bristol: The Policy Press, pp.95-116.

Charlton, R, Imison, C. and Curzon, J. (2011) How to get the best outcomes when measuring productivity. *Health Service Journal*, July. [Online] Available at: https://www.hsj.co.uk/topics/workforce/how-to-get-the-best-outcomes-when-measuring-productivity/5031573.article [Accessed 23 October 2014].

Charles, M. and Grusky, B. (2004). *Occupational Ghettos: The Worldwide Segregation of Women and Men*. Stanford: Stanford University Press.

Chau, R. and Yu, S. (2003). Marketisation and residualisation - recent reforms in the medical financing system in Hong Kong. *Social Policy and Society*, 2(3), 199-207.

Checkland, K., Harrison, S. and Coleman, A. (2009). Structural interests in health care: evidence from the contemporary National Health Service. *Journal of Social Policy*, 38, 607-625.

Checkland, K., Harrison, S., McDonald, R., Grant, S., and Guthrie, B. (2008). Biomedicine, holism and general medical practice: responses to the 2004 general practitioner contract. *Sociology of Health and Illness*, 30, 788-803.

Cheung, A. (1995). *Politics of administrative reforms in Hong Kong – corporatization of public services during the 1980s*. PhD. London School of Economics and Political Science.

Cheung, A. (2002a). The politics of New Public Management; some experience from reforms in East Asia. K. McLaughlin, S. Osborne, and E. Ferlie, (Eds.). *The New Public Management: current trends and future prospects*. London: Routledge, pp.243-273.

Cheung, A. (2002b). Modernizing public healthcare governance in Hong Kong: a case study of professional power in the New Public Management. *Public Management Review*, 4(3), 343-365.

Chiu, S. and Wong, V. (2005). Hong Kong: from feministic to Confucian welfare. In A. Walker, and C. Wong, (Eds.). *East Asian welfare regimes in transitions*. Bristol: The Policy Press, pp.73-93.

Chiu, S. Ho, K. and Lui, T. (2011). Reforming health: contrasting trajectories of neoliberal restructuring in the city-states. In B. Park, R. Hill, and A. Saito, (Eds.). *Locating neoliberalism in East Asia: neoliberalizing spaces in developmental states*. Malden, Mass.:Wiley-Blackwell, pp. 225-256.

Chow, N. (1995). *Shehui fuli de gainian he zhidu* (Social welfare: concept and system). Hong Kong: Zhonghua Book Company. (In Chinese)

Clarke, J., Newman, J., Smith, N., Vidler, E. and Westmarland, L. (2007). *Creating citizen-consumers: changing publics and changing public services*. London: Sage.

Coburn, D., Rappaport, S. and Bourgeault, I. (1997). Decline vs retention of medical power through re-stratification: an examination of the Ontario case. *Sociology of Health and Illness*, 28(2), 178-202.

Coburn, S. (1993). State authority, medical dominance and trends in the regulation of the health professions: the Ontario case. *Social Science & Medicine,* 37(7), 841- 850.

Coleman, W. (1999). *Internationalised policy environments and policy network analysis*. *Political Studies*, 47 (4), 691-713.

Conklin, A., Morris, Z. and Nolte, E. (2015). What is the evidence base for public involvement in health-care policy? Results of a systematic scoping review. *Health Expectations*, 18, 153-165.

Council for Healthcare Regulatory Excellence (2012). *An approach to assuring continuing fitness to practise based on right-touch regulation principles*. [Online]. Available at: http://www.professionalstandards.org.uk/docs/default-source/publications/policy-advice/continuing-fitness-to-practise-based-on-right-touch-regulation-2012.pdf?sfvrsn=4 [Accessed 10 March 2016].

Courpasson, D. (2000). Managerial strategies of domination: power in soft bureaucracies. *Organization Studies*, 21(1), 141-161.

Crawford, M., Aldridge, T., Bhui, K. et al. (2003). User involvement in the planning and delivery of mental health services: a cross-sectional survey of service users and providers. *Acta Psychiatrica Scandinavica*, 107, 410-414.

Currie, G. and Suhomlinova, O. (2006). The impact of institutional forces upon knowledge sharing in the UK NHS: the triumph of professional power and the inconsistency of policy. *Public Administration*, 84 (1), 1-30.

Currie, G., Finn, R. and Martin, G. (2009). Professional competition and modernizing the clinical workforce in the NHS. *Work, employment and society*, 23 (2), 267-284.

Currie, G., Finn, R. and Martin, G. (2010). Role transition and the interaction of relational and social identity: new nursing roles in the English NHS. *Organization Studies*, 31(07), 941-961.

Danon-Leva, E., Cavico, F. and Mujtaba, B. (2010). Business ethics: a cross-cultural comparison between Hong Kong and the United States. *Journal of Business Studies Quarterly*, 1(4), pp. 1-20.

Davies, C. (2003). Introduction: a new workforce in the making? In C. Davies, (Ed.). *The future health workforce*. Houndmills: Palgrave, pp.1-13.

Davies, J. (2011). *Challenging Governance Theory*. Bristol: The Policy Press.

Dent, M. (1993). Professionalism, educated labour and the state: hospital medicine and the new managerialism. *Sociological Review*, 41(2), 244-273.

Department of Health, UK (2000a). *The NHS plan*. London: Department of Health.

Department of Health, UK (2000b). *Patient and public involvement in the new NHS*. London. Department of Health.

Department of Health, UK (2001). *Shifting the balance of power within the NHS: securing delivery*. London: Department of Health.

Department of Health, UK (2002). *Liberating the talents*. London: Department of Health.

Department of Health, UK (2004a). *Agenda for change final agreement*. London: Department of Health.

Department of Health, UK (2004b). *General Practitioner with Special Clinical Interest in Genetics - Framework document*. London: Department of Health.

Department of Health, UK (2006). *Our health, our care, our say*. London: Department of Health.

Department of Health, UK (2010). *Equity and excellence*: *liberating the NHS*. [Online]. Available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf [Accessed 10 March 2016].

Department of Health, UK (2013). *Effective clinical and financial engagement: a best practice guide for the NHS*. [Online]. Available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/255655/effective_clinical_financial_engagement.pdf [Accessed 10 March 2016].

Department of Health, UK (2015). *Culture change in the NHS: applying the lessons of the Francis Inquiries.* [Online] Available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/403010/culture-change-nhs.pdf [Accessed 10 March 2016].

Dexter, A. (2006). *Elite and specialized interviewing*. Colchester, UK: European Consortium for Political Research.

DiMaggio, J. (1988). Interest and agency in institutional theory. In J. Zucker, (Ed.). *Institutional patterns and organizations: culture and environment*. Cambridge, MA: Ballinger, pp. 3-22.

DiMaggio, J. and Powell, W. (1983). The iron cage revisited - institutional isomorphism and collective rationality in organizational fields. *American Sociological Review*, 48, 147-160.

Doolin, B. (2001). Doctors as managers: new public management in a New Zealand hospital. *Public Management Review*, 3(2), 231-54.

Drennan, V. Grant, R. and Harris, R. (2014). Trends over time in prescribing by English primary care nurses: a secondary analysis of a national prescription database. *BMC Health Services Research*, 14 (54). [Online]. Available at: DOI: 10.1186/1472-6963-14-54 [Accessed 5 July 2015].

Du Gay, P. (1996). *Consumption and identity at work*. London: Sage.

Dunn, M. and Jones, C. (2010). Institutional logics and institutional pluralism: the contestation of care and science logics in medical education, 1967–2005. *Administrative Science Quarterly*, 55, 114-149.

