Clinician-managers in South Africa: a qualitative enquiry into the combination of clinical and managerial roles in healthcare

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Abstract

Clinicians who occupy managerial roles, clinician-managers, are widespread throughout the South African healthcare system and play a key role in influencing the quality of care that is delivered to patients. They face competing clinical and managerial priorities, often engage in ongoing clinical work, face resource constraints and are confronted with ethical dilemmas. In this research programme, I explored the research question: how do clinician-managers combine their clinical and managerial roles in the South African healthcare system?

I conducted 33 in-depth interviews with current and former clinician-managers as well as key informants, complemented by fieldnotes and document reviews. Most of the clinician-managers had worked in district or regional hospitals, although some participants had also worked in primary and tertiary care centres, and most were based or had been based in the public healthcare system. Participant experiences also included rural and urban settings. I used a constructivist paradigm, and approached my data analysis using thematic analysis and theorisation. My research makes an original contribution to understanding how clinician-managers learn to manage, how they view the logics of work and what their normative role is.

My main findings included that clinician-managers enter into their roles through a variety of routes and rely on heterogenous learning strategies to enact their roles. I theorised this through three lenses, namely functionalism (professional roles are more or less given and serve to stabilise society), the critical lens on power (professionals amass power and are motivated at least partly by self-interest) and

neo-institutionalism (by enacting their roles, professionals both produce and reproduce the social order).

Using an institutional logics framework, I found that clinical logic differed from clinicians' perceptions of managerial logic. Within this framework, I showed how some participants had constructed an assimilated clinical-managerial logic, which had incorporated aspects of managerial procedure and language to serve clinical goals, which has important implications for healthcare management.

I also found that clinician-managers play a normative role – in determining what ought to be done by the healthcare organisation – when faced with ethical dilemmas. Through considering how participants balance prioritising patients, the healthcare organisation, colleagues, and procedure, my analysis made the ethical dimensions of these conflicts explicit.

Recent public examples described in-depth in the South African media have portrayed some of these conflicts between clinician-managers and clinicians and I have used one such example to demonstrate how my research could be applied to better understand how and why such conflicts arise and what could be routes for resolution.

Through this thesis, I have provided a detailed description and theorisation of clinician-managers' role combination in the South African setting. I have also related these findings to empiric work on clinician-managers in the United Kingdom, Kenya and other regions, and contrasted the findings to those settings with reference to contextual differences. Understanding clinician-managers' role combination through theory provides new avenues to approach the training and support of these important role players in the healthcare system. I also recommend the creation of a

national framework which outlines the knowledge and skills required of healthcare managers, and propose ways of empirically and theoretically grounding such initiatives.

Abbreviations

"Admin"	Colloquial abbreviation for "administration", but referring to a wide variety of non-clinical work. See chapter 5
CEO	Chief Executive Officer
CM	Clinician-manager or Clinical Manager (will be specified in text)
DoH	Department of Health (either national or provincial)
GMC	General Medical Council (of the United Kingdom)
HCM	Hybrid clinician-manager
HoCU	Head of Clinical Unit
HoD	Head of Department
HPCSA	Health Professions' Council of South Africa
ICU	Intensive Care Unit
LMIC	Low- and Middle Income Countries or Country
MBA	Masters in Business Administration
MO	Medical Officer
Paeds	Paediatrics, a branch of healthcare focused on child health
PHM	Public Health Medicine
RSA	Republic of South Africa (often abbreviated to SA)
UCT	University of Cape Town
UK	United Kingdom

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Part 1: Introduction, theory, methods and methodology and introduction to literature

Chapter 1: Introduction and aims

A statement which led to an interest in clinician-managers

"These things take time."

I have thought about these words for six years.

Years prior to conducting this research, I was speaking to a specialist in a South African regional hospital. The specialist themselves was the head of their department, internationally recognised and published in their field and regarded by their peers as knowledgeable and hardworking. For many years, I had been studying from a medical text that they had written.

Among several challenges I had encountered in this environment, I was wondering why newly graduated doctors in their department were sometimes working with little to no supervision from senior medical staff, and caring for patients from admission until either they were discharged or dead. Some of the medical staff, who were supposed to be providing supervision and guidance, seemed to be absent from the hospital for long stretches of the day, or days at a time.

How does a clinician combine their role as excellent specialist with that of a manager to result in a role which would accept absenteeism and an apathetic approach to patient care? I did not pose the question as bluntly, but I did allude to these problems in our last conversation.

"These things take time," was the somewhat cryptic response of the head of department.

I thought about this sentence and looked about my surroundings for clues. Their office was tucked up several flights of stairs, in a part of the building which was rumoured to have been condemned, but remained in continuous use. I thought about the cracking paint and partially collapsed walls of the hospital and the rats which scurried through the medical waste stacked outside some wards, and remained silent. The paper-strewn office seemed quite neat in comparison to the shabby hallway outside the door.

Clearly, there was much about the situation that I had yet to understand. In this thesis I explore one question that this experience posed: how doctors and other clinicians combine their clinical role with a managerial one in the particular circumstances of the South African healthcare system?

The South African healthcare system: history, structure and ongoing challenges

Both the structure and the challenges faced by the South African healthcare system reflects its “fragmented and contested past” (Gray et al. 2016, p.36). The Union of South Africa was established in 1910. The ensuing century saw the Union’s transition into a republic and the establishment of a racially discriminatory regime under Apartheid. The term apartheid is Afrikaans for “separateness” and denotes a system of racial segregation which was legislatively established and maintained in South Africa between 1948 and 1994.

Following their election by a limited franchise in 1948, the National Party of South Africa sought to create a white supremacist state where, under social apartheid, interactions between persons of different ethnicities were curtailed. This process culminated in “high apartheid”, which sought to create homelands or “Bantustans”

for persons classified as African (Baker 2010, p.80). This system was dismantled after the election of a democratically elected government in 1994 (Katuu 2018).

The transition to democracy post-1994 posed numerous challenges, and the provision of healthcare was important among these. The economic inequality wrought by apartheid, and the colonialism which preceded it, had also resulted in highly inequitable health outcomes, with non-white groups systematically disadvantaged (Baker 2010, p.83; Van Rensburg 2014, p.4). The health systems of 14 separate homelands had to be integrated into a national system and a new system of national governance was established. A sharp divide remained, however, between South Africa's public healthcare sector and its highly developed private one, with the latter serving only a minority of the population (Katuu 2018, p.136; Gray et al. 2016, p.36). South Africa also faces what some have called a quadruple burden of disease, with high levels of communicable diseases (such as HIV and TB), non-communicable diseases (such as cardiovascular disease), high maternal and child mortality, and high levels of violence, placing an additional strain on health services (Basu 2018).

Access to healthcare was enshrined as a right in South Africa's constitution in 1996, and several new pieces of legislation were enacted in the following years, culminating in the National Health Act in 2003. This act sought to create a national health system, establish a district health system and advance primary care, among other goals (Coovadia et al. 2009, p.820).

The structure of the modern South African healthcare system is decentralised, operating at national, provincial and local government levels, with funding systems mirroring this organisation. There is a national department of health, responsible

for health policy and guidance, as well as nine provincial departments of health responsible for the delivery of healthcare. Local governments are tasked with environmental health management (Gray et al. 2016, p.36).

On a provincial level, healthcare is organised into districts, of which there are 52 (Massyn et al. 2020). In the public sector, healthcare is divided into levels, ranging from primary health care clinics, community health centres, district hospitals, regional hospitals, tertiary hospitals to central hospitals (Gray et al. 2016; Ranchod et al. 2017). A parallel private sector exists, which entails its own hospitals and private practices. This thesis focuses on the public healthcare sector, which is utilized by the majority of the population.

Clinician-managers

Several writers have described a "crisis" of management in South African healthcare (Maphumulo and Bhengu 2019, p.4; Van Rensburg 2014, p.2). Doherty summarised the management challenges of South African public hospitals as including piecemeal implementation of improvement strategies, excessive centralisation of authority at the levels of provincial or district management level, high turnover of hospital CEOs, inexperienced senior managers and weak administrative systems (2013, p.23).

Reporting on the history and ongoing challenges of the South African public health system, a Lancet commission argued that apartheid-era employment practices did not regard competence as a criterion for public sector employment. When these were replaced with affirmative action policies, this further led to a loss of

institutional memory and resulted in inexperienced managers being in senior positions without support (Coovadia et al. 2009, p.830).

Writing about the problems facing the healthcare sector in the late 2000s, the editor of the South African Medical Journal blamed “autocratic rule” and “appointment of managers and other senior staff in the health sector on grounds other than competence” (Van Niekerk 2009). Citing this “lack of health management capacity”, one researcher conducted a survey of hospital chief executives[1] in South Africa’s public and private sectors. They found the majority of respondents in the private sector had non-clinical backgrounds, whereas the majority of public sector respondents had clinical backgrounds (Pillay 2010, p.31). Furthermore, the clinician-managers rated their own competence in all but clinical skills as lower than their non-clinical counterparts. This reflects a broader finding in both South Africa and other countries where clinicians in management roles report feeling underprepared and unconfident in their ability to manage, sometimes citing a lack of management training and experience (Parbhoo 2020, p.64; Imran et al. 2021, p.7; Spehar et al. 2012).

In spite of this, one solution which was proposed to address the crises described above was to ensure that certain managerial roles in South African public hospitals could be filled only by persons with a qualification in a “health-related field”, with management experience in the health sector. A management

[1] Chief executives represent only one managerial role in the healthcare sector. The heterogeneity of titles and accompanying expectations in the public healthcare sector are explored further alongside a description of the dataset.

qualification was seen as “an added advantage” (National Department of Health 2012, p.13).

Although this policy was likely addressing an important set of challenges for the healthcare sector, it does reflect an assumption in South Africa’s public healthcare sector: that large parts of it should be managed by clinicians. Even if this policy had not been proposed, there are also several other managerial roles which clinicians occupy as a matter of course: various levels of nurse managers, clinical managers, medical managers, heads of department and others. Stewart and Wolvaardt describe this as a model of “amateur management” and although this may appear pejorative, this is also how some medical chief executives described themselves in the United Kingdom (Stewart and Wolvaardt 2019, p.2; Ham et al. 2011).

Throughout South Africa (and also in many other parts of the world), clinicians who have trained and practiced for many years as doctors, nurses or rehabilitation professionals are expected to transition part- or full-time into management positions in healthcare. As this thesis will explore, some do so with support, training and preceding experience. Others, however, might not be so fortunate. These individuals are expected to combine or hybridise two roles. In one role, they act as a clinician who might still be expected to work with patients and, as importantly, to bring clinical expertise and experience to new a position within the healthcare system. In the other role, they are expected to act as a manager, a role which might differ substantially both in scope and expectations from their experiences up to that point. I have used the term “role” in a broad sense, to encompass the expectations which might be placed upon clinician-managers, on

the one hand as a result of their clinical training (and possible continued work as a clinician) and on the other hand as a result of their managerial position.

The primary aim of my thesis is to understand and theorise how clinician-managers combine their roles as clinicians and managers in the South African healthcare setting, including understanding the challenges and opportunities resulting from this hybridisation.

The secondary aim is to inform both policy (workforce planning, support and training) and the academic literature (extending an interdisciplinary theorisation) in relation to the role and practice of clinician-managers in the South African healthcare setting.

The term “hybrid” has, for some authors, come to denote clinician-managers who are involved in clinical work (Parbhoo 2020, p.iv; Imran et al. 2021, p.7). This definition uses the word “hybrid” in a manner which does not reflect its actual meaning. Furthermore, this definition relies on an assumption that it is the ongoing clinical practice of a clinician-manager which is important, rather than the years of clinical training and experience that they bring to the role of manager. In this thesis clinician-manager and hybrid clinician-manager mean the same thing. This is further explored in chapter 3.

Structure of this thesis

I have composed this thesis of seven chapters spread over three parts. In this chapter I explain the background and aims of the research. Below, I provide an outline of the remainder of this thesis.

In Chapter 2 I will consider the theoretical approach, methodology and methods I have taken throughout this research project.

The literature relevant to researching clinician-managers is distributed throughout several bodies of scholarship. Numerous avenues for analysis were available and I have selected those fields which best suited the data. Summarising such diverse areas of research in a single chapter would have constituted a challenge for a reader who was not already familiar with the results and analysis. I have therefore chosen to summarise the research relevant to each chapter in separate sections throughout the thesis to facilitate reading. Chapter 3 provides a general introduction to the literature on clinician-managers and hybridity, and provides theory informed definitions for key terms used throughout the thesis.

As part of the introduction to part 3 of the thesis, I describe the dataset: a series of interviews with clinician-managers and certain key informants, and selected documents gathered throughout fieldwork. As the COVID-19 pandemic has affected this research in various ways, this and other limitations of this research are discussed here and throughout the thesis.

Thereafter, I have used chapters 4, 5, and 6 each to focus on a separate aspect of the findings. I used thematic analysis to categorise the interview data and then theorised these categories using various approaches. Throughout this process, my use of theory was aimed at providing an appropriate explanatory fit to the data. The resulting three chapters each contain the theorisation of a particular set of themes.

In chapter 4 I describe and analyse the journey of becoming a clinician-manager, and the processes of learning involved in this. The participant accounts chiefly

relied on a functional view of the role of clinicians in healthcare management, with some critical perspectives also present. This meant that three theoretical approaches taken from the sociology of the professions were well-suited to understanding these accounts reflecting on the presence and continual creation of clinician-manager hybrids within the healthcare system. These approaches were the functionalist, power and neo-institutional theories of the professions.