Eckstein, H. (1958). *The English Health Service: Its Origins, Structure, and Achievements*. Cambridge, MA: Harvard University Press.

Eckstein, H. (1960). *Pressure Groups politics: the case of the British Medical Association*. London: George Allen and Unwin.

Elston, M. (1991). The politics of professional power: medicine in a changing medical service. In J. Gabe, M. Calman, and M. Bury, (Eds.). *The Sociology of the Health Service*. Routledge, pp. 187-273.

Enany, N., Currie, G. and Lockett, A. (2013). A paradox in healthcare service development: professionalization of service users. *Social Science & Medicine* , 80, 24-30.

Evetts, J. (2003). The sociological analysis of professionalism. *International Sociology*, 18 (2), 395-415.

Evetts, J. (2009). New professionalism and new public management: changes, continuities and consequences. *Comparative Sociology*, 8, 247-266.

Exworthy, M. and Powell, M. (2012). Case studies in health policy: an introduction. In Exworthy, M. Peckham, M., Powell, Hann, A. (Eds.), *Shaping Health Policy: Case Study Methods and Analysis*. Policy Press at the University of Bristol, pp. 3-20.

Falkner, G. (1997). Corporatist governance and Europeanisation: no future in the multi-level game? *European Integration Online Papers*, 1(11). [Online]. Available at: http://eiop.or.at/eiop/pdf/1997-011.pdf [Accessed 15 November 2016].

Fawcett, P. (2013). *How are we governed? Decentred theory and the core executive*. [Online]. Available at: https://www.psa.ac.uk/sites/default/files/684_358.pdf [Accessed 23 October 2014].

Ferlie, E., Firlzgerald, L., Mcgivern, G., Dopson, S. and Bennett, C. (2011). Public policy networks and 'wicked problems': a nascent solution? *Public Administration*, 89 (2), 307-324.

Fitzgerald, L. (1994). Moving Clinicians into Management. *Journal of Management in Medicine*, 8 (6), 32-44.

Flynn, R. (2002). Clinical governance and governmentality. *Health, Risk and Society*, 4(2), 155-173.

Flynn, R. (2004). "Soft bureaucracy", governmentality and clinical governance: theoretical approaches to emergent policy. In A. Grey, and S. Harrison, (Eds.) *Governing medicine: theory and practice*. Milton Keynes: Open University Press, pp. 11-26.

Food and Health Bureau, Hong Kong (2008). *Your health, your life: healthcare reform consultation document*. Hong Kong: Govt. Printer.

Food and Health Bureau, Hong Kong (2012). *For discussion on 18 December 2012, Legislative Council Panel on Health Services: issues relating to the development and operation of private hospitals*. [Online]. Available at: http://www.legco.gov.hk/yr12-13/english/panels/hs/papers/hs1218cb2-334-1-e.pdf [Accessed 23 October 2014].

Foot, C., Sonola, L., Maybin, J. and Naylor, C. (2012). *Service-line management: can it improve quality and efficiency?* [Online] Available at: https://www.kingsfund.org.uk/sites/files/kf/service-line-management-quality-efficiency-kings-fund-january2011.pdf [Accessed 10 March 2016].

Forbes, T. and Hallier, J. (2006). Social identity and self-enactment strategies: adapting to change in professional-manager relationships in the NHS. *Journal of Nursing Management*, 14(1), 34-42.

Fotaki, M. (2011). Towards developing new partnerships in public services: users as consumers, citizens and/or co-producers in health and social care in England and Sweden. *Public Administration*, 89 (3), 933-955.

Fournier, V. (2000). Boundary work and the (un)making of the professions. In N. Malin, (Ed.). *Professionalism, boundaries and the workplace*. London: Routledge, pp.67-86.

Freidson, E. (1961). *Patients' Views of Medical Practice: A Study of Subscribers to a Prepaid Medical Plan in the Bronx*. New York: Russell Sage Foundation.

Freidson, E. (1984). The changing nature of professional control. *Sociology*, 10, pp.1-20

Freidson, E. (1985). The Reorganization of the medical profession. *Medical Care Review*, 42(1), 1-20.

Freidson, E. (1988). *Profession of medicine: a study of the sociology of applied knowledge*. Chicago: University of Chicago Press.

Freidson, E. (1994). *Professionalism reborn: theory, prophecy and policy*. Oxford: Polity Press.

Freidson, E. (2001). *Professionalism: the third logic*. Cambridge: Polity Press.

Friedman, M. and Friedman, R. (1980). *Free to choose: a personal statement*. Harmondsworth: Penguin.

Fudge N., Wolfe C. and McKevitt, C. (2008). Assessing the promise of user involvement in health service development: ethnographic study. *British Medical Journal*, 336-313.

Fung, K. (2016). Controversies over Medical Council reform (in Chinese). *HK01*, 13 July 2016. [Online] Available at: http://www.hk01.com/article/31283 [Accessed 13 July 2016].

Gemmell, I., Campbell, S., Hann, M. and Sibbald, B. (2009). Assessing workload in general practice in England before and after the introduction of the pay-for-performance contract. *Journal of Advanced Nursing*, 65 (3), 509-515.

General Medical Council (2016). *The State of Medical Education and Practice in the UK*. [Online]. Available at: http://www.gmc-uk.org/SOMEP_2016_Full_Report_Lo_Res.pdf_68139324.pdf [Accessed 9 July 2017]

George,V. and Wilding, P. (1994). *Welfare and Ideology*. New York; London: Harvester Wheatsheaf.

Gerada, C., Wright, N. and Keen, J. (2002). The General Practitioner with a Special Interest: new opportunities or the end of the generalist practitioner? *British Journal of General Practice*, 52 (483), 796-798.

Gerring, J. (2004). What is a case study and what is it good for? *American Political Science Review*, 98 (2), pp. 341-354.

Gerring, J. (2007). *Case Study Research: Principles and Practices*. Cambridge: Cambridge University Press.

Giaimo, S. (2002). *Markets and medicine: the politics of health care reform in Britain, Germany, and the United States*. Ann Arbor: University of Michigan Press.

Giddens, A. (1984). *The Constitution of Society: An Outline of a Theory of Structuration.* Cambridge: Polity Press.

Giddens, A. (1993). *New Rules of Sociological Method*. Stanford: Stanford University Press.

Goodrick, E. and Reay, T. (2011). Constellations of institutional logics: changes in the professional work of pharmacists. *Work and Occupations*, 38, 372-416.

Goodstadt, L. (2007). Business friendly and politically convenient - the historical role of functional constituencies. In C. Loh, and Civic Exchange (Eds.). *Functional constituencies: a unique feature of the Hong Kong Legislative Council*. Hong Kong: Hong Kong University Press, pp.41-57.

Grant, W. (1995). *Pressure Groups, Politics and Democracy*. London: Harvester Press.

Greenway, J., Salter, B. and Hart, S. (2007). How policy networks can damage democratic health: a case study in the government of governance. *Public Administration*, 85, 717-738.

Griffiths, L. and Hughes, D. (2000). Talking contracts and taking care: managers and professionals in the British National Health Service internal market. *Social Science & Medicine* , 51, 209-222.

Haig, B. (1995). Grounded theory as scientific method. *Philosophy of Education*, 28 (1), pp.1-11.

Ham, C., Clark, J., Spurgeon, P., Dickinson, H. and Armit, K. (2011). Doctors who become chief executives in the NHS: from keen amateurs to skilled professionals. *Journal of the Royal Society of Medicine*, 104, 113-119.

Ham, C. and Hunter, J. (1988). *Managing clinical activity in the NHS - Briefing Paper 8.* London: King's Fund Institute.

Hammersley, M. (1992). *What's Wrong with Ethnography? Methodological Explorations.* London and New York: Routledge.

Hardyman, W., Daunt, K. and Kitchener, M. (2015). Value co-creation through patient engagement in health care: a micro-level approach and research agenda. *Public Management Review*, 17(1), 90-107.

Harrison, S. (1999). Clinical autonomy and health policy: past and futures. In M. Exworthy, and S. Halford, (Eds.). *Professionalism and the New Managerialism in the public sector. Buckingham*: Open University Press.

Harrison, S. (2002). New Labour, modernisation and the medical labour process. *Journal of Social Policy*, 31(2), 1-24.

Harrison, S. (2009). Co-optation, communication and the medical model: governing UK Medicine since 1991. *Public Administration*, 87, 184-197.

Harrison, S. and Ahmad, W. (2000). Medical Autonomy and the UK State 1975 to 2025. *Society and Sociology*, 34 (1), 129-146.

Harrison, S. and Dowswell, G. (2002). Autonomy and bureaucratic accountability in primary care: what English General Practitioners say. *Sociology of Health and Illness*, 24 (2), 217-241.

Harrison, S. and Lim, J. (2000). Clinical governance and primary care in the English National Health Service: some issues of organization and rules. *Critical Public Health*, 10(3), 321-329.

Harrison, S. and Lim, J. (2003). The frontier of control: doctors and managers in the NHS 1966 to 1997. *Clinical Governance International*, 8 (2), 13-17.

Harrison, S. and McDonald, R. (2008). *The Politics of Healthcare in Britain*. London: Sega.

Harrison, S. and Smith, C. (2003). Neo-bureaucracy and public management: the case of medicine in the National Health Service. *Competition and Change*, 7(4), 243-254.

Harrison, S. and Wood, B. (2000). Scientific-bureaucratic medicine and U.K. health policy. *Review of Policy Research*, 17, 25-42.

Harrison, S., Hunter, D. and Pollitt, C. (1990). *The Dynamics of British Health Policy*. London: Unwin Hyman.

Harvey, W. (2010). Methodological approaches for interviewing elites. *Geography Compass*, 4 (3), pp. 193 -205.

Harvey, W. (2011). Strategies for conducting elite interviews, *Qualitative Research*, 11 (4), pp.431-441.

Haug, M. (1973). Deprofessionalisation: an alternative hypothesis for the future. *Sociological Review*, 20, 195-211.

Healey, J. and Robinson M. (1992). *Democracy, governance, and economic policy: sub-Saharan Africa in comparative perspective*. London: Overseas Development Institute.

Healey, P. (1997). *Collaborative planning: shaping plans in fragmented societies*. Macmillan: England.

Health Education England (2015). *District Nursing and General Practice Nursing Services Education and Career Framework*. [Online]. Available at: https://www.hee.nhs.uk/sites/default/files/documents/District%20nursing%20and%20GP%20practice%20nursing%20framework_0.pdf [Accessed 12 December 2016].

Herod, A. (1999). Reflections on interviewing foreign elites: praxis, positionality, validity, and the cult of the insider. *Geoforum*, 30, pp. 313–327.

Héritier, A. and Lehmkuhl, D. (2008). The shadow of hierarchy and new modes of governance. *Journal of Public Policy*, 28 (1), 1-17.

Hirst, P. (2000). Democracy and Governance. In J. Pierre, (Ed.). *Debating governance: authority, steering and democracy*. Oxford: Oxford University Press, pp.13-35.

Hoare, K., Mills, J. and Francis, K. (2012). The role of government policy in supporting nurse-led care in general practice in the United Kingdom, New Zealand and Australia: an adapted realist review. *Journal of Advanced Nursing*, 68 (5), 963-980.

Hoff, T. (1999). The social organization of physician-managers in a changing HMO. *Work and Occupations*, 26 (3), 324-351.

Hoff, T. (2000). Professional commitment among US physician executives in managed care. *Social Science & Medicine,* 50, 1433-1444.

Hofstede G. and Hofstede G. (2005). *Cultures and Organizations: Software of the Mind*. New York: McGraw-Hill.

Hoggett, P. (1991). A new management in the public sector? *Policy & Politics*, 19 (4), 243-256.

Holliday I. (2003). Healthcare. In I. Holliday, and P. Wilding, (Eds.). *Welfare capitalism in East Asia: social policy in the tiger economies*. Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, pp. 70-98.

Holliday, I. (2000). Productivist welfare capitalism: social policy in East Asia. *Political Studies*, 48 (4), 706-723.

Holtman, M. (2011). Paradoxes of professionalism and error in complex systems. *Journal of Biomedical Informatics*, 44 (3), 395-401.

Hong Kong Hospital Authority (2015). *The Annual Report 2014-15*. [Online]. Available at: http://www.ha.org.hk/ho/corpcomm/AR201415/html/en/index.html [Accessed 10 March 2016].

Hong Kong Housing Authority (2013). *Housing in figures*. [Online]. Available at: http://www.housingauthority.gov.hk/en/common/pdf/about-us/publications-and-statistics/HIF.pdf [Accessed 4 December 2014].

Hsiung, P. (2012). The globalization of qualitative research: challenging Anglo-American domination and local hegemonic discourse. *Forum: Qualitative Social Research*, 13(1), Art. 21.

Huang, K, Keith, G. and Provan, G. (2007). Resource tangibility and patterns of interaction in a publicly funded health and human services network. *Journal of Public Administration Research and Theory*, 17, 435 -54.

Hunter, B. and Segrott, J. (2014). Renegotiating inter-professional boundaries in maternity care: implementing a clinical pathway for normal labour. *Sociology of Health Illness*, 36 (5), 719-737.

Hunter, D. (1994). From tribalism to corporatism: the managerial challenge to medical dominance. In J. Gabe, D. Kelleher, and G. Williams, (Eds.). *Challenging medicine*. London: Routledge, pp.1-22.

Jay, J. (2013). Navigating paradox as a mechanism of change and innovation in hybrid organizations. *Academy of Management Review*, 56 (1), 137-159.

Jessop, B. (1997). Capitalism and its future: remarks on regulation, government and governance. *Review of International Political Economy*, 4, 561-581.

Jessop, B. (2004). Multi-level governance and multi-level metagovernance - changes in the European Union as integral moments in the transformation and reorientation of contemporary statehood. In I. Bache, and M. Flinders, (Eds.). *Multilevel Governance*. Oxford: Oxford University Press, pp. 49-74.

Jones, L. and Exworthy, M. (2015). Framing in policy processes: a case study from hospital planning in the NHS. *Social Science & Medicine,* 124, 196-204.

Jones, N. and Charlesworth, A. (2013). *The anatomy of health spending 2011/2012: a review of NHS expenditure and labour productivity*. Nuffield Trust. [Online] Available at: http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/130305_anatomy-health-spending_0.pdf [Accessed 10 March 2016].

Jordan, A. (1981). Iron triangles, woolly corporatism and elastic nets. *Journal of Public Policy*, 1, 95-123.

Marinetto, M. (2012). Case studies of the health policy process: a methodological introduction. In Exworthy, M. Peckham, M., Powell, Hann, A. (Eds.), *Shaping Health Policy: Case Study Methods and Analysis*. Policy Press at the University of Bristol, pp. 21-40.

Kanter, M. (1977). *Men and Women of the Corporation*. New York: Basic Books.