In chapter 5 I explore the diverse perspectives on the work of clinician-managers as they perceived it. This theme showed that some clinician-managers were engaging in an ongoing process of reinterpretation with regards to their conception of work, while reconciling clinical and managerial approaches to organising work in healthcare facilities. In this chapter I applied an institutional logics approach to demonstrate how clinician-managers were developing clinical-managerial logic, which is clinical logic that has incorporated aspects of managerial logic to serve its own objectives.

In chapter 6 I analyse the normative[2] aspects of clinician-managers' role in healthcare delivery. After exploring various frameworks for clinical-managerial ethics, I apply Shale's framework for moral leadership in healthcare. In particular, I show how clinician-managers must balance between several proprieties: fiduciary (prioritising patients), bureaucratic (prioritising the organisation), collegial (prioritising fellow professionals) and inquisitorial (prioritising fair processes after transgressions). This approach is contrasted with other ethical frameworks to

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[2] This term is explored in detail in chapter 6. In brief, "normative" in this context refers to notions of what ought or ought not to be done, both as a result of deliberation within an ethical framework or set of rules and also with consideration to contextual norms.

show that clinician-managers are required to identify scenarios where these proprieties conflict and how challenging it may be to solve these conflicts when a commitment to certain proprieties (such as the collegial) are largely implicit. I also explore the application of the moral leadership framework to published literature on clinician-managers to show that there is an implicit normative dimension visible in other researchers' findings as well.

The third section of this thesis contains a discussion and conclusion chapter, as well as the coda to the thesis (which follows on the references as an appendix).

In chapter 7, I consider the wider context to which these results contribute. After summarising the findings, I discuss the limitations of this study and provide a research agenda for future research into clinician-managers and for the wider application of the theories used in this thesis. This chapter also contains suggestions for ways in which these results may inform the training and support of clinician-managers in the South African setting.

Writing this thesis has been more akin to the process of exploration than the straight-forward writing up of findings, as others have also noted (Yoo 2017). As part of this exploration, I have also produced an allegorical retelling of the thesis as a coda. In the empiric chapters that follow, I provide a thematically linked and theorised account of clinician-managers' challenges, successes and failures in their attempts to combine the clinical and the managerial aspects of their work. While this approach has allowed me to focus on aspects of clinician-managers' role combination, I also wished to emphasise that participant accounts were based on their own lives and their interactions with others. In addition, the meaning of participants experiences was further elaborated upon through their interpretations

of events in retrospect, as part of the interview process. This research was an additional act of interpretation across these accounts and in dialogue with bodies of scholarly literature. In the allegory, I use the framing of archaeological excavation, which is followed by translation and interpretation of a meaning-laden account in order to depict this layered process. The story I have written is allegorical in nature and explores the empiric findings of this thesis in a fictional setting.

The physicist Richard Feynman wrote about the “pleasure of finding things out”. This is an apt description of what I aim to present here: a research project and a journey which has been a continual source of discovery and intellectual stimulation. Earlier in this chapter, and upon setting out in this project, I provided the aims for this research. I will return to these in the concluding pages to consider how I have achieved these and provided an answer to the research question.

Chapter 2: Theoretical approach, methodology and methods

Introduction

In this chapter, I discuss the theoretical positioning of this thesis and how this informs the choice of methods and sources of data. The methods employed in this research project are described in detail and reflected on with regards to the role of the researcher and limitations of the approaches used.

Philosophical perspectives

In order to answer the research question "*How do clinician-managers in the South African healthcare system combine their clinical and managerial roles?"* I will first state the philosophical perspectives which will underpin my approach. In this section I will provide an outline of two possible stances a researcher might select with regards to foundational concepts and position my own research project relative to these concepts.

In the *SAGE Handbook of Qualitative Research,* differing approaches to research are considered in terms of research paradigms (Lincoln et al. 2018, p.108). A paradigm, in the sense it is used here, is "a basic set of beliefs that guide action" (Denzin and Lincoln 2017). To avoid confusion with other uses of the term paradigm in philosophy of science, I will refer to philosophical perspectives. In particular, these philosophical perspectives imply particular stances with regards to ontology ("the nature of reality"), epistemology ("what counts as knowledge and how knowledge claims are justified"), axiology or ethics ("the role of values in research") and methodology ("the process of research") (Cresswell and Poth 2013; Denzin and Lincoln 2017)

To clarify my own position, it is useful to compare two perspectives. The first, positivism, is likely to be familiar (or implicitly familiar) to many researchers in healthcare as well as healthcare workers, who are trained with rely on certain forms of evidence, such as clinical trials and basic sciences research, as part of their practice. The second, constructivism, describes the perspectives and approaches I have taken in this research project and which is familiar to qualitative researchers both within healthcare and other fields. I will limit my discussion to the above for the sake of clarity. Furthermore, it is important to note that no part of this discussion is to imply that a specific perspective is “better” than another, but rather to understand which view is most appropriate to the research question which I have posed. I have summarised the differences between positivism and constructivism below and will expand upon these differences below.

Table 1. A summary of the main differences between positivist and constructivist philosophical perspectives (also called paradigms by the authors) from Lincoln et al. (2018).

Aspect of philosophical perspective	Positivism	Constructivism (also known as naturalistic inquiry)
Ontology (the nature of reality)	There exists a single reality which is discoverable	That which is regarded as reality is constructed by individuals or co-constructed between persons
Epistemology (the nature of knowledge)	Knowledge is something which can be acquired, accumulated and added to and researchers can be separated from this (objectivism)	Individuals and groups can create reconstructions of knowledge and this can be added to through better informed reconstructions, but ultimately the inquirer and the subject of inquiry are bound together in this process (subjectivism)
Axiology (ethics)	As the purpose of inquiry is to study the nature of reality, values are not seen as a part of this perspective	As it is not regarded as possible to separate values from the inquiry process, values are acknowledged as an important influence on the research and researchers
Methodology (how knowledge is sought out)	The scientific method is regarded as the gold standard, and the process is therefore experimental, aiming at the verification of hypotheses	Interpretation and refinement of interpretation is regarded as an important part of the approach, and a dialectical process is central, through the resolution of disagreements by means of reasoned discussion
Methods used	Chiefly, quantitative methods are used, although qualitative methods may also be used in a manner similar to quantitative methods (for example, in order to confirm hypotheses and in seeking to establish a single, definable reality)	Qualitative methods are used, but quantitative methods may also be relied upon
Quality criteria	Rigorousness: reliability, internal and external validity	Trustworthiness and authenticity

Ontology

At the fundamental level, the ontologies, the beliefs with regards to the "nature of reality" (Cresswell and Poth 2013, p.20) of the two perspectives differ. In positivism, there is a belief in a single, discoverable reality (Lincoln et al. 2018, p.114). By contrast, constructivism entails the view that reality is either constructed by individuals or co-constructed within groups (Lincoln et al. 2018, p.114).

As part of this research project I accept that spoken, personal accounts do play a role in "constructing" a version of reality, whilst also accepting that these accounts

make reference to an independent social reality, the reality which exists between individuals (Seale 1999, p.470; Pope and Mays 2020, p.17).

In seeking to understand how clinicians in management positions combine their clinical and managerial roles, I recognised that different participant accounts would inevitably provide differing and perhaps divergent answers to the research question. By adopting a constructivist ontology, I accepted these as valid reflections of participants' perception of reality, whilst simultaneously recognising that these perceptions influenced how individuals functioned within the healthcare setting.

Epistemology

Epistemology can be defined as the "relationship between what we know and what we see" (Lincoln et al. 2018, p.115). In positivism, researchers' approach to epistemology might assume that it is possible to be completely objective and separate from the research. As such the role of the researcher might be seen as collecting, rather than co-creating (Kvale 1996, p.281), the findings of a research enquiry and to extract knowledge from the amassed information.

Within constructionism, a more subjective epistemology undergirds the approach (Lincoln et al. 2018, p.115). Here, the researcher is understood to be co-creating knowledge alongside research participants (Cresswell and Poth 2013, p.36). In this research project I participated in conversations with participants to construct a version of social reality, based on our setting (Lincoln et al. 2018, p.116). The goal of this process was to understand how individuals interpret or make meaning of a phenomenon (clinician-managers) while acknowledging that I was not simply collecting findings, but co-producing the research (Cresswell and Poth 2013, p.32).

The role of values

Values are, with regards to research philosophies, a collection of the assumptions, theories, perspectives and social or personal norms which individuals bring to the research process (Lincoln and Guba 1985, p.161). Lincoln, Lynham and Guba encourage researchers to make explicit their perception of the role of values within their research (2018, p.132). In their view, constructivism entails an acknowledgment that the researcher's values are bound up with the larger research project. This follows on an earlier critique of the positivism by Lincoln and Guba, undermining the implicitly held belief within this perspective that research is, and should be, value free (Lincoln and Guba 1985, pp.160–186).

In the opening chapter of this thesis, I wrote of a puzzling and troubling conversation I had had with a clinician-manager prior to starting the research. Through the vignette I aimed to convey that I perceived some degree of dysfunction, both in the manner which healthcare was delivered to patients within that setting and in the response (or lack thereof) which the clinician-manager gave to this situation. It is not possible to make sense of this animating incident without resorting to values. I value healthcare, primarily because it cares for the ill and secondarily because it is my profession. I value accountability from health professionals because the social contract between society and a group of privileged experts demands accountability.

Conducting research into healthcare is replete with implicit values and I have reflected on this throughout. In pursuit of this, I have made the notion of professionals and their role in society a focus of both chapters 4 and 5. I have, furthermore, devoted chapter 6 to the exploration of the normative role of clinician-managers, making the role of values more explicit.

Methodology

Justification of methods

Given the nature of the research question and the philosophical perspective within which I have situated my approach, the methods which were most suitable were qualitative in nature. Qualitative research "consists of a set of interpretive, material practices" which seek to turn "the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self" (Denzin and Lincoln 2017). The goal of this transformation is to gain an understanding of that which is being studied "in terms of the meanings people bring to them" (Denzin and Lincoln 2017). Within the domain of qualitative research, I had to decide which sources of data would be sought and which analytic approach was to be taken in order to develop an understanding of clinician-managers' experiences.

My original research plan

My original, pre-pandemic research plan was to remain open to any data which may further enhance my understanding of clinician-managers. I intended to conduct in-depth interviews as a means of studying participants' own understandings of their roles. This was then to be complemented by ethnographic observations with some of the participants, an approach which would have included gathering documents related to their day-to-day work, including anonymised communications, protocols, contracts and more.

The anthropologist Clifford Geertz used the term "thick description" to refer to highly detailed descriptions of events, places and social interactions (Geertz 1973). Others have further argued that thick descriptions also contain crucial of interpretation in

addition to these details (Freeman 2014). Through gathering and remaining open to these various sources of data, my intention with this research plan was to achieve a detailed, emic, understanding of the work of clinician-managers from their own perspective and to combine this with my researcher, etic, perspective in order to achieve a thick description (Cresswell and Poth 2013, p.94).

How my methodology changed as a result of the pandemic

I undertook my first field work expedition to South Africa between November 2019 and February 2020. There I conducted several interviews and began limited ethnographic observations. Unfortunately, as captured in some of my field notes from an early research site visit in February 2020, the spectre of COVID-19 was already emerging over the horizon. After one meeting with a clinical manager at a district hospital in February 2020, a nurse called the clinical manager to the casualty to review a patient. According to the nurse, the patient had been on a flight which was briefly quarantined, because a passenger on board was suspected of having COVID-19. The clinical manager themselves, however, expressed great doubt about this and dismissed the possibility. Shortly after I left South Africa, however, the country recorded its first official case of COVID-19.

The spread of the novel coronavirus to most of the world hereafter precluded international travel and became the chief preoccupation for many potential participants. The effect was to make the ethnographic (and the intended accompanying documentary research) component of this project unfeasible.

After a period of adjustment, I was able to continue with remote interviews with participants, however. In spite of this, it was still challenging to communicate with

and recruit healthcare managers – especially at the height of uncertainty early in the pandemic. All of the interviews were transcribed and these transcripts have served as the main data source for this project.

In order to supplement the interviews, which were now my chief data source, I also included documents which some participants highlighted or referred to as being particularly important or influential with regards to their role combination. With a few exceptions, such as a contract or an induction presentation at a regional hospital, these documents were resources available to the public, including books and academic articles. These documents were not, however, as comprehensive and illustrative of everyday work for participants as might have been achieved as part of ethnographic work. Instead, they were incorporated into the analysis when participants made reference to these in order to contextualise quotes.

Although this represented a deviation from the original research plan, the data have still allowed me to generate an answer to the research question which I posed at the outset. However, in order to do so I have had to remain adaptable as the circumstances required. Despite the challenges posed and uncertainty which pervaded the early months of the COVID-19 pandemic, the in-depth interviews I was able to conduct have still allowed for a detailed and rich study of clinician-managers in South Africa.

Researcher identity

Qualitative research in constructivism holds that all positions are perspectival – that is, there is no 'view from nowhere' and the data gathered will inevitably be influenced by who is gathering them and how the interviewees see the interviewer. An important

aspect of my own identity which I bring to my research is that I was trained as a clinician. I spent six years studying medicine as an undergraduate, followed by two years of work as a full-time doctor in an internship programme in primary and secondary care. This was followed by nine months as a community service medical officer in a rural part of South Africa. I had conducted some mixed methods research during my time as an undergraduate and clinician, but immediately prior to joining the DPhil programme, I had been working in full-time clinical practice. During this period of training, I worked in settings where clinicians were managers and this both influenced my interest in this topic and began to shape some of my early views on clinician-managers.

In conducting the research, and also in interpreting the data, I thus drew primarily upon my identity and experiences as a medical doctor. This clinical perspective created a very specific interpretive lens. During my DPhil journey I learnt some analytic techniques from the social sciences which supplemented this clinical perspective. I am aware that my final analysis is primarily that of a clinician, informed by social science theories.

Researcher identity cannot simply be reduced to education and training. As Guba and Lincoln have argued, reflexivity is a critical reflection on the "self as researcher" and the "human as instrument" (Lincoln et al. 2018, p.143). Part of this is recognizing other salient aspects of identity, including age, ethnicity, language, socio-economic class and more. However, reflexivity also includes being self-aware about the dynamics these identities might create between me and participants, but also to scrutinise my own responses and assumptions throughout the research process

(Finlay 2002). Later in this chapter and at other points in this thesis, I will describe how I engaged in this process and how it affected my own stance.

Justification of analytic approach: thematic analysis

Choosing an analytic approach required that I consider the type of data which would be available to me as well as my own background as a clinician and researcher. Crucially, the analytic approach I chose would also influence both how and when I would engage with theory. Qualitative analysis can proceed in different manners, depending on the relation between the data and theory. One approach is induction (also described as a data-driven approach) where the research attempts to remain grounded within the data and not to use existing theory and terminology so as to remain open to unexpected sources of insight in the data (Gioia et al. 2013, p.9; Kuckartz and Rädiker 2019, p.96). An alternative approach is deduction (also described as a concept or theory-driven approach), where concepts from the existing literature or a specific theory are used as categories into which the data are coded (Kuckartz and Rädiker 2019, p.96). Finally, a mixed approach which relies both on the data as well as concepts from theories, and is thus both inductive *and* deductive, can also be taken. Due to prior epistemological assumptions and familiarity with theoretical concepts, it has been argued that inductive research is usually also somewhat deductive (Braun and Clarke 2006, p.86). As my research question emerged from encountering clinician-managers in my clinical work, rather than from proposed or actual application of a specific theory or framework, my research was bound to be inductive to a certain degree. However, as I planned on utilising relevant social science theory to describe and understand the data and to engage iteratively

in a cycle of refinement of my interpretations (Ritchie et al. 2003, p.255), my research would also be deductive.

Thematic analysis is a method used for identifying and organising “patterns of meaning” across different sources of data (Braun and Clarke 2012, p.1947). In thematic analysis, these patterns of meaning are referred to as themes.

I chose thematic analysis for two main reasons. Firstly, it is compatible with both an inductive and deductive approach, including the combined approach described above. Indeed, as Braun and Clarke note:

> *[R]esearchers cannot free themselves of their theoretical and epistemological commitments, and data are not coded in an epistemological vacuum.* (Braun and Clarke 2006, p.84)

Braun and Clarke have described this iterative refinement of the analysis, which can alternate between induction from the data and deduction based on appropriate theory, as reflexive thematic analysis (Braun and Clarke 2020, p.7). This is in contrast to codebook thematic analysis (which is more deductive) and coding reliability thematic analysis (which is concerned with notions of accuracy and reliability and thus more positivist).

Secondly, thematic analysis is an accessible research method. It provides a systematic approach for undertaking qualitative research, and relating findings to existing theory (Braun and Clarke 2012, p.1951). Using thematic analysis, I would be able to analyse the data descriptively, but also in an interpretative fashion, seek out latent meaning in addition to “surface” level semantic meanings (Braun and Clarke 2019, p.594). This process of refinement and interpretation would require the incorporation of relevant theory, followed by revisiting the data. Thus, thematic

analysis is well suited to the theoretical position of this research, my skills as a researcher, and to make use of relevant theories.

The importance of theory

Theory can be viewed as “an abstract description of the relationships between concepts” (Varpio et al. 2020, p.990). As mentioned above, theory was a vital source of additional insight and of developing a deeper understanding of the latent meaning both within and across interviews.

I posed the research question and approached the interviews in an open fashion, without attempting to impose or test a particular concept or theory beyond the foundational concepts: there were clinicians being appointed to managerial positions. As the next chapter will explore, there are numerous ways of understanding this, including identity, leadership, power and ethics. I sought to use theories which were descriptive and explanatory, particularly in terms of “clarifying the relationships between phenomena” (Varpio et al. 2020, p.990). However, I did so only after seeking to understand the surface level meaning within the interviews (and will expand on this more later in this chapter).

Kislov and colleagues propose that social science theory can be divided into three levels, depending on the scale at which they propose to describe, explain and predict social phenomena. Such theories can be “grand”, seeking to provide a “unified theory of the social world”, which might make them difficult to falsify (such as Marxism) (2019, p.2). Alternatively, theories might either be mid-range, with a limited area of application and a stronger link to empiric observations, or programme (also called “small”) theories, which aim to provide more “concrete working models” (Kislov

et al. 2019, p.2). With regards to a reliance on theory, Kislov writes elsewhere on the importance of finding a balance between the “empirical question, ‘What is going on here?’” and the “theoretical question, ‘What is this a case of?’” (2019, p.177). In each of the empiric chapters, I have firstly summarised the findings, providing an answer to the first question. I then followed this with theorisation, drawing from preceding related research, and also introducing other theoretical concepts with the aim of answering the latter question.

Methods

Ethical considerations and research approvals

My ethical considerations focused chiefly on protecting the anonymity of participants and ensuring the well-being of participants during and after the interviews. Interview transcripts are therefore anonymised to person and place, with further information altered as deemed necessary, such as references to years of graduation or commencing a post.

I was cognisant that in-depth interviews with healthcare workers may have to focus on difficult experiences and was explicit during the briefing of participants that they were free to decline to answer questions, terminate the interviews or withdraw from the research at any point. Problems of this nature were not encountered during the research process.

Another concern was what should be done if I was made aware of practices which might harm others or possibly be illegal. It was agreed that this would be discussed *ad hoc* with my supervisors, one of whom is an experienced South African doctor. Discussions of this nature were not necessary.

This research was approved and categorized as minimal risk by the Oxford Tropical Research Ethics Committee (OxTREC reference 542-19) and approved by the University of Cape Town Human Research Ethics Committee (reference 439/2019). Further provincial department of health approvals were applied for and granted for the three provinces in which the research was undertaken, including the Western Cape, Eastern Cape and Kwazulu-Natal, subject to approvals by the managers at each of the facilities, where relevant.

Sampling of interviewees

This research made use of a combination of snowball and purposive sampling. Potential participants were identified by means of orientation interviews with clinician-managers who were already familiar to myself or one of my supervisors (who is a South African doctor and former clinician-manager). As part of the interview process, participants were asked whether they could nominate another clinician-manager or key informant who would be able to provide another perspective on the research question as they understood it.

In seeking a varied sample, participants were specifically also asked to nominate individuals whose experiences or perspectives would be different from their own. This allowed for multiple differing accounts of certain aspects of the research question (such as being a clinician-manager in a rural district hospital). However, possibly due to professional networks, participants tended to suggest peers who were similar to them in many other regards (such as age, training and region). To overcome this, I conducted further orientation interviews and approached several participants purposively to include persons with experiences in specific settings

(such as being a manager in a regional or tertiary institution or being a nursing manager).

Prior to the pandemic, I had sought to recruit participants in two categories. Index participants had to be clinicians (that is, health professionals), who had both a clinical and managerial role (which could include administrative or clinical governance roles) in their organisations. The goal was to allow for ethnographic observations in multiple settings of the participants' work. The purpose of the "index" label was to differentiate observed participants from those who were only interviewed. A specific consent form for index participants contained additional information about ethnographic observations. However, due to the global pandemic's impact on health services and international travel, the ethnographic component could not be included. I have, however, retained the index and secondary participant numbering in reporting of results, as I had already collected most of the index participants at that point.

Participants for whom ethnography would not have been possible, or who were identified as key informants either by other participants or myself, were categorised as secondary participants. Most of the secondary participants were clinician-managers with whom ethnography would not have been possible, or who were no longer working as clinician-managers. Some of the participants were included as key informants due to either their experiences (having been acting clinical managers, or working closely with a specific clinician-manager), or their knowledge about an aspect of the research (such as the establishment of certain specialty training programmes).

The value of this flexible approach was to allow me to include participants who could elaborate on emerging findings (such as the role of specific specialties or professional backgrounds) as I identified them in the concurrent data analysis. The final sample on which this thesis is based contains a varied set of experiences which may not have been included if a strict, pre-defined set of inclusion criteria had foreclosed the admissible sources of data.

Early in the research process, I recognised that medical doctors, nurses and other health professionals followed different, only partially overlapping, career paths when it came to managerial roles, largely influenced by their professional background.

Prior to the pandemic, I was spending several days at a health facility as part of recruitment and preparation for ethnography. This allowed me to establish rapport with a wide variety of staff, be introduced to them by colleagues (often another clinician-manager) and give potential participants time to consider participation. Once I was no longer able to visit facilities, this gradual introduction was lost. While I was not having success in recruiting many nurses or allied health professionals, I was exploring numerous experiences amongst medical practitioners, who continued to suggest yet more medically qualified clinician-managers with particular experiences. Due to the practical and time limitations of this research project, this required that I make a purposive decision with regards to the sample. On the one hand, I was discovering a great deal of depth and breadth among the experiences of medical clinician-managers, yet I was aware that these accounts might differ substantively from those of their non-medical clinician-manager colleagues.

After purposively interviewing two senior nurse managers with the particular focus on understanding how the nursing and medical experiences differed, and after further

difficulties in recruiting rehabilitation professionals, I made the decision to focus on the cohort that I was able to recruit – largely that of medically qualified clinician-managers and related key informants. Furthermore, I was aware of the opportunity cost of interviewing healthcare workers and managers during a pandemic. My decision to rely on the participants who were available to me, rather than potentially disrupt service delivery as part of a wider sampling strategy, was also the result of ethical considerations. It is important to emphasise, then, that my major findings relate mostly to medically-qualified clinician-managers.

Within this cohort, I have aimed for as varied a sample as possible with regards to career stage, region, rural versus urban, level of care, ethnicity, gender and further qualifications. The sample spans the breadth of the healthcare system, ranging from primary care to tertiary level facilities. Several participants have held multiple positions at various facilities and were encouraged to reflect on how these roles differed and contrasted.

Sample size

Some qualitative researchers rely on a data saturation threshold to determine their ultimate sample size. The concept of data saturation was originally proposed by Glaser and Strauss as part of the grounded theory approach (Malterud 2012, p.801), but it is not fully compatible with constructivism (Braun and Clarke 2021b, p.202). Data saturation can mean different things. Concept saturation implies that either the researcher has ceased to encounter new concepts during the data analysis and can thus describe the remainder of their sample in terms of “information redundancy” (Braun and Clarke 2021b, p.201). Theoretical saturation implies that the sample and subsequent analysis has so thoroughly described the phenomenon that a theory can

be proposed (Morse 2015, p.588). Braun and Clarke have critiqued the concept of data saturation as positivist, in that it implies that there are finite concepts or a definitive theory awaiting discovery (2021, p.221), and therefore that it is incompatible with the ontological and epistemological underpinnings of constructivism.

The question, then, is how one might determine an appropriate sample size for a qualitative research study. Braun and Clarke suggest that sample size may ultimately be a pragmatic decision. Thus considerations such as the complexity of the data, whether the research question has been answered, and whether different accounts have been collected and analysed influence the number of participants (2021, p.211). Other authors have also emphasised the importance of "outlier" or "negative" cases in data collection and analysis (Pope et al. 2006, p.66). Malterud and colleagues have provided a systematic approach to considering these and other factors. They proposed the concept of information power to determine the adequate sample size of a study (2016), with higher information power requiring fewer participants. This is summarised in the table below.

Table 2: Study factors which increase or decrease the information power and thus influence the decision regarding sample size from Malterud et al. (2016).

Aspect of the study under consideration	Factors which decrease information power	Factors which increase information power
Study aims	Broad study aims	Narrow study aims
Sample specificity	Study participants have very little in common	Study participants belong to a specified target group with specific experiences, with some variation
Use of theory	Study does not use existing theory	Study applies existing theory to analysis
Quality of dialogue	Communication between researcher and participants lacks clarity or there is difficulty establishing rapport	Strong and clear communication between researcher and participants
Analysis strategy	A wider variety of different cases are studied using a cross-case approach	A limited number of purposively selected cases are studied

My primary study aim, to understand and theorise the role combination of clinician-managers in the South African healthcare setting, contains elements which are both broad (clinician-managers within the healthcare system more broadly), and narrow (a specific focus on South Africa and the question of role combination or hybridity). I have discussed the varieties of experiences I encountered early in the recruitment process and explained how this influenced by decision to focus on medically qualified clinician-managers, thus increasing sample specificity and information power. My use of existing theory to describe and explain aspects of the results also served to enhance information power, as did the in-depth interview approach alongside my familiarity with the setting. Finally, the purposive sampling approach I followed, seeking to include participants (or cases) whose experiences both overlapped (for example, in aspects such as position or training background) and differed (for example, in terms such as hospital size or age), also served to enhance information power.