Kelleher, D. (1994). Self-help groups and their relationship to medicine. In J. Gabe, D. Kelleher, and G. Williams, (Eds.). *Challenging medicine*. London: Routledge, pp.104-117.

Miles, M. (1979). Qualitative data as an attractive nuisance: the problem of analysis. *Administrative Science Quarterly*, 24 (4), pp. 590-601.

Miles, M. and Huberman, A. (1994). *Qualitative Data Analysis: An Expanded Source-book*. Thousand Oaks, CA: Sage.

Miller, G. (1997). Contextualizing texts: Studying organizational texts. In Miller, G. and Dingwall, R. (Eds), *Context and Method in Qualitative Research*. London: Sage, pp.77-91.

Miller, J. and Glassner, B. (2004). The "insider" and "outside": finding realities in interviews. In Silverman, D. (ed.), *Qualitative Research: Theory, Method and Practice*. London: Sage, pp.125-139.

King, A. (1975). Administrative absorption of politics in Hong Kong: emphasis on the grass roots level. *Asian Survey*, 15 (5), 422-439.

King, O., Nancarrow, S., Borthwick, A. and Grace, S. (2015). Contested professional role boundaries in health care: a systematic review of the literature. *Journal of Foot and Ankle Research*, 8 (2). [Online]. Available at: DOI: 10.1186/s13047-015-0061-1 [Accessed 10 March 2016].

Kippist, L. and Fitzgerald, A. (2009). Organizational professional conflict and hybrid clinician managers: the effects of dual roles in Australian health care organizations. *Journal of Health, Organization and Management*, 23 (6), 642-655.

Kirkpatrick, I., Ackroyd, S. and Walker, M. (2005). *The new managerialism and public service professions: change in health, social services, and housing*. Basingstoke: Palgrave Macmillan.

Kitchener, M. (2000). The bureaucratization of professional roles: the case of Clinical Directors in UK hospitals. *Organization*, 7 (1), 129-154.

Kjaer, A. (2004). *Governance*. Cambridge: Polity.

Klein, R. (1990). The state and the profession: the politics of the double bed. *British Medical Journal*, 301 (6754), 700-702.

Klein, R. (1995). Big bang health care reform-does it work? The case of Britain's National Health Service reforms. *Millbank Quarterly*, 73 (3), 301-337.

Knoke, D. (1994). Networks of elite structure and decision-making. In S. Wasserman, and J. Galaskiewicz, (Eds.). *Advances in social network analysis*. Thousand Oaks, CA: Sage Publications, pp.274-294.

Kuan, H. and Lau, S. (1990). Public attitude toward laissez faire in Hong Kong. *Asian Survey*, 30 (8), 766-781.

Kuhlmann, E. (2006). *Modernising health care: reinventing professions, the state and the public*. Bristol: The Policy Press.

Kuhlmann, E. and Allsop, J. (2008). Professional self-regulation in a changing architecture of governance: comparing health policy in the UK and Germany. *Policy & Politics*, 36 (2), 173-189.

Mullings, B. (1999). 'Insider or outsider, both or neither: some dilemmas of interviewing in a cross-cultural setting' in *Geoforum*, 30, pp. 337–350.

Kurunmäki, L. (2004). A hybrid profession: the acquisition of management accounting expertise by medical professionals. *Accounting, Organizations and Society*, 29 (3-4), 327-347.

Knoke, D. (1994). Networks of elite structure and decision-making. In S. Wasserman, and J. Galaskiewicz, (Eds.). *Advances in social network analysis*. Thousand Oaks, CA: Sage Publications, pp.274-294.

Kwok, R. and Tak, C. (2006). The dynamics of social policy making in Hong Kong: The role of functional representatives (1998–2004). In C. Loh, and Civic Exchange, (Eds.). *Functional constituencies: a unique feature of the Hong Kong Legislative Council*. Hong Kong: Hong Kong University Press, pp.199-264.

Kwon, H. (1998). Democracy and the politics of social welfare: a comparative analysis of welfare systems in East Asia. R. Goodman, G. White, and H. Kwon, (Eds.). *The East Asian welfare model: welfare orientalism and the state*. London; New York: Routledge, pp.27-74.

Lam, J. (2012). District Councils, advisory bodies, and statutory bodies. In W. Lam, P. Lui, and W. Wong, (Eds.). *Contemporary Hong Kong Government and politics: expanded second edition*. Hong Kong Hong Kong University Press, pp.111-132.

Landell-Mills, P. and Serageldin, I. (1991). Governance and the external factor. In L. Summers, and S. Shah, (Eds.). *Proceedings of the World Bank annual conference on development economics 1991, supplement to the World Bank Economic Review and The World Bank Observer*. Washington DC: World Bank, pp.303-320.

Latimer, J. (2014). Nursing, the politics of organization and meanings of care. *Journals of Research in Nursing*, 19(7-8), 537-545.

Lau, S., Kuan, H. (1990). Public attitude toward laissez faire in Hong Kong. *Asian Survey*, 30(8): 766-81.

Laughlin, R. Broadbent, J. and Willig-Atherton, H. (1994). Recent financial and administrative changes in GP Practices in the UK: initial experiences and effects. *Accounting, Auditing and Accountability Journal*, 7 (3), 96-124.

Ledger, A., and Slade, B. (2015). Coproduction without experts: a study of people involved in community health and wellbeing service delivery. *Studies in Continuing Education*, 37(2), 157-169.

Lemer C., Allwood D., Foley. T (2012*). Improving NHS productivity: the secondary care doctor's perspective*. [online]. Available at: www.kingsfund.org.uk/leadershipreview [Accessed 17 April 2014].

Lehmbruch, G. (1984). Concertation and the structure of corporatist networks. In J. Goldthorpe, (Ed.). *Order and conflict in contemporary capitalism*. Oxford: Clarendon Press, pp.60-80.

Levac, D., Colquhoun, H., and O'Brien, K. (2010). Scoping studies: advancing the methodology. *Implementation Science*, 5 (69). [Online]. Available at: DOI: 10.1186/1748-5908-5-69 [Accessed 4 December 2014].

Levay, C. and Waks, C. (2009). Professions and the pursuit of transparency in healthcare: two cases of soft autonomy. *Organization Studies*, 30 (5), 509- 527.

Levi-Faur, D. (2012). *The Oxford Handbook of Governance*. Oxford: Oxford University Press 2012.

Levin, N. and Yung, C. (2016). An era in Hong Kong is ending, thanks to China's tight embrace. *Wall Street Journal,* 23 September 2016. [Online]. Available at: http://www.wsj.com/articles/an-era-in-hong-kong-is-ending-thanks-to-chinas-tight-embrace-1474647072 [Accessed 15 November 2016].

Lindberg, K., Styhre, A. and Walter, L. (2012). *Assembling health care organizations practice, materiality and institutions*. New York: Palgrave Macmillan.

Lui, T. (2010). *Ning ju li liang*. Hong Kong: San lian shu dian Xianggang you xian gong si. (In Chinese)

Maisey, S., Steel, N., Marsh, R., Gillam, S., Fleetcroft, R. and Howe, A. (2008). Effects of payment for performance in primary care: qualitative interview study. *Journal of Health Service Research and Policy*,13, 133-139.

March, J. and Olsen, J. (1995). *Democratic Governance*. New York; London: Free Press.

Marinetto, M. (2003). Governing through the centre: a critique of the Anglo-governance School. *Political Studies*, 51, 592-608.

Marsh, D. (2008). What is at stake - a response to Bevir and Rhodes. *The British Journal of Politics and International Relations*, 10, 735-739.

Marsh, D. and Rhodes, R. (1992). Policy communities and issue networks: Beyond typology. In D. Marsh and R. Rhodes, (Eds.). *Policy networks in British Government*. Oxford: Clarendon Press, pp. 1-26.

Marsh, D., Richards, D. and Smith, M. (2001). *Changing patterns of governance in the United Kingdom: reinventing Whitehall?* Houndmills, Basingstoke, Hampshire; New York: Palgrave.

Marshall, C. and Rossman, G. (2006). *Designing qualitative research*. London: Sage

May, N. (2009). Interest groups and civil society in public health policy. G. Carrin, K. Buse, K. Heggenhougen, S. Quah, (Eds.). *Health systems policy, finance, and organization*. Geneva: Elsevier, pp.115-123.

Martin, G. (2008). Representativeness, legitimacy and power in public involvement in health-service management. *Social Science & Medicine,* 67, 1757-1765.

Martin, G., Currie, G. Finn, R. (2009). Reconfiguring or reproducing intra-professional boundaries? Specialist expertise, generalist knowledge and the 'modernization' of the medical workforce. *Social Science & Medicine,* 68, 1191-1198.

Martinussen, P. and Magnussen, J. (2011). Resisting market-inspired reform in healthcare: the role of professional subcultures in medicine. *Social Science & Medicine,* 73(2),193-200.

Masterson, A. (2002). Cross-boundary working: a macro-political analysis of the impact on professional roles. *Journal of Clinical Nursing*, 11, 331-339.

McDonald, D., Barnes, M., Crawford, M., Omeni, E., Wilson, A. and Rose, D. (2014). Service user governors in mental health foundation trusts: accountability or business as usual? *Health Expectation*, 18, 2892-2902.

McDonald, R. (2012). Restratification revisited: the changing landscape of primary medical care in England and California. *Current Sociology*, 60(4), 441-55.

McDonald, R., Campbell, S. and Lester, H. (2009). Practice nurses and the effects of the new general practitioner contract in the English National Health Service: the extension of a professional project? *Social Science & Medicine,* 68, 1206-1212.

McDonald, R., Checkland, K., Harrison, S. and Coleman, A. (2009). Rethinking collegiality: Restratification in English general medical practice 2004-2008. *Social Science & Medicine,* 68, 1199-1205.

McDonald, R., Harrison, S. Checkland, K. Campbell, S., and Roland, M. (2007). Impact of financial incentives on clinical autonomy and internal motivation in primary care: ethnographic study. *British Medical Journal*, 334 (1357). [Online]. Available at: doi: http://dx.doi.org/10.1136/bmj.39238.890810.BE. [Accessed 12 December 2016]

McDowell, L. (1998). Elites in the City of London: some methodological considerations. *Environment and Planning*, A30(12), 2133-2146.

McGivern, G. and Ferlie E. (2007). Playing tick-box games: interrelating defences in professional appraisal. *Human Relations,* 60 (9), 1361-1385.

McGivern, G., Currie, G., Ferlie, E., Fitzgerald, L. and Waring, J. (2015). Hybrid manager-professionals' identity work: the maintenance and hybridization of medical professionalism in managerial contexts. *Public Administration,* 93 (2), 412-432.

McGregor, W., Jabareen, H., O'Donnell, C., Mercer, S. and Watt, G. (2008). Impact of the 2004 GMS contract on practice nurses. *British Journal of General Practice*, 58 (555), 711-719.

McKinlay, J. and Stoeckle, J. (1988). Corporatization and the social transformation of doctoring. *Health Services*, 18, 191-205.

McLaughlin, E. (1993). Hong Kong: a residual welfare regime. In A. Cochran, and J. Clarke, (Eds.). *Comparing welfare states: Britain in international context*. London; Newbury Park, Calif.: Sage Publications.

McLaughlin, J. (2001). EBM and risk: rhetorical resources in the articulation of professional identity. *Journal of Management in Medicine*, 15 (4-5) 352-363.

McLeod, H. (1995). *Speech of the Finical Secretary at the Budget Debate in the Legislative Council, 29 March, 1995*. Hong Kong: Govt. Printer.

Mechanic, D. (1978). Approaches to controlling the costs of medical care: short-range and long-range alternatives. *New England Journal of Medicine*, 298, 249-254.

Medical Development Advisory Committee, Hong Kong (1974). *The Further Development of Medical and Health Services in Hong Kong*. Hong Kong: Govt. Printer.

Meyer, J. and Rowan, B. (1983). Institutional organizations: formal structure as myth and ceremony. *American Journal of Sociology*, 83, 340-363.

Meyer, R. and Höllerer, M. (2010). Meaning structures in a contested issue field: a topographic map of shareholder value in Austria. *Academy of Management Journal*, 53 (6), 1241-1262.

Mort, M. and Harrison, S. (1999). Healthcare users, the public and the consultation industry. In T. Ling, (Ed.). *Reforming health care by consent: involving those who matter*. Oxford: Radcliffe Medical Press, pp.107-120.

Mo, T. (2008). Doctors as managers: moving towards general management? *Journal of Health Organization and Management*, 22 (4), 400-415.

Mok, K. (2003). Education. In I. Holliday, and P. Wilding, (Eds.). *Welfare capitalism in East Asia: social policy in the tiger economies*. Houndmills, Basingstoke, Hampshire: Palgrave Macmillan, pp. 37-69.

Moran, M. (1999). *Governing the health care state: a comparative study of the United Kingdom, the United States, and Germany*. New York: Manchester University Press.

Milewa, T. (2004). Local participatory democracy in Britain's health service: innovation or fragmentation of a universal citizenship. *Social Policy and Administration*, 38, 240-252.

Mitton, C., Smith, N., Peacock, S., Evoy, B. and Abelson, J. (2009). Public participation in health care priority setting: a scoping review. *Health Policy*, 91(3), 219-228.

Nancarrow, S. and Borthwick, A. (2005). Dynamic professional boundaries in the healthcare workforce. *Sociology of Health and Illness*, 27, 897-919.

NHS Confederation (2010). *Clinical Responses to the Downturn*. London: Joint Medical Consultative Council, British Medical Association, Academy of Royal Medical Colleges, and the NHS Confederation.

NHS Confederation. (2016). *2016/17 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF) - guidance for GMS contract 2016/17*. [Online]. Available at: http://www.nhsemployers.org/~/media/Employers/Documents/Primary%20care%20contracts/QOF/2016-17/2016-17%20QOF%20guidance%20documents.pdf [Accessed 16 December 2016].

NHS Digital (2016). *General and Personal Medical Services, England 2006-2016, as at 30 September, Experimental Statistics*. [Online]. Available at: http://www.content.digital.nhs.uk/searchcatalogue?productid=24768&q=general+medical+&sort=Relevance&size=10&page=1#top [Accessed 9 July 2017]

Nelson, E., Batalden, P. and Lazar, J. (2007). *Practice-based learning and improvement: a clinical improvement action guide*. Illinois: Joint Commission Resources, Inc.

Newman, J. and Kuhlmann, E. (2007). Consumers enter the political stage? The modernization of health care in Britain and Germany. *Journal of European Social Policy*, 17 (2), 99-111.

Newman, J. and Clarke, J. (2009). *Publics, politics and power: remaking the public in public services*. Sage: London.

Newman, J., Glendinning, C. and Hughes, M. (2008). Beyond modernisation? Social care and the transformation of welfare governance. *Journal of Social Policy*, 37 (4), 531-557.