Malterud and colleagues further suggest that, in addition to considering the information power of a study, one should consider whether the study has offered “new insights that contribute substantially to or challenge current understandings” (2016, p.1759) and that analysis of the data approaches completion when there are clear, “coherent stories” within an “information-rich” data set (2012, p.801). These are the criteria against which I have weighed the analysis and theorisation of the chapters in the next part of this thesis and which guided me in determining the final sample size.

Conducting the interviews

Initially, interviews were conducted in-person and later remotely as a result of the pandemic. Interviews were audio recorded and then transcribed and anonymised to person, place and other significant identifying information.

Initial interviews made use of a topic guide, which contained specific questions regarding the participants' background, day-to-day work and decision-making. This was largely intended to aid me in enquiring about topics, which my literature review had suggested might be important. This was also to assist me in the transition from clinical interviews, which are aimed at discovering specific information, to a more open style of interviewing, which does not immediately seek to categorise the participants' responses (Hunt et al. 2011, p.193).

Although the topic guide did introduce valuable avenues for discussion, the introduction of new questions interrupted participant narratives and limited the depth which interviews were able to achieve. The solution was then to move away from the topic guide and to pose the research question to participants, clarify their understanding of it and engage with their responses, as suggested by Britten (1995, 311).

For each interview, I would explain the interview format, my own role, and my intention to hear the participants' responses. I would then ask the question, "How do clinicians in management positions combine their clinical and managerial roles in the South African healthcare setting?". I would often clarify words such as clinician (health professionals such as doctors or nurses), or roles (what is expected from someone) if the participant asked or expressed hesitation. This "problem-focused"

approach (while noting that the research question is not a “problem” as such) was to focus the interviews on the research question (Rädiker and Kuckartz 2020, p.13) and to limit the introduction of routine, less-informative questions amidst the richer uninterrupted participant narratives.

This approach could take the form of a personal account, based around the individual’s own background as a clinician who had later acquired various management roles. If the participant paused, I would summarise what I had heard and sometimes repeat the research question in some form, especially if a narrative appeared to have concluded. The repetition and summary also allowed me to check whether I had understood the participant narrative in their estimation. This sometimes prompted a new narrative, a clarification, or an example illustrative of something which had been said before.

Analytic method

Chiefly, I followed a reflexive thematic analysis approach (Braun and Clarke 2006; Braun and Clarke 2020; Braun and Clarke 2021a; Braun and Clarke 2021b), and complemented this with other manuals on applied thematic analysis (Rädiker and Kuckartz 2020, p.15). The table below explores how I applied these approaches to my analytic process.

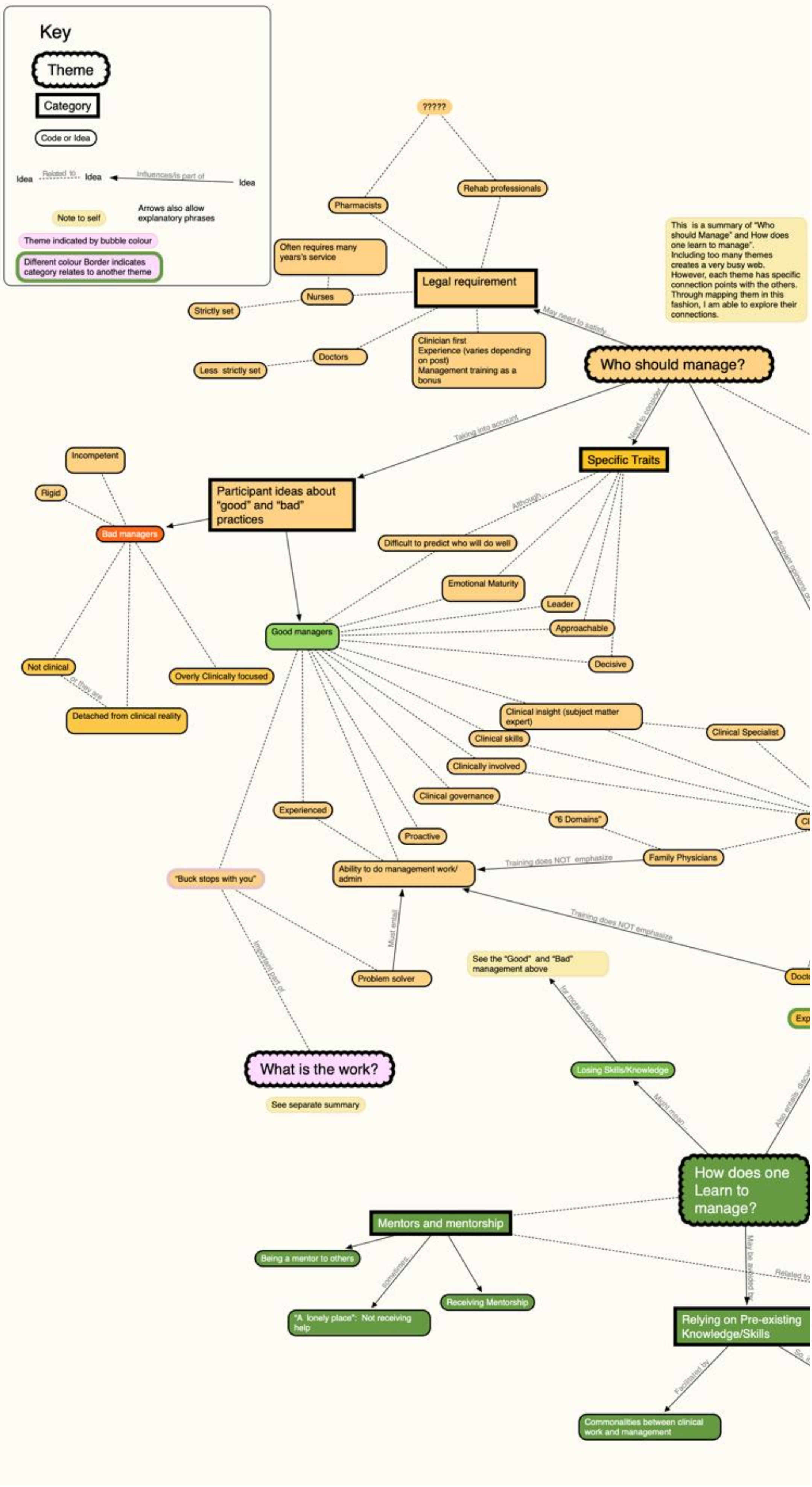
Table 3: Application of thematic analysis in my research, based on Braun and Clarke (2020) and Rädiker and Kuckartz (2020).

Phases of the thematic analysis process	**Notes**
Data familiarisation and writing familiarisation notes	After conducting the interviews, I read and re-read the transcripts. During this time, I kept notes in a research journal and made notes in the CAQDAS software (MaxQDA).
Systematic data coding	I coded each of the interviews line by line. As I proceeded with the coding process, I began to group similar codes into categories.
Generating initial themes from coded and collated data	As the code book expanded, I started to group the remaining codes into categories and group similar categories into preliminary themes. Throughout this period, I continued to code additional interviews and would create new codes and categories as necessary.
Developing and reviewing themes	Once I had developed the preliminary themes, I would keep notes on the themes and discuss these themes with my supervisors. At this stage I began to engage with research literature regarding the themes in order to make sense of them. I also produced visual summaries of the codes (see below) and explored the relationships between themes, categories and codes.
Refining, defining and naming themes	I drafted several thematic summaries, combining and refining the thematic groupings. Ultimately, these summaries collated into three main documents, each with distinct sub-themes. These were “Learning to Manage”, “What is the work” and “The normative role of clinician-managers”.
Writing the report	Each of these summaries underwent extensive drafting and redrafting. Although I had begun to engage with the research literature earlier in this research process, I now proceeded to theorise the results, and to compare and contrast them to other published studies. As these summaries developed further, they became the three empiric chapters around which the thesis was based.

With the aid of a computer assisted qualitative data analysis software MaxQDA, I coded the transcripts line by line. My aim was to be thorough and systematic in terms of coding every meaningful aspect of the interviews. As coding proceeded alongside the conduct of further interviews, codes were collated and revised using a constant comparative approach on the available interviews in an iterative manner. This yielded a comprehensive codebook which contained numerous categories of codes.

Code categories and their content were explored, searching for patterns of meaning related to the research question (Braun & Clarke, 2006, p. 82). Through this process, several potential thematic groupings were explored using multiple methods, including visual representations and narrative summaries. The figure below shows a draft

diagram, functioning as a “thematic map” (Terry et al. 2017) or “one sheet of paper” (Ziebland and McPherson 2006) summary, depicting early codes and categories and how they were related. I continually relied on my experience as a clinician, orientation and research interviews, as well as specific questions posed to participants to evaluate the codes and categories which I was creating.



Key
Theme
Category
Code or Idea
Idea
Related to
Idea
Influences/is part of
Idea
Note to self
Arrows also allow explanatory phrases
Theme indicated by bubble colour
Different colour Border indicates category relates to another theme
?????
Pharmacists
Rehab professionals
Often requires many years's service
Legal requirement
Nurses
Strictly set
Doctors
Less strictly set
Clinician first
Experience (varies depending on post)
Management training as a bonus
May need to satisfy
This is a summary of "Who should Manage" and How does one learn to manage".
Including too many themes creates a very busy web.
However, each theme has specific connection points with the others.
Through mapping them in this fashion, I am able to explore their connections.
Who should manage?
Need to consider
Taking into account
Specific Traits
Incompetent
Rigid
Participant ideas about "good" and "bad" practices
Bad managers
Although...
Difficult to predict who will do well
Emotional Maturity
Leader
Good managers
Approachable
Decisive
Not clinical
Overly Clinically focused
or they are
Detached from clinical reality
Clinical insight (subject matter expert)
Clinical Specialist
Clinical skills
Clinically involved
Clinical governance
Experienced
"6 Domains"
Proactive
Family Physicians
Training does NOT emphasize
Ability to do management work/ admin
"Buck stops with you"
Training does NOT emphasize
Must entail
See the "Good" and "Bad" management above
Problem solver
Important part of
for more information
What is the work?
See separate summary
Losing Skills/Knowledge
Might mean
Also entails
How does one Learn to manage?
Mentors and mentorship
May be avoided by
Being a mentor to others
sometimes
Related to
Receiving Mentorship
"A lonely place": Not receiving help
Relying on Pre-existing Knowledge/Skills
Facilitated by
Commonalities between clinical work and management

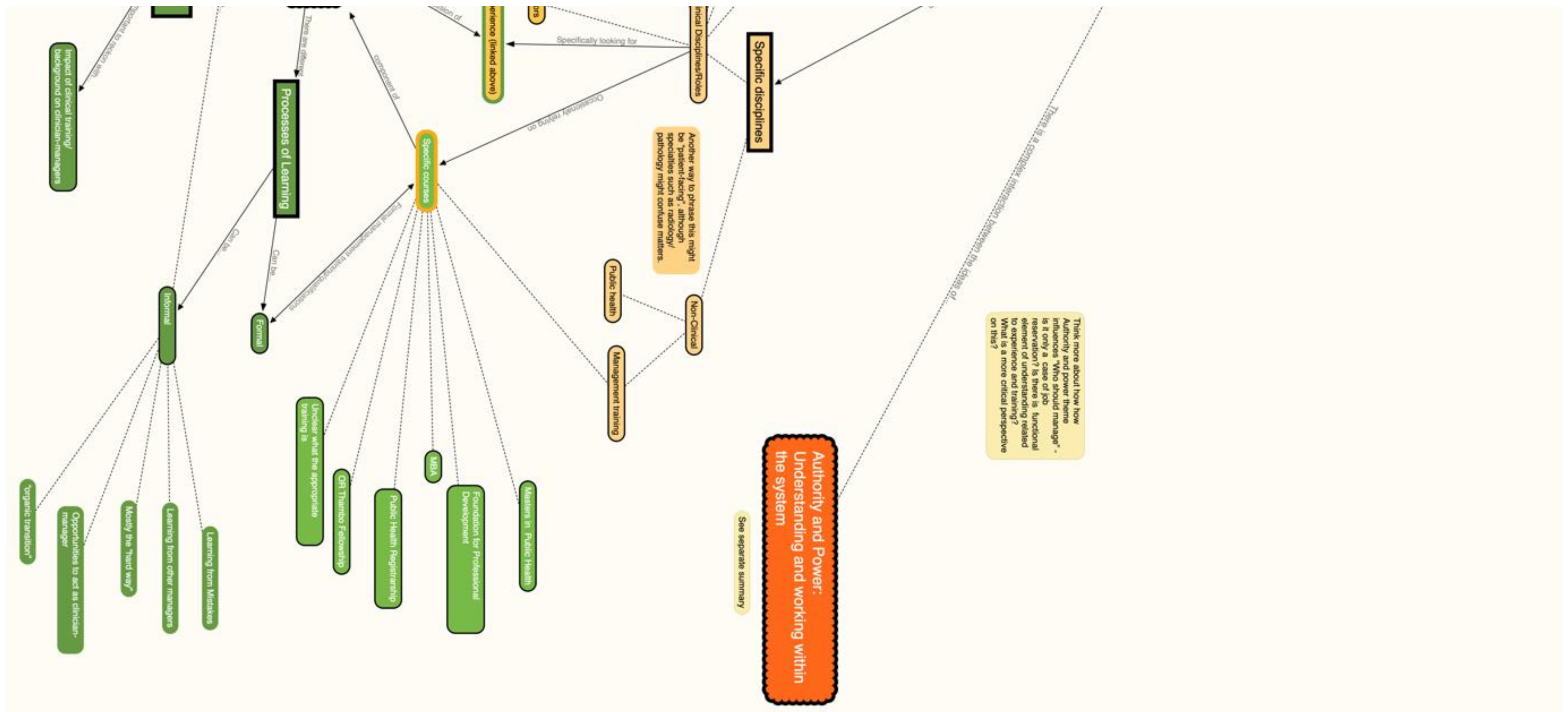


Figure 1: A draft map (enlarged over 2 pages) of themes from early 2021, exploring both the content of and relationships between possible thematic groupings of the data. This draft assisted in the creation of early draft summaries, which were then refined through writing and re-drafting of the texts.