Niezen, M. and Mathijssen, J. (2014). Reframing professional boundaries in healthcare: a systematic review of facilitators and barriers to task reallocation from the domain of medicine to the nursing domain. *Health Policy*, 117, 151-169.

Noordegraaf, M. (2007). From 'pure' to 'hybrid' professionalism: present-day professionalism in ambiguous public domains. *Administration and Society*, 39 (6), 761-785.

Noordegraaf, M. (2015). Hybrid professionalism and beyond: (new) forms of public professionalism in changing organizational and societal contexts. *Journal of Professions and Organization*, 0, 1-20.

Numerato, D., Salvatore, D. and Fattore, G. (2012). The impact of management on medical professionalism: a review. *Sociology of Health and Illness*, 34 (4), 626-644.

Offe, C. (1981). Attribution of public status to interest groups. In S. Berger, (Ed.). *Organizing interests in Western Europe - Pluralism, Corporatism, and the transformation of politics*. New York: Cambridge University Press, pp. 123-158.

OECD (2016a). Income distribution. *OECD Social and Welfare Statistics (database)*. [Online]. Available at: DOI: http://dx.doi.org/10.1787/data-00654-en [Accessed 17 December 2016].

OECD (2016b). Social expenditure: aggregated data. *OECD Social Expenditure Statistics (database)*. [Online]. Available at: DOI: http://dx.doi.org/10.1787/data-00166-en [Accessed 17 December 2016].

OECD (2016). National accounts at a glance. *OECD National Accounts Statistics (database).* [Online]. Available at: DOI: http://dx.doi.org/10.1787/data-00369-en [Accessed 18 December 2016).

Oliver, K., de Vocht, F., Money, A. and Everett, M. (2013). Who runs public health? A mixed-methods study combining qualitative and network analyses. *Journal of Public Health (Oxford)*, 35 (3), 453-459.

Oppenheimer, M. (1973). Proletarianization of the professional. In P. Halmos, (Ed.). *Professionalization and Social Change*. Keele, England: University of Keele, pp. 213-227.

Ouchi, W. (1979). A conceptual framework for the design of organizational control mechanisms. *Management Science*, 25 (9), 833-848.

Pawlson, G. and O'Kane, E. (2002). Professionalism, regulation, and the market: impact on accountability for quality of care. *Health Affairs*, 21 (3), 200-207.

Peckham, S. Exworthy, M., Powell, M. and Greener, I. (2008). Decentralizing health services in the UK: a new conceptual framework. *Public Administration*, 86 (2), 559-580.

Perkin, H. (1996). *The third revolution: professional elites in the modern world*. London: Routledge.

Park, H. and Rethemeyer, K. (2012). The politics of connections: assessing the determinants of social structure in policy networks. *Journal of Public Administration Research and Theory*, 24, 349-379.

Pollitt, C. (2007). Decentralization: a central concept in contemporary public management. *The Oxford handbook of public management*. In E. Ferlie, E. Laurence and C. Pollitt, (Eds.). Oxford: Oxford University Press, pp.372-393.

Ramesh, M. and Holliday, I. (2001). The health care miracle in East and Southeast Asia: activist state provision in Hong Kong, Malaysia and Singapore. *Journal of Social Policy*, 30, 637-651.

Raynard, M. (2016). Deconstructing complexity: configurations of institutional complexity and structural hybridity. *Strategic Organization*,14 (4), 310-335.

Reay, T. and Hinings C. (2009). Managing the rivalry of competing institutional logics. *Organization Studies*, 30, 629-652.

Renedo, A. and Marston, C. (2011). 'Healthcare professionals' representations of 'patient and public involvement' and creation of 'public participant' identities: implications for the development of inclusive and bottom-up community participation initiatives. *Journal of Community and Applied Social Psychology*, 21, 268-280.

Renedo, A. and Marston. C. (2015). Developing patient-centred care: an ethnographic study of patient perceptions and influence on quality improvement. *BMC Health Services Research*, 15, 122. [Online]. Available at: DOI: 10.1186/s12913-015-0770-y [Accessed 18 December 2016].

Reskin, F. and Roos, A. (1990). *Job Queues, Gender Queues: Explaining Women's Inroads into Male Occupations*. Philadelphia: Temple University Press.

Rhodes, R. (1996). The new governance: governing without government. *Political Studies*. 44 (4), 652-667.

Rhodes, R. (1997). *Understanding Governance*. Buckingham and Philadelphia: Open University Press.

Rhodes, R. (2007). Understanding governance: ten years on. *Organization Studies*, 28, 1243-1264.

Rhodes, M. (2001). The political economy of social pacts: 'competitive corporatism' and European welfare reform. In P. Pierson, (Ed.). *The new politics of the welfare state.* Oxford: Oxford University Press, pp. 165-194.

Park, S. and Lunt, N. (2015) Confucianism and Qualitative Interviewing: Working Seoul to Soul. *Qualitative Research Method*, 16 (2;7). [On-line]. Available at: http://www.qualitative-research.net/index.php/fqs/article/view/2166 [Accessed on 22 Dec 2016]

Richardson, L. (1990). *Writing Strategies: Reaching Diverse Audiences*. SAGE Publications.

Riska, E. (2001). *Medical Careers and Feminist Agendas: American, Scandinavian, and Russian Women Physicians*. New York : Aldine de Gruyter.

Riska, E. (2008). The Feminization Thesis: Discourses on gender and medicine. *Nordic Journal of Feminist and Gender Research*, 16(1), pp. 3-18.

Pierson, P. (1998). Irresistible forces, immovable objects: post-industrial welfare states confront permanent austerity. *Journal of European Public Policy*, 5 (4), 539-560.

Pierson, P. (2001). Coping with permanent austerity welfare state - restructuring in affluent democracy. In P. Pierson, (Ed.). *The new politics of the welfare state.* Oxford: Oxford University Press, pp. 410-456.

Pierre, J. and Peters, B. (2000). *Governance, Politics and the State*. Basingstoke: Macmillan.

Pierre, J. and Peters, B. (2005). *Governing complex societies: trajectories and scenarios*. Houndmills, Basingstoke, Hampshire; New York: Palgrave.

Richards, A., Carley, J., Jenkins-Clarke, S. and Richards, D. (2000). Skill mix between nurses and doctors working in primary care-delegation or allocation: a review of the literature. *International Journal of Nursing Studies*, 37, 185-197.

Poocharoen, O. and Ting, B. (2015). Collaboration, co-production, networks: convergence of theories. *Public Management Review*, 17 (4), 587-614.

Powell, W. and DiMaggio, P. (1991). *The New Institutionalism in Organizational Analysis, Chicago*. Chicago: The University of Chicago Press.

Professional Standards Authority, UK. (2015). *Right-touch Regulation*. [Online] Available at: http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015.pdf [Accessed 10 March 2016].

Provan, G., Huang, K. and Milward. B. (2009). The evolution of structural embeddedness and organizational social outcomes in a centrally governed health and human services network. *Journal of Public Administration Research and Theory*, 19, 873-93.

Provan, K., Fish, A. and Sydow, J. (2007). Interorganizational networks at the network level: a review of the empirical literature on whole networks. *Journal of Management*, 33 (3), 479-516.

Provan, K. and Kenis, P. (2008). Modes of network governance: structure, management, and effectiveness. *Journal of Public Administration Research and Theory*, 18 (2), 229-252.

Rose, M., Barnes, M., Crawford, M., Omeni, E., MacDonald, D. and Wilson, A. (2014). How do managers and leaders in the National Health Service and social care respond to service user involvement in mental health services in both its traditional and emergent forms? The ENSUE study. *Health Services and Delivery Research, No. 2.10*. Southampton (UK): NIHR Journals Library. [Online]. Available at: https://www.ncbi.nlm.nih.gov/books/NBK259692/ doi: 10.3310/hsdr02100 [Accessed 16 December].

Russell, V., Wyness, L. McAuliffe, E. and Fellenz, M. (2010). The social identity of hospital consultants as managers. *Journal of Health Organization and Management*, 24 (3), 220-236.

Salter, B. (2001). Who rules? The new politics of medical regulation. *Social Science & Medicine,* 52, 871-83.

Salter, B. (2003). Patients and doctors: reformulating the UK health policy community? *Social Science & Medicine,* 57, 927-936.

Sanders, T., Harrison, S. and Checkland, K. (2008). Evidence-based medicine and patient choice: the case of heart failure care. *Journal of Health Services Research & Policy*,13 (2), 103-108.

Sandström, A., and Carlsson, L. (2008). The performance of policy networks: the relation between network structure and network performance. *Policy Studies Journal*, 36 (4), 497-524.

Saltman, R. and Bankauskaite, V. (2006). Conceptualizing decentralization in European health systems: a functional perspective. *Health Economics, Policy and Law*, 1, 127-147.

Saward, M. (1990). Cooption and power: who gets what from formal incorporation. *Political Studies*, 38, 588-602.

Saz-Carranza, A. and Ospina, S. (2011). The behavioral dimension of governing interorganizational goal-directed networks: managing the unity-diversity tension. *Journal of Public Administration Research and Theory*, 21, 327-65.

Scharpf, F. (1994). Games real actors could play: positive and negative coordination in embedded negotiations. *Journal of Theoretical Politics*, 6, 27-53.

Schön, D. (1983). *The reflective practitioner*. New York: Basic Books.

Scott, I. (1989). *Political change and the crisis of legitimacy in Hong Kong*. London: Hurst.

Scott, R. Ruef, M., Mendel, M. and Carol, C. (2000). *Institutional change and healthcare organizations: from professional dominance to managed care*. Chicago: University of Chicago Press.

Scott, W. & Co. (1985). *The delivery of medical services in hospitals: a report for the Hong Kong Government*. Hong Kong: Hong Kong Govt. Printer.

Scourfield, P. (2007). Social care and the modern citizen: client, consumer, service user, manager and entrepreneur. *British Journal of Social Work*, 37(1), 107-122.

Shaw, I. and Gould, N. (2001). *Qualitative Research in Social Work*. London: Sage.

Sheaff, R., Charles, N., Mahon, A., Chambers, N., Morando, N., Exworthy, M., Byng, R., Mannion, R. and Llewellyn, S. (2015). NHS commissioning practice and health system governance: a mixed-methods realistic evaluation. *Health Service and Delivery Research*, 3 (10). [Online]. Available at: DOI: 10.3310/hsdr03100 [Accessed 10 December 2016].

Sheaff, R., Marshall, M., Rogers, A., Roland, M., Sibbald, B. and Pickard, S. (2004). Governmentality by network in English Primary Healthcare. *Social policy & Administration*, 38(1), 89-103.

Simon, H. (1956). Rational choice and the structure of the environment. *Psychological Review*, 63 (2), 129-138.

Sackett, D., Rosenberg, W., Gray, A. Haynes, R. and Richarsdon, W. (1996). Evidence-based medicine: what it is and what it isn't. *British Medical Journal*, 312, 71-2.

Sackett, D., Straus, S., Richardson, W., Rosenberg, W. and Haynes, R. (2000). *Evidence-based medicine: how to practise and teach EBM*. Edinburgh: Churchill Livingstone.

So, Y. (1999). *Hong Kong's embattled democracy: a societal analysis*. Baltimore, MD: Johns Hopkins University Press.

Social welfare Department, Hong Kong. (2016). *Salary Scale of Common Posts in the Non-governmental Organizations w.e.f. 1.4.2016*. [On-line]. Available at: http://www.swd.gov.hk/doc/ngo/PayWage/Salary%20Scale%20of%20Common%20Posts%20wef%2001-04-2016(clean).pdf [Accessed on 22 May 2017]

Solomon, J., Knappc, P., Raynorb, D. and Atkin, K. (2013). Worlds apart? An exploration of prescribing and medicine-taking decisions by patients, GPs and local policy makers. *Health Policy*, 112, 264-272.

Solomon, J., Raynor, K., Knapp, P. and Atkin, K. (2012). The compatibility of prescribing guidelines and the doctor-patient partner-ship: a primary care mixed-methods study. *The British Journal of General Practice,* 62 (597), 275-281.

Southon, G., Perkins, R. and Galler, D. (2005). Networks: a key to the future of health services. *Australian Health Review,* 29 (3), 317-326.

Spehar, I., Frich, J. and Kjekshus, L. (2015). Professional identity and role transitions in clinical managers. *Journal of Health, Organization and Management*, 29(3), 353-366.

Spyridonidis, D. and Calnan, M. (2011). Are new forms of professionalism emerging in medicine? The case of the implementation of NICE guidelines. *Health Sociology Review*, 20 (4), 394-409.

Spyridonidis, D., Hendy, J. and Barlow, J. (2015). Understanding hybrid roles: the role of identity processes amongst physicians. *Public Administration*, 93 (2), 395-411.

Staniland, K. (2009). A sociological ethnographic study of clinical governance implementation in one NHS Hospital Trust. *Clinical Governance: An International Journal*, 14 (4), 271-280.

Staniland, K. (2010). Studying organizations: the revival of institutionalism. In I. Bourgeault, R., Dingwall, and R. De Vries, (Eds.). *The SAGE Handbook of Qualitative Methods in Health Research*. London: SAGE Publications, pp.249-264.

Staniland, K. (2008). Clinical governance and nursing - a sociological analysis. (unpublished PhD Thesis). England: University of Salford.

Strauss, A., Schatzman, L., Bucher, R., Ehrlich, D. and Sabshin, M. (1964). *Psychiatric Ideologies and Institutions*. London: Collier-Macmillan/Free Press.

Streeck, W. and Schmitter, P. (1985). Community, market, state and associations? The prospective contribution of interest governance to social order. *European Sociological Review*, 1(2), 119-138.

Stoker, G. (1998). Governance as theory: five propositions. *International Social Science Journal*, 50 (155), 17-25.

Stone, D. (1980). *The limits of professional power: national health care in the Federal Republic of Germany*. Chicago: Chicago University Press.

Sullivan, W. (2000). Medicine under threat: professionalism and professional identity. *Canadian Medical Association Journal*, 162 (5), 673-675.

Sørsensen, E. and Torfing, J. (2005). Democratic anchorage of governance networks. *Scandinavian Political Studies* 28, 195-218.

Tam, T. and Yeung, S. (1994). Community perception of social welfare and its relations to familism, political alienation, and individual rights: the case of Hong Kong. *International Social Work*, 31(7), 47-60.

Tang, K. (1998). *Colonial state and social Policy: social welfare development in Hong Kong 1842-1997*. Lanham, Md.; Oxford: University Press of America.

Temple, B., Edwards, R. and Claire, A. (2006). Grasping at context: cross language qualitative research as secondary qualitative data analysis. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 7(4). [Online]. http://nbnresolving.de/urn:nbn:de:0114-fqs0604107 [Accessed 17 December 2016].