These themes were then reviewed by considering how they assisted in answering an aspect of the research question, how they overlapped and related to other themes, as well as whether their content formed a coherent narrative. I paid careful attention to the plausibility of the themes as I was coming to understand them, relying on my experience, testing my understanding in concurrent interviews, and engaging with relevant bodies of literature.

I used this iterative process of "refining" themes (Braun and Clarke 2020, p.4) also to achieve as much analytic "depth" as possible (Ziebland and McPherson 2006, p.409). This allowed me to move from a descriptive summary of the data, through codes and categories, to larger coherent groupings. Some of these themes do still have a fair amount of surface level description, but much of this process also allowed theorisation of latent meaning – a process which continued iteratively as each theme was developed into a chapter, drafted and redrafted. The resultant themes, functioning as "central organising concepts" (Braun and Clarke 2019, p.589) are further developed and their content analysed both descriptively and theoretically in the chapters hereafter.

Analysing narratives

In the process of creating themes, I also sought to create an analytic narrative in order to "tell the story" of each theme (Clarke and Braun 2014, p.7). Having found the meaning *across* interviews, I also remained aware of meaning within interviews and the need to maintain fidelity to these. This was especially the case in chapter 6, which concerned moral narratives which defied illustration with shorter quotes.

Instead, in order to faithfully illustrate these narratives, chapter 6 made use of longer quotes from selected participants, which conveyed the richness and complexity of the broader participant accounts which informed the chapter. Petty has emphasised the importance of appreciating a “core story” in a narrative alongside thematic analysis, and the potential this can have as an educational resource (Petty et al. 2018). In writing her own empiric work on moral dilemmas among clinician-managers in the UK, Shale used narratives to illustrate her own findings, which they had synthesised using grounded theory (Shale 2011, p.264). As the use of narrative is more applicable to one chapter, this is discussed in further detail in the introduction to chapter 6.

Reflexivity

I have approached reflexivity in this thesis, not only as a recognition of my starting position, but also a process of engagement with the research and the results as I was analysing and constructing them.

I am a medical doctor and as such trained in a strongly positivist scientific tradition. Adjusting to a more constructivist approach to research has been a continual and ongoing process. This has been facilitated by engaging with the qualitative literature and developing an understanding of the limits of positivist and empiricist approaches to studying healthcare management. Realising what might be missed by certain research approaches, such as surveys and frameworks, has encouraged me in adopting a qualitative approach.

As a South African, I may have understood some aspects of the health system and the delivery of healthcare more than an outsider might have. However, this similarly

may have limited the degree to which I notice the peculiarities of an environment which I had largely come to take for granted. In this instance, spending time abroad and engaging with a different health system, that of the United Kingdom, has assisted in making a familiar environment feel “strange” once more, a crucial step towards studying it (Fillery-Travis and Robinson 2018).

Recognising my position in South African society is also an important aspect of understanding the research process and my findings. As a white, Afrikaans-speaking man, I was positioned relative to each of my participants in a particular way and embedded in a history of relations beyond our individual interactions. Whether I was similar or different to participants or potential participants in terms of ethnicity, language, gender, or profession, would have played a part in the responses I received and I recognise that. Given the centrality of the researcher in qualitative research, this is a limitation of this study and one which future researchers can attempt to overcome by departing from different positions.

It was also clear that my position and identity may have been influencing the responses I was receiving as part of the recruitment, sampling and interview process. Being invited to participate in a research study on clinician-managers by a white, male doctor from the University of Oxford may have influenced the willingness of certain participants to participate in the research. This was part of my experience in person, and could also have affected responses from electronic invitations to participate.

As part of this ongoing process of reflection, I was interviewed by one of my supervisors, Steve Reid, (SR) prior to commencing data collection, and they posed several reflexivity-focused questions to me. This interview was transcribed and only

reviewed and analysed after data collection and analysis had been completed. The transcript largely focuses on what I expected to find as well as what might affect my findings.

SR commenced the interview with the question:

> *What is it that you are expecting that they will say to you and what do you think that the data is going to show? - SR*

In response, I outlined a possible “spectrum”, ranging from positive views of clinicians in management to negative views:

> *I suspect that I will find probably different groupings of different opinions on the combination of clinical and managerial skills and my suspicion, or my expectation, is that that would probably fall around a spectrum of how they view that from positive to negative. So, my anticipation would be that there would be a group of clinicians who believe that the clinical orientation is very important for doing any sort of managerial work within the healthcare setting, and that is really the core of what it is about to them and that if anyone has to do management it must be clinicians because non-clinicians cannot be trusted to do management.*
>
> *And then I think on the far other side of the spectrum I expect to find either clinicians or non-clinicians who would hypothesise that management is a skill in itself, which must be learned and cultivated, and that the clinical orientation is not necessarily an asset in that setting, and that a clinical orientation may actually hinder effective management and that management … is a generic skill which can be transferred for example from business and that the management of the facility should not necessarily or even should not at all be done by doctors. – Jacobus Kotze (JK)*

Here, I outlined an anticipation, largely informed by different strands in the existing research about the appropriateness of having clinicians or non-clinicians in healthcare management. I oversimplified each stance as a far point on a “spectrum” in order to juxtapose them, but also to imply that there are likely to be many gradations of each view, moderating the extremes.

The interview also showed an expectation that “stories” and “experiences” would play a role in influencing participants’ views:

> *I wonder if that [their views on healthcare management] would be influenced… by thinking… in the abstract or whether people would be heavily influenced by their experiences, and what the particular backgrounds were of the people who shaped their own view on this. - JK*

I spent some time speaking about the individuals' own background and position in the system, and therefore the capacity in which they might interact with clinicians and managers might influence their views. For example, that a non-clinical manager or researcher studying health systems might come to hold views strongly influenced by their training and position, but also by the particular individuals they have encountered in clinician-manager roles ("the people who shaped" the views).

Upon further probing by SR, I acknowledged how oversimplified the spectrum was and how it did not answer the research question, leading to the speculation that there might be different ways in which the presumed "tension" between the clinical and the managerial role might be resolved:

> *I think there would be a variety of ways in which this tension between clinician role and managerial role will be interpreted and what I would think is that that would take the form of stories … So the one could be ethics… What is one's ethical duty?... Your clinical role, what to do for this patient right now and tension between as a manager you have to manage the facility or the resources for the small population that you have to serve.*
>
> *The other one would be… What is your identity?... For many clinicians there is probably this beginning as a clinician and then one gradually starts to migrate towards managerial [roles]. - JK*

This quotation introduces two threads by which the clinician-manager role can be (and, indeed, has been) analysed: ethics and identity. That these are theoretical approaches already in use, shows the impact of the literature review on my preconceptions at this point, but also that I had judged these as plausible theorisations.

During the interview I also speculated on possible reasons that clinicians might take on the managerial role, including “seniority”, “job satisfaction”, “meaning”, and seeking to make an “impact”, as well as considering the role of “leadership”.

Noting the addition of so many dimensions, I reflected on how “inadequate” the simplistic polarity presented at the start of the interview was. In response to this, SR drew a diagram based on my description, outlining the multiple aspects to the clinician-manager combination I expected to find, situating the increasingly complex “wheel” of polarities inside “environmental” influences. This impromptu diagram is reproduced below:

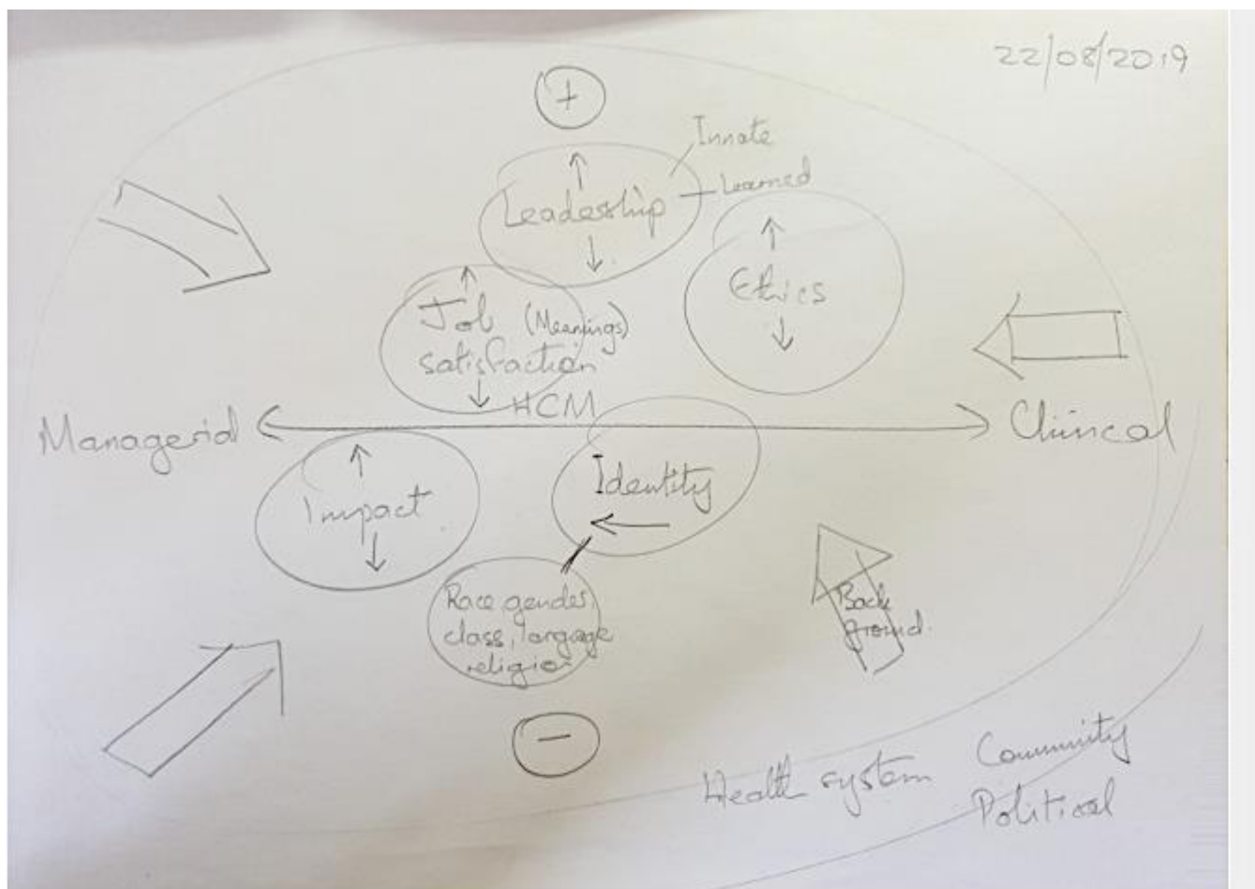


Figure 2: A framework of possible findings drawn during the reflexivity interview.

Moving away from the anticipated findings and more to the role of positionality, I reflected on the role of identities more broadly in the research context:

> *Class, race, gender, language, sexuality, cultural background, religion… they permeate every single one of the other aspects…*
>
> *On the one hand [there is] my own identity as a white male doctor of relative privilege… and also if people see you as a researcher coming from Oxford, that reinforces all of those roles. - JK*

Here, I reflected on how my perceived identities might influence what responses I was likely to receive, prompting the interviewer to ask:

> *So you're going to be blind to some… potential data? - SR*

To which I responded:

> *People will not want to disclose some part of [their experience] … but it's good to reflect on it and to realise that it is unlikely that I would be able to get the complete picture no matter how many people I interview on this. - JK*

This exchange highlights how, as an interviewer, I would always be bound to the accounts provided by my participants (if relying on interview data). I accepted that I was influencing these accounts as they were related to me, in line with the constructivist perspective described at the beginning of this chapter.

That the anticipated findings outlined in this interview reflected the relevant literature as I then understood it, as well as my own experiences and intuitions, shows that it is not possible to approach qualitative research free from "bias" or preconceived ideas. However, that the anticipated findings overlap only partially with the findings in the following chapters, illustrates that the research has also been an inductive process, driven by the data, yet influenced by the researcher and the existing literature.

Conclusion

In this chapter I have positioned this thesis within the larger theoretical landscape of qualitative research. In doing so, I laid out the ontological and epistemological positions inherent to a constructivist philosophical perspective. I have also made the

role of values explicit by emphasising their centrality to this project. I have also provided a detailed account of how I selected particular sources of data, methods of analysis and demonstrated how I have used these methods to produce this thesis. The researcher is a co-producer of research findings and as such, entailed in this have been a focus of reflection throughout my time researching this topic. The reflexivity sections in this chapter, and in other parts of this thesis, are an illustration of my engagement with this important area, but this does not imply that reflexivity can be separated from the rest of the research process. In this chapter I have therefore provided the foundation for the remainder of this thesis and the analyses which follow.

Chapter 3: Introduction to literature

This chapter provides a general background to this research and has been kept intentionally brief, because additional literature is covered elsewhere in the thesis. Each of the empiric chapters (4, 5 and 6) draws on a distinct research tradition. For clarity, the relevant literature to each of those chapters has been summarised within those respective chapters. The topic covered in this overview chapter is the concept of clinician-manager.

Clinician-managers in South Africa and other settings

In this study I have defined a hybrid clinician-manager or simply a clinician-manager as someone who combines a "professional background with a formal position in management" (Spehar et al. 2014, p.2). This is also the definition used by other authors studying hybrid professionals and hybrid clinician-managers in general (McGivern et al. 2015; Giacomelli 2020).

Professions are "closed collegial, self-regulating expert occupations" (McGivern et al. 2015). Professionalism refers to the "set of institutions which permit the members of an occupation to make a living while controlling their own work" (Freidson 2001, p.17). Healthcare is populated by various clinical professionals, such as doctors, nurses, rehabilitation professionals and others whose occupational circumstances fit the above descriptions. These clinical professionals are sometimes referred to simply as clinicians (Spehar 2014, p.15) and that is the sense in which this term clinician is used throughout this thesis.

The term "hybrid clinician-manager" or "hybrid" is used by some authors to refer specifically to clinician-managers who still practice as clinicians (Parbhoo 2020, p.iv;

Imran et al. 2021, p.7) as opposed to clinician-managers who do not participate in ongoing clinical practice. This conflicts with a more general use of the term “hybrid”, denoting something of mixed origin. Clinically practicing managers are included in this study alongside those who are not actively engaged in clinical practice, but who bring a clinical background to the position. In this research, I have referred to the participants I have interviewed as clinician-managers: they are clinicians who are also managers. They are “hybrid” clinician-managers as they combine two things: a clinical background (with or without ongoing clinical work) with the role of a manager.

The history of clinician-managers is likely to be highly dependent on the development of local (that is, national and regional) norms, regulations and legislation. According to one author, the appointment of a clinically qualified person as the manager within a healthcare organisation is said to be the results of three factors: clinicians use most of an organisation’s resources, they are a powerful decision-making group used to a high degree of autonomy and having a clinician in this role would allow for more control over clinicians (Brandis et al. 2016, p.16). The position of clinician-manager places individuals at the intersection between two “divergent” collections of goals: those of clinicians and managers (Kippist and Fitzgerald 2009, p.1). In this role, clinician-managers are expected to “act as the junction between the professional and managerial domains” and to work across various boundaries (Giacomelli 2020, p.1624). A 2020 systematic review of the role of hybrid professionals in the public sector included 57 studies, of which 43 focused on the healthcare sector (Giacomelli 2020, p.1630). The review found that most studies on hybrid professionals were qualitative in their approach, which the author concluded suits the phenomenon under investigation. The reviewer also grouped the papers into three groups, based on their analytic approaches: studies that

understood hybrid professionals in terms of logics (which I will discuss below and in more detail in chapter 5), studies that analysed hybrid professionals as undergoing a change in identity, and studies which sought to understand the enabling conditions for hybrid professionals.

One strand of research on hybrid professionals explores the implications of this liminal position on individuals' felt and perceived professional, managerial or hybrid identity (Giacomelli 2020, p.1633). Changes in identity, as well as the "identity work" of clinician-managers has been the analytic approach for several European studies (Hartley 2012; Spehar 2014; McGivern et al. 2015), as well as in other LMIC settings (Nzinga 2016, p.28). In the South African context, the identity transition for nurse managers in primary care has been studied, with the authors concluding that the development of a leadership identity may be beneficial in performing a managerial role (Daire and Gilson 2014). Identity doubtless plays an important role in the transition from clinician to clinician-manager, but this theoretical approach did not fit the empiric findings of this thesis.

Another finding from the literature on hybrid professional managers is that of enabling conditions. This concept is related, according to Giacomelli, to Mintzberg's proposition that professionals "require little direction" and instead require "support" (Mintzberg 1998, p.146; Giacomelli 2020, p.1636). Some of the research into this support takes the form of identifying barriers to clinicians engaging in management (Kippist and Fitzgerald 2009), or of the introduction of specific measures such as meetings or forums to enable clinician-managers to act as effective managers of fellow professionals (Quartz-Topp et al. 2018). These forums relate to the formal and

informal learning processes relied upon by clinician-managers, and I will return to this in chapter 4.

As part of this summary of literature, it is also important to note that the studies and reviews cited include research on clinician-managers in a variety of contexts. Observations from one context, such as the UK, Australian or Kenyan healthcare system, might not readily apply to the South African public healthcare setting. I have remained mindful while referring to studies conducted in a particular setting, that the findings described are at least in part influenced by contextual factors. In this chapter I have aimed to provide an overview of the literature on clinician-managers more broadly and as such, I have cited studies from numerous settings. Although I provided background to the South African healthcare system in chapter 1, I would like to emphasise select contextual factors.

One author writing about the South African healthcare system described “the crisis of ineffective management, incompetence and failure of leadership and governance at all levels of the health system, exacerbated by a general lack of accountability” (Rispel 2016, p.18), and this was described briefly in chapter 1. Some of the research on hybrid professionals, particularly hybrid clinician-managers, has emphasised the role of clinicians in resisting market-based reforms (Giacomelli 2020; Numerato et al. 2012). These have been characterised as initiatives which make the public service more market-oriented with the aim of becoming more cost-effective (Getacher and Bardill 2013). South Africa has maintained, at the healthcare facility level, a model of “amateur management”. (Stewart and Wolvaardt 2019). Directives have been made to reserve positions for healthcare professionals as preferred candidates for hospital management positions, with management training

an “added advantage”(National Department of Health 2012). Where market-based, so-called “New Public Management” style reforms have been made in other low- or middle-income countries, such as Kenya, other researchers have found these to have limited impact on mid-level management in healthcare (Nzinga, Mcgivern and English 2018, p.184).

Previous research has shown that clinicians have limited knowledge of administrative processes and have to undergo significant amounts of learning in order to act as managers, with two studies from Australia have suggested that this lack of knowledge may contribute to reluctance to engage in management (Kippist and Fitzgerald 2009, p.10; Imran et al. 2021). However, what has received less attention has been an exploration of individual preferences for clinical work. Although some studies have noted that clinical work can be a source of meaning and satisfaction (Berghout et al. 2017; O’Connor et al. 2002), clinicians’ desire for clinical work has been framed by others as a means of maintaining legitimacy or credibility (Imran et al. 2021; Spehar et al. 2014). Part of individual-level preference and regard for clinical work, however, may also be the result of a complex interplay of perceptions and is further explored in chapter 5.

Leadership and management

My research largely draws from the stream of research which focuses on clinician-managers and considers the approaches used to understand professionals, in particular clinicians, in management roles. This research might sometimes also be described as “leadership” research (Berghout et al. 2017, p.2). There is a substantial overlap between leadership and management as concepts in the research literature,

with various authors suggesting definitions for leadership as compared to management in healthcare (Grint 2010; Spurgeon et al. 2015).

However, in a review of management and leadership literature, Nienaber demonstrated that the two concepts overlapped substantially in how they were conceptualised by various authors (2010, p.669). Furthermore, one systematic review of 34 studies on medical leadership found that only two of the included articles had provided a definition for leadership, the very concept they were studying (Berghout et al. 2017, p.8). In contrast, the same review found that studies on medical management referred simply to doctors in management positions, with or without ongoing clinical roles.

Several scholars have surveyed the leadership and management literature and attempted to provide definitions and taxonomies of leadership, and to distinguish it from management (Parry and Bryman 2006; Yukl 1989; Lyons 2021). Writing about the dichotomy between leadership and management, Lyons concluded that although leadership broadly includes the activities of management, the concepts can be seen as overlapping yet distinct roles, which “need not necessarily reside in more than one person” (2021). For the purpose of Lyons’ research on medical leadership development programmes, he used a “pragmatic definition” of leadership, citing Blake and Mouton, which he described as “achieving results with and through others” (Blake and Mouton 1985 as cited in Lyons 2021, p.18).

Doherty conducted a literature review on clinical leadership and management with a focus on applying findings to South African public hospitals and defined leadership as being “about developing a values-based vision and direction for an organisation, motivating and inspiring members of that organisation to implement the vision,

aligning the efforts of various members, guiding the organisation through periods of change and instability, and developing and empowering followers". In contrast, she defined management as being "more about achieving stability through planning and operational problem-solving, including developing concrete plans and budgets, setting targets, and marshalling and organising resources" (2013, pp.7–8). This latter definition of management overlaps with the activities participants sometimes informally referred to as "admin" (see chapter 5). However, as I demonstrate in many other parts of this thesis (for example, chapter 6), clinician-managers also described some challenges as distinctly values related (what I have called normative) and some did not view their managerial role in such limited terms, lending further credence to the overlap between management and leadership as concepts described above

The research question I posed when embarking on this research aimed to understand clinician-managers, whether or not they satisfied specific criteria to be referred to as leaders. As such, the participants I included were mostly (or had previously been) appointed to or had acted in management positions[3], or provided insight with regards to the emerging data, in line with the constructivist approach I described in the previous chapter

The concept of clinician-manager was used and the literature which referred to the same concept was drawn upon throughout, where appropriate. However, as there is a substantial overlap in the concepts of leadership and management, I have also drawn upon the clinical leadership literature where appropriate. This was especially

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[3] In the introduction to the next section, the various titles for some clinician-managers in the South African healthcare system will be considered.

the case for the concept of "moral leadership", as proposed by Suzanne Shale (2011), which was instrumental in theorising the findings of chapter 6.

Key studies on clinician-managers

Parbhoo conducted interviews with 12 clinician-managers in a tertiary hospital in the Western Cape province of South Africa, which was published as a masters thesis in 2020, after my own research project had begun. The intention of her study was to "explore the managerial experiences of senior clinical staff at a tertiary academic hospital to understand how well-equipped… hybrid managers are to manage people", due to the fact that "most hybrid managers in [that] setting do not have formal management training" (Parbhoo 2020, p.16). As such, her study focused on management preparedness, competencies and opportunities, as well as challenges by thematically analysing in-depth interviews.

Among the challenges faced by these clinician-managers, Parbhoo listed "negotiating the bureaucracy" (dealing with "the large administrative burden" that comes with the managerial role), as well as inadequate training whereas ongoing clinical work was regarded as a source of ongoing job satisfaction, positive relationships with subordinates, and up-to-date knowledge (Parbhoo 2020, pp.62–63). As such, the author made a series of recommendations, focusing on providing support to recently appointed clinician-managers in the form of induction, training and mentorship and to move away from the "sink-or-swim" experiences described by some of their participants.

My own research aims to build on these findings as well as to introduce descriptive and explanatory theory to the existing understanding of clinician-managers. Although

my research also uses qualitative methods, it differs from the above in a few important ways. My own sample was not limited to tertiary hospitals or the Western Cape, as noted in chapter 2. Secondly, as discussed above, I included participants who were full-time and part-time managers, and did not exclude those who had had short, recent, or acting appointments as managers, as I chose not to presuppose that ongoing clinical work was necessarily more influential than clinical training and prior clinical experiences. These differences notwithstanding, I will return to Parbhoo's findings throughout this thesis as they provide a valuable source of additional insight and data regarding the South African healthcare setting from an author experienced in many aspects of its function.

Another important set of work to consider is that of Nzinga[4], who initially set out to study the function of district hospitals in Kenya, and how health workers influence efforts to improve or otherwise change services. However, after realising that "clinical team leaders" or "mid-level managers" were "pivotal" in service delivery, they changed their focus to studying these individuals (Nzinga 2016, p.5). Nzinga's work, which formed their doctoral thesis aimed to study the factors influencing evidence-based practices district hospitals, but also in later papers studied "hybrid clinical managers"[5] themselves.

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[4] For an overview of Nzinga's work, I am referring to the narrative summary they provided as part of their doctoral thesis, although throughout this thesis I will cite several papers which they have written alongside colleagues. Hence in this section, I am referring largely to this author's work as an individual, but later in this thesis, I will refer to their and their colleagues' contributions as listed in various journal publications.

[5] This author variously refers to mid-level managers, middle-level leaders, clinical mid-level managers, department leaders, and clinical team leaders to refer to clinicians in management positions. I will refer to clinician-managers, the term I use throughout this thesis.

Nzinga offers more than one analysis of clinician-managers in the LMIC context. Using methods such as literature review, interviews, focus groups, observations, and ethnography across multiple health facilities in Kenya, she studied frontline health workers as well as clinician-managers within these organisations. Her analysis and use of the term institutional logics is most relevant to chapter 5 of this thesis and I will describe this body of work in more detail in the literature summary of that section. To summarise briefly, however, Nzinga draws on the concept of institutional logics ("frames of reference" which shape, enable and constrain an individual's decisions, how they make sense of the world, and their "sense of self and identity" (Giacomelli 2020, p.1631)) to argue that clinical professionals who enter into management must reconcile two competing institutional logics: clinical logic and professional logic (Nzinga 2016, p.41). As part of her ethnographic work, she expanded upon an existing typology of hybrid clinician-managers (McGivern et al. 2015), from willing (those who embrace management) and reluctant (those who resist), to include ambivalent (those who are either in transition or truly ambivalent) (Nzinga 2016, p.42; Nzinga, Mcgivern and English 2018, p.179). The hybridisation between these logics was considered in terms of the identity transition of the clinician-managers, as well as through their negotiation with various types of norms (such as official, local and practical) (Nzinga 2016, p.43; Nzinga, McGivern and English 2018). In this thesis, the latter analysis focusing on norms was most appropriate to the participant narratives and will be explored further in the chapters that follow. The ways in which these processes occurred were linked, according to the author, to the absence of orientation and training available to clinician-managers.

Whereas Parbhoo's and other clinical authors' research stem from a perception of a lack of management training and competency among clinician-managers, Nzinga's

research also sought to understand the role clinician-managers play in influencing healthcare organisations, particularly through understanding their motivations, the institutional logics governing them, and their identities, among other concepts. Nzinga's use of ethnography in addition to interview data, as well as a focus on organisations for portions of their research, yielded valuable insights into the role of clinician-managers in the healthcare system, particularly the LMIC setting.

My own approach to clinician-managers is informed by the advances presented here, as well as by other pieces of information. In the introduction, I noted that my interest in clinician-managers started upon noticing excellence as a clinician might not translate to excellence as a manager. In terms of context, my research is also influenced by an understanding of the South African healthcare system: in particular the paradox that clinicians are not trained as managers, but expected to fulfil certain management positions, both informally and formally.

With an awareness of the numerous strands of research into clinician-managers and the adjacent streams of research which can be drawn upon to understand clinician-managers, I sought to frame my research question in as broad terms as possible, and then engage in an ongoing inductive-deductive analytic process, where I engage with the existing literature alongside my findings. As this chapter demonstrates, there are numerous theoretical approaches in use to describe, explain, justify, and sometimes question, the role of clinicians in management. The subsequent chapters will present my own findings and demonstrate how I have contributed to this body of literature. I have done so while drawing on particular theoretical concepts and referring back to the empiric work of other authors to demonstrate the relevance of my analysis.

Part 2: Empiric results and theorisation

Overview of dataset

In chapter 2, I provided a detailed description of the methods and sampling approach I used in gathering these data. Below, I provide an overview and description of the dataset, with select explanations for certain features of the dataset.

Interview dataset

The main dataset consisted of 33 in-depth interviews which were transcribed and analysed as described in chapter 2.

Table 4: Characteristics of participants

Characteristics of participants (n=33)	**Number**
Men	18
Women	15
Professional background	
Medicine	29
Nursing	4
Specialty/Other relevant background or qualification	
Family Medicine	12
Public Health	6
Masters in Business Administration	3
Emergency Medicine/Critical Care	2
Surgery	1
Sector	
Public	32
Private	2[6]

[6] One of the participants had worked as a clinician-manager in both private and public hospitals.

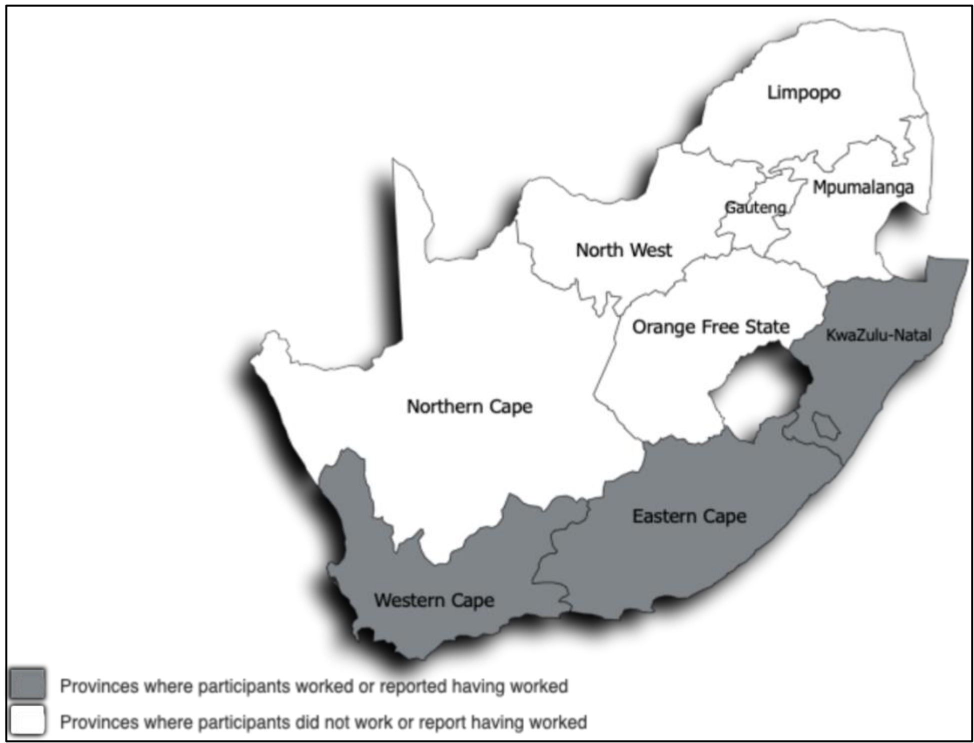

Figure 3: Map depicting South Africa's nine provinces, with the shaded regions indicating where participants worked or reported having worked in the past during the interviews.

Table 5: List of Participants

Participant Designator	Description	Notes
IP0A (Pilot interview number 1)	Former manager at a district hospital, family physician	
IP0B (Pilot interview number 2)	Former clinical manager at a district hospital, former chief executive officer at a private hospital	
IP1	Clinical manager of a district hospital	
IP2	Former clinical manager at a district hospital, family physician with clinical governance roles. Acting clinical manager when IP1 is on leave (shared with SP1 and 2)	
IP3	Family physician at a district hospital with clinical governance roles. Supports IP4 in various capacities	Interviewed as both a clinician-manager and colleague of IP4, suggested by IP1 and IP2
IP4	Clinical manager at a district hospital	
IP5	District clinical specialist in family medicine	Functions in a supporting role to clinicians and managers in her district for both clinical and managerial issues. Also has managerial responsibilities as part of her role as a district clinical specialist
IP6	Clinical manager of a private hospital group. Background in emergency medicine	
IP7	Family physician in a district hospital	Supports IP8 through various clinical governance roles. Specifically identified by SP4 as an important person to interview
IP8	Clinical manager at a district hospital	Specifically identified by SP4 as an important person to interview.
IP9	Head of clinical unit at a regional hospital	
IP10	Until recently, an acting clinical manager, and then-current family physician at a primary healthcare clinic	Previously trained by IP9 with whom they have an ongoing mentor-mentee relationship
IP11	Former chief executive officer of a primary healthcare clinic and clinical manager in a regional hospital	
IP12	Head of division of surgery in a large hospital	
SP1	Family medicine registrar and acting clinical manager at a district hospital	
SP2	Family medicine registrar and acting clinical manager at a district hospital	
SP3	Medical doctor and head of a clinical research unit	Interviewed as a key informant as recommended by SP1 and SP2
SP4	Former medical superintendent at a district hospital	
SP5	Family physician	Interviewed as a key informant to understand the role of the family physician in terms of managerial and clinical governance
SP6	District family physician responsible for clinical governance	Has held numerous managerial responsibilities before. Recommended during orientation interviews with other clinician-managers

SP7	Medical manager at a tertiary hospital	
SP8	Head of primary health care for a subdistrict	
SP9	Deputy head of nursing at a district hospital	
SP10	Former medical superintendent at a regional hospital	
SP11	Former medical superintendent at a district hospital	
SP12	Medical manager at a tertiary hospital	
SP13	Former clinical manager at a district hospital	
SP14	Head of department at a regional hospital	
SP15	Medical manager at a tertiary hospital	
SP16	Former medical manager at a district hospital	
SP17	Medical manager at a tertiary hospital	
SP18	Head of nursing at a tertiary hospital	Purposively approached in order to understand how nursing and medical careers with regards to managerial roles overlap and differ
SP19	Deputy head of nursing at a tertiary hospital	

The heterogenous titles and roles of clinician-managers in South Africa

In this thesis, I aimed to study the phenomenon of hybrid professionalism, specifically as it applies to clinician-managers in South Africa. I set out with a purposefully broad approach as I expected results which varied across time (in individuals' careers or the eras in which they entered into or advanced in their capacities as clinician-managers) and location (the district, province, size and focus of the facilities they found themselves in). Within my constructivist approach, I was seeking different perspectives and as a qualitative researcher and looking for patterns of meaning *across* the dataset. As such, this study did not set out to identify systematic sources of variation among clinician-managers. However, given this approach and the systematicity of my analysis, I still became aware of prominent differences from one interview to the next. These observations were usually presented as part of longer participant accounts and I did not always have the opportunity to ask follow up questions about these elements. The interviews mostly focused on a single overarching question, "how do clinicians in management positions combine their clinical and managerial roles in the South African healthcare system". Although many accounts were rich in contextual data, I did not routinely

gather data on a set of pre-defined criteria (such as number of years in their role, the qualifications they held for the role, size of the facilities they managed or had managed), and instead allowed them to include, add or clarify the details relevant to their narrative, assisted by my own summaries or questions. As is attested by the detail of this thesis, the narratives were rich in content and have allowed me to formulate a multi-faceted answer to the overarching research question and that is the focus of the chapters which follow. However, in order to address the question of heterogeneity, I have summarised a few of the differences across interviews below.

There was variation with regards to managerial titles, including clinical manager, medical manager, chief executive officer, head of clinical unit, head of division and more. Some of these posts were fully managerial, with either no clinical role, or a clinical role as part of after-hours duty (or “overtime”). Others were part-time managerial and clinical, with varying “splits” between the clinical and managerial components. There was heterogeneity, it seemed, from region to region in terms of the scope size of a role’s accompanying responsibility, as expressed by one participant, who was a medical manager at a tertiary hospital:

> *You will have clinical managers that are clinically managing a certain component… it differs at a regional level where a clinical manager could... be for a certain component. For instance, orthopaedics or internal medicine, you might have a clinical manager, but … they've changed that into head of clinical units of respective disciplines.*
>
> *A medical manager will then overlook all the components [which are managed by clinical managers or heads of clinical units]. [This] is different to a District Hospital, because there are no heads of clinical units there, so you rely only on clinical managers and a medical manager.* – IP12

This short extract is illustrative of how the managerial hierarchy varies by region, but also over time. Another position which has also been replaced over time has been that of medical superintendent.

Whether certain posts existed on hospital organograms, also differed based on the size of the hospital (in terms of bed capacity), as stated in the *Policy on the management of public hospitals* gazetted in South Africa in 2012:

> *Due to the size of the small district hospital [with less than 150 beds], it will be unnecessary and an absolute waste of resources to have both a CEO and a Clinical Manager. For this reason such hospitals will have a CEO as a medically trained person to serve as both.* (National Department of Health 2012, p.9)

This excerpt further illustrates that the titles given to clinician-managers could vary considerably depending on the facility, while not necessarily denoting characteristics of the role.

Several interviews were conducted at district hospitals, where family physicians were the most specialised medical personnel and held some degree of managerial responsibility. Family physicians are a relatively new medical specialty in South Africa, recognised by the government in 2007, with specialty training introduced thereafter (Hellenberg and Gibbs 2007). Some participants in this study had completed this specialty training, whereas others had been recognised as family physicians when the specialty was established as a result of previous work and education.

Furthermore, family physician appointments were regarded as partially managerial posts at some facilities, as family physicians would be expected to take on a portion of managerial work (split with a medical manager) in the absence of a clinical manager being appointed. Other participants, however, held no specialty beyond their medical qualification.

One participant commented on what they perceived to be the split between clinical and managerial work at their previous and other workplaces for district hospital clinical managers:

> *A clinical manager usually is 80% [administrative]. I think they are doing at [another hospital] 80% admin, 20% clinical. So just a little bit of a clinical function… I think basically so that they don't lose their skills, but I was the other way around and that was just not enough. – IP2*

A clinical manager (IP1) at a district hospital commented on what his role entailed, saying "there is very little that I don't think of that was in my job description". A clinical manager at a regional hospital, spoke of his own responsibilities thus:

> *…The only time I'm actually in contact with patients right now at a Regional Hospital where I'm working as a [clinician] is when I am doing my overtime and that is when I'm actually in contact with the patients. But other than that, I'm mostly involved in all medical management issues that has to do with how we run our facility and all the meetings that are associated with patient safety incidents with management of complaints with making sure that we provide adequate services for our employees to be able to function at their duties. – IP12*

Another participant shared their contract as a family physician, which outlined a role which would be majority clinical, with a substantial "clinical governance" and a minor "clinical training portion" role. Furthermore, the contract stated that "in the absence of a clinical manager, certain human resource administrative functions relating to rosters (calls, leave, allocations)" would be also a required output. This participant worked without a clinical manager for an extended period prior to the facility appointing one, fulfilling these and other staff management functions during that time.

The above quotes come from or relate to participants who had reported working in all of the provinces studied and at facilities ranging from district to regional hospitals. Even if I had limited my participants to clinical managers (a specific cohort of

medically qualified clinician-managers), there would have remained variation in the expected division of work between clinical and non-clinical work and the kinds of activities which fell to these individuals. Given the dataset available to me, it is not possible to comment on whether there were factors which systematically affected the scope and size of a clinician-manager's managerial workload, or how closely these reflected their job descriptions or individual's role in the organogram. Overall, the *variability* of these role was particularly noticeable across several interviews.

Documentary dataset

The documents gathered as part of the research process were chiefly used as contextual information to further understand participant narratives. These included regional protocols, contracts, job descriptions and correspondences before or after interviews. Several books or scholarly articles were referenced by participants, including various popular books on leadership development. These were read for background context, but not systematically analysed.

The Guidebook for District Hospital Managers (de Villiers M, Couper I, Conradie H, Hugo J 2005), which was referenced by several participants, was included as a data source alongside interview transcripts due to its relevance to the research question. This 96 page text was developed by the Health Systems Trust in South Africa as commissioned by the North West Province Department of Health. It is based on published research, as well as interviews conducted with district hospital managers in several provinces, with the resulting draft having been further reviewed by a panel of senior managers. The aim of the guidebook is to "assist the hospital management team in assessing the critical elements for the efficient functioning of a district

hospital" and "instituting action plans". The authors also emphasise that this resource would be relevant at healthcare settings beyond the district hospital.

Chapter 4: Learning to manage: strategies for enacting a clinician-manager role

Chapter summary

Those interviewed had followed heterogenous routes from their clinical careers towards more managerial posts, and this influenced much of their subsequent experiences. Analysis of the interview data revealed three broad strategies relied on by clinician-managers to enact their managerial roles.

Utilising clinical knowledge and experience, and claiming to rely on a clinical approach more generally, is the first of these. However, this strategy had its limitations, as some managerial knowledge is required and there are crucial challenges to translating the clinical method to management. As an additional two strategies, clinician-managers therefore turned to formal and informal learning paths. Interviewees referenced wide ranging management, administration or leadership courses, degrees or specialty programs. Several emphasised, however, that theory and practice could differ substantially. Informally, clinicians stated that they learned to manage through trial-and-error, through watching others and through mentors.

This chapter makes use of the notion of street-level bureaucracy, as well as functional, power and institutional lenses in order to analyse these findings and discuss them relative to wide-ranging scholarship on clinicians in management and the professions more broadly. Each approach yields its own insights into the strategies relied on by clinicians in enacting their managerial roles. These lenses also point to the organisational and societal factors which should be accounted for, and enriches our understanding of the transition from clinician to manager.

Summary of literature relating to this chapter

A number of empirical studies and theoretical lenses are relevant to this chapter. This section both summarises the background literature to the research and the theoretical approaches which will be applied to the results.

Several authors, in the South African setting and others, have written that clinicians in management report feeling underprepared for management roles (Imran et al. 2021; Parbhoo 2020; Giacomelli 2020). This lack of preparation is thought to contribute to clinicians' reluctance to engage in management (Kippist and Fitzgerald 2009).

Research on learning in the workplace distinguishes between formal and informal learning. Formal learning can be understood as being prescribed or organised, having an appointed trainer or teacher, resulting in a qualification (or some form of recognition) and having a specific objective and outcome (Manuti et al. 2015, p.4). Informal learning is learning which occurs outside classroom settings; it can be incidental, experiential or possibly involve a mentor or team (Manuti et al. 2015, p.5).

Tied to the process of professional learning is that of socialisation, specifically with regards to the formation of a professional identity and habitus. The concepts of habitus and field, originally developed by Pierre Bourdieu, have been used to understand clinicians in healthcare management or the doctors in "the lead" (Witman et al. 2011). Whereas "field" refers to the external, social world in which the individual finds themselves, habitus refers to the "internal model of social reality" which results from socialisation (Witman et al. 2011, p.482). In this context, the "patterns of behaviour, manners and beliefs" or "second nature" which are shaped by a clinician's

training and experiences are part of a professional habitus (Witman et al. 2011, p.482).

Another approach through which to view the combination of user-facing and organisational roles for an individual, is that of street-level bureaucracy (Lipsky 2010). In this framework street-level or frontline civil servants, have to exercise discretion in terms of service delivery, using various strategies such as screening, labelling and obstructing users' attempts to access resources (which include themselves). This, Lipsky argues, is an attempt to make their jobs manageable in the face of overwhelming demand and limited resources, through the exercise of discretion. The result is that a gap between "policy as written and policy as performed" which emanates from the way in which street-level bureaucrats' work is structured (Gilson 2015, pp.3–4). This framework has been applied to the South African and Kenyan healthcare settings and will be explored further in the discussion (Gaede 2016; Nzinga 2016, p.48).

In terms of specific theoretical lenses, I have drawn on three different approaches to the study of the professions, summarised in Table 3: functionalism (professional roles are more or less given and serve to stabilise society), power or critical approaches (professionals amass power and are motivated at least partly by self-interest) and institutionalism (by enacting their roles, professionals both produce and reproduce the social order). These represent various attempts at understanding the professions, from the mid-twentieth century to the present, as summarised by Muzio and colleagues in a recent publication (Muzio et al. 2020, p.8).

Table 6: A comparison of theoretical lenses with which to view the professions. Adapted from Scott (2008) and Muzio, Aulakh, and Kirkpatrick (2020).

Aspect	Functional lens	Power lens	Institutional lens
View of the professions	As "altruistic sources of social solidarity and cohesion"	As a process whereby "self-interested agents" gain legitimacy and establish a monopoly in a particular field	As "cultural producers" which give shape to organisations and "societal institutions"
Professionals such as doctors and nurses…	Are working for the public good by using their expertise. They are paid in order to do their work.	Are the beneficiaries of processes which monopolise (or medicalise) aspects of life.	Are "core societal" institutions with a "distinct logic". They are part of how we make sense of the social world.

I will use the theoretical frameworks outlined by Scott (2008) and expanded upon by Muzio and colleagues (Muzio, Aulakh, and Kirkpatrick 2020). I will also draw upon specific instances of functional and power approaches in the discussion section, in order to analyse specific findings. These theories will be further illustrated alongside the findings. As each of the terms describing a lens carries with it a history within the study of the professions, I will briefly summarise key literature influencing each lens.

The functionalist lens views professionals as possessing special traits which sets them apart from other expert and non-expert workers and is associated with scholarship from the mid-twentieth century, which drew on an idealised view of medicine and other professions such as law (Muzio et al. 2020, p.15). Although this lens has fallen out of favour as a justification for professional power within the sociology of the professions, it is a valuable lens for understanding the rhetoric which is used to justify professional hegemony and dominance (Muzio and Kirkpatrick 2011, p.4), especially in healthcare.

Viewed through this lens, portions of the medical management and leadership literature can be seen as stemming from an implicitly functionalist lens, where clinicians are assumed to be best suited to have managerial control over their

professional peers. As one systematic review demonstrated, this is not a position necessarily supported by empiric evidence. Despite several international publications advocating for clinicians (particularly doctors) to be involved in medical leadership (a term used synonymously with management by the authors), only modest evidence supported the involvement of doctors at organisational board level (with little or no evidence for their involvement at other levels), with the authors concluding that the area was “under-researched” (Clay-Williams et al. 2017).

Early sociologists of the professions not only attempted to catalogue the traits of ideal-type professionals, but also to differentiate between mere occupations and professions. This, alongside a disillusionment with the functionalist lens, contributed to a focus on processes of professionalisation, which also necessitated a focus on power (Muzio et al. 2020, p.16). In particular, the power lens incorporates the notion of occupational closure, whereby a jurisdiction is closed off to those not belonging to the profession, creating a “quasi-monopoly” (Freidson 1994, p.83). According to Larson, so-called “old” professions (such as law or medicine) perform their work in the national interest in exchange for this legal protection from competition (2017, p.xxii).

Scott also refers to this view as the “conflict” model where attention is paid to how the “obvious rewards – money, status, influence – [accrue] to winners” (Scott 2008, p.220). The tensions between the power (or conflict) lens and functionalist lens, as Scott also notes, have not been resolved, which have led him and other authors to argue for an institutional approach to studying professions.

Institutionalism (also known as neo-institutionalism to differentiate it from the early institutionalists of the late nineteenth and early twentieth century, which are not

under consideration in this thesis) requires further introduction here. Institutions are "multifaceted, durable social structures, made up of symbolic elements, social activities, and material resources" (Scott 2014). In this framework, the professions are regarded as institutions, in that they entail "social processes" which are ubiquitous, followed "without debate" and are stable over time (Muzio et al. 2020, p.16).

Larson cites Tawney with approval, when the latter indicated that while the individual doctor or lawyer may grow rich from practicing their profession, the profession makes "health, or safety, or knowledge, or good government, or good law" (Tawney 1948, p.94; Larson 2017, p.xxx). As Scott also notes:

> *[T]he knowledge claims advanced by professionals can be both somewhat arbitrary and sincerely advanced… [P]rofessional jurisdictions can be contested and changing without being a simple matter of political clout…*

This nuanced view of the professions can be incorporated into the institutional view, but this is a process which is greatly facilitated once they have been viewed through the functionalist and power lenses. Professional institutions are undergirded by three "pillars", through which the professions are further institutionalised. These pillars, the regulative, normative and cultural-cognitive, are explained in the table below.

Table 7: The three institutional pillars in neo-institutional theory. Adapted from Institutions and organisations: ideas interests and identitites (Scott 2014)

Institutional pillars	Regulative	Normative	Cultural-cognitive
Explanation	The existence and creation of specific rules, laws or sanctions serves to legitimate certain professions.	Notions of moral obligation are tied to what certain professions state to be their mission or purpose.	At an individual level, the role of the profession in a certain aspect of life (such as healthcare or illness) is taken for granted, and professionals themselves are guided by "shared logics of action".

Each of these theoretical concepts will aid in the analysis of the participant narratives and allow for a deeper understanding of the learning journeys of clinician-managers.

Descriptive findings

This section describes and contextualises the main findings of this chapter. The section hereafter theorises those findings, using three contrasting lenses, and discuss the findings with regards to the literature.

Varying transitions into management

There was a great deal of variation in how participants came to enter a managerial role. Two of the nurse participants described a gradual transition into fully managerial roles as their careers progressed, with increasing levels of responsibility and specific training available as they become more senior:

> *From a young age we are mentored in the profession and taught to progressively acquire skills in management in the profession. We have a system of you are a junior nurse, a senior nurse shift leader. And then the shift leader applies to become operational managers and then you climb the ladder from there all the way to where I am, which is the head of nursing. In that you always have in your management decisions... You must have the clinical background to make decisions that are to the best interest of the patient's care. I always say that a good manager which takes wise decisions can change systems and can improve things in the best interest of patient care…*
>
> *Doctors are not as commonly exposed to the management skills and the administration. [Nurses] are more exposed to the HR perspective compared to clinicians [doctors]...also…disciplinary and corrective procedures. I want to say that this is our daily bread, whereas for clinicians [doctors] they focus mostly on clinical care for the first eight to ten years of their profession and then later they realise that there's an HR [human resources] and a people management and administration and how… the other cogs in the system work. - SP18*

This interviewee, the head of nursing at a tertiary facility, provided a broad overview which was supported by other accounts in my dataset. The more integrated path towards becoming a manager corresponded across the narratives provided by the nurse participants.

By contrast, most doctors in my sample had not been "exposed" to formal management courses during their undergraduate and postgraduate training, only encountering these some years later. At this point, as the informant above put it, doctors encountered the various aspects of management, such as human resources, "people management" and other factors which represent the "cogs" in the healthcare system.

Some medical participants, however, did describe a process of progressively taking on various management responsibilities as they became more senior clinicians, which was later formalised when they applied for positions and were appointed as clinician-managers.

> *Generally when the doctors make their switch... it is not that they are a clinician up to point A and thereafter they become administrators...*
>
> *I joined this hospital as an Intern and then I was a medical officer and during that time I did my postgraduate studies at the university that's attached to the hospital. So I never left the hospital. And then I continued to become a junior consultant, then a consultant, then an associate prof and now I'm a professor and head of department. So what has changed? It's the proportion of things that I do in those different responsibilities. Those changed. When I was a medical officer maybe I did 80% of care to individual patients and 20% was other things.*
>
> *…In more senior roles… Responsibility for looking after the other components of the system becomes more in need than actually prescribing a particular medication to patient. - SP14*

This participant describes a progressive path towards gradually increasing management responsibility over the course of a career as a doctor. She illustrates the climb from intern to head of department, with intermediate steps, as one which not only saw her specialise and gain expertise, but also as moving away from clinical work (such as "prescribing" medicine) to "looking after other components of the system".

Another participant related a more idiosyncratic entry into management:

> *Where I was working [at a small hospital], we went from nine doctors down to two, so I became the medical superintendent. We [played rock paper scissors.] Who wants to be in charge?...*
>
> *It's not necessarily… [that way everywhere]. Some people tend to get the qualifications and then they get into a post. But it doesn't always work out like that. - SP13*

Some spoke of suddenly being put into a management position by necessity, as demonstrated in this quote. When their clinical team was reduced in size, someone needed to step forward and assume the role of acting superintendent. Neither he nor his colleague could decide who would be superintendent, so they left the decision to a game (although it is not clear whether the winner or loser would take on the managerial role). This event had taken place some decades ago, and SP13 added that this was not how things were usually done. However, the quote explains another narrative thread: some doctors entering management positions felt unprepared for their role as manager, a role which they “ended up” in.

Other accounts included participants’ own interests in leadership or management, with reference to past experience in such roles, or focused on an individual’s clinical experience and expertise prior to entering the role of manager.

Having explored some of the varying pathways taken into management, the next section describes the strategies used by clinicians once they found themselves in managerial positions.

Applying the "clinical method": relying on pre-existing knowledge and skills

Clinical knowledge as an asset

Some interviewees described relying on their clinical knowledge and experience. This could be useful when engaging with clinicians on detailed matters such as resource utilisation:

> *So when I asked the anaesthetists, you know, "Why is our rocuronium bill up this month?" They will start explaining to me what rocuronium is. And then I'll have to say, "No, I know what rocuronium Is