Temple, B. and Young, A. (2004). Qualitative research and translation dilemmas. *Qualitative Research*, 4(2), 161-178.

Ten Have, H. (2000). Re-evaluating professional autonomy in health care. *Theoretical Medicine and Bioethics*, 21(5), 503-513.

The Harvard Team (1999). *Improving Hong Kong's health care system, why and for whom?* Hong Kong: Printing Department.

The Health Foundation (2013). *Involving patients in improving safety: an evidence scan*. London: Health Foundation.

The Heritage Fund (2016). *2016 Index of Economic Freedom*. [Online]. Available at: http://www.heritage.org/index/ranking [Accessed 15 November].

The Hong Kong Government (1964). *The development of health services*. Hong Kong: Govt. Printer.

The Hong Kong Government (1965). *Aims and policy for social welfare in Hong Kong: a white paper*. Hong Kong: Govt. Printer.

The Hong Kong Government (1973). *Social welfare in Hong Kong: the way ahead*. Hong Kong: Government Printer.

The Hong Kong Government (1977). *The personal social work among young people*. Hong Kong: Govt. Printer.

The Hong Kong Government (1991). *Social welfare into the 1990s and beyond: a white paper*. Hong Kong: Govt. Printer.

The Hong Kong Government (2013a). *Hong Kong Yearbook 2012*. [Online]. Available at: http://www.yearbook.gov.hk/2012/en/ [Accessed 15 November].

The Hong Kong Government (2013b). *Government Budget 2013-14*. [Online]. Available at: http://www.budget.gov.hk/2013/eng/speech.html [Accessed 15 November].

The Hong Kong Government (2016). *Hong Kong - the Facts*. [Online]. Available at: http://www.gov.hk/en/about/abouthk/facts.htm [Accessed 15 November].

The Hong Kong Hospital Authority (2016). *Hong Kong Hospital Authority website*. [Online]. Available at: http://www.ha.org.hk/visitor/ha_index.asp [Accessed 15 November].

The King's Fund (2011). *The future of leadership and Management in the NHS: report from The King's Fund Commission on leadership and management in the NHS*. London: The King's Fund.

The National Assembly for Wales (1999). *An introduction to clinical pathways, putting clients first*. Cardiff: NHS Wales.

The World Bank (1992). *Governance and development*. Washington, DC: The World Bank. [Online]. Available at: http://documents.worldbank.org/curated/en/604951468739447676/Governance-and-development [Accessed 16 December].

The World Bank (2016). *Data: GNI per capita, PPP (current international $)*. [Online]. Available at: http://data.worldbank.org/indicator/NY.GNP.PCAP.PP.CD?year_high_desc=true [Accessed 10 December 2016].

Thorne, M. (2002). Colonizing the new world of NHS management: the shifting power of professionals. *Health Services Management Research*, 15(1), 14-26.

Traxler, F., Blaschke, S. and Kittel, B. (2001). *National labour relations in internationalized markets: a comparative study of institutions, change, and performance*. Oxford: Oxford University Press.

Tsang, M. (2016). Doctors opposing medical council reform are 'irrational': ex-council head. *South China Morning Post*, 14 July 2016. [Online]. Available at: http://www.scmp.com/news/hong-kong/health-environment/article/1989911/doctors-opposing-medical-council-reform-are [Accessed 14 July 2016].

Tu, J., Liu, S. and Ting, M. (2009). A Comparative Analysis of Culture among Taiwan, Hong Kong, and Mainland China: Employing Hofstede's Cultural Dimensions. *Journal of*

Science and Technology and Humanities of Transworld Institute of Technology, 9, pp.43-59.

United Nations (2016). *Human development reports*. [Online]. Available at: http://hdr.undp.org/en/data [Accessed 10 December 2016].

Veronesi, G. and Keasey, K. (2015). Patient and public participation in the English NHS: an assessment of experimental implementation processes. *Public Management Review,* 17(4), 543-564.

Visser, J. and Hemerijck, A. (1997). *A Dutch miracle: job growth, welfare reform and corporatism in the Netherlands*. Amsterdam: Amsterdam University Press.

Wallerstein, M. (1988). Review by: Michael Wallerstein. *American Journal of Sociology*, 93 (6), 1499-1501.

Waring, J. (2007). Adaptive regulation or governmentality: patient safety and the changing regulation of medicine. *Sociology of Health and Illness*, 29 (2),163-179.

Waring, J. (2014). Restratification, hybridity and professional elites: questions of power, identity and relational contingency at the points of 'professional-organizational intersection'. *Sociology Compass*, 8, 688-704.

Waring, J. and Currie, G. (2009). Managing expert knowledge: organizational challenges and managerial futures for the UK medical profession. *Organization Studies*, 30(7), 755-778.

Watkins, P. (1993). Centralized decentralization: Sloanism, marketing quality and higher education. *Australian Universities Review,* 36 (2), 9-17.

Welsh, V., Sanders, T., Richardson, R., Wynne-Jones, G., Jinks, C. and Mallen, C. (2014). Extending the authority for sickness certification beyond the medical profession: the importance of 'boundary work'. *BMC Family Practice*, 15(100). [Online]. Available at: http://dx.doi.org/10.1136/bmj.39238.890810.BE [Accessed 12 December 2016]

Williamson, P. (1989). *Corporatism in perspective: an introductory guide to corporatist theory*. London; Newbury Park: Sage Publications.

Windolf, P. (1989). Productivity coalitions and the future of European Corporatism. *Industrial Relations*, 28, 1-20.

Witz, A. and Annandale, E. (2006). The challenge of nursing. In D. Kelleher, J. Gabe and G. Willliams, (Eds.). *Challenging medicine*. London: Routledge, pp. 23-45.

Wong, L. (2008). *Hong Kong's welfare model reconsidered - what model? What Traits? And what functions*. Paper presented in East Asian and Social Policy 5th Conference, 3 November, 2008. [Online]. Available at:
http://www.welfareasia.org/5thconference/session-1/stream-4/ [Accessed 15 November].

Wood, B. (2000). *Patient power? Patients associations in Britain and America*. Buckingham: Open University Press.

Woods, M. (1998). Rethinking elites: networks, space, and local politics. *Environment and Planning*, A 30, pp. 2101- 2119.Wright, J., Dempster, P., Keen, J., Allen, P. and Hutchings, A. (2012). The new governance arrangements for NHS Foundation Trust hospitals: reframing governors as meta-regulators. *Public Administration*, 90 (2), 351-69.

Yip, W. and Hsiao, W. (2003). Autonomizing a hospital system: corporate control by central authorities in Hong Kong. In A. Harding, and A. Preker, (Eds.). *Innovations in health service delivery: the corporatization of public hospitals, Volume 1*. Washington DC: The World Bank, pp.391-424.

Yuen, P. (1995). The corporatization of public hospital services in Hong Kong: a possible public choice explanation. *The Asian Journal of Public Administration*, 6 (2), 165-182.

Yuen, P. (2005). Dissatisfaction of health providers and consumers: health care reform impasse and SARS outbreak mismanagement. In Cheng, J. (Ed.). *The July 1 Protest Rally: Interpreting a Historic Event*. City University Press, Hong Kong, pp.443-468.

Yeung, C. (1995). Qualitative personal interviews in international business research: some lessons from a study of Hong Kong transnational corporations. *International Business Review*, 4(3), pp. 313–339.

Yin, R.K. (2009). *Case Study Research: Design and Methods*. London: Sage.

Zakaria, F. (1997). The Rise of Illiberal Democracy. *Foreign Affairs*, 76 (6), 22-43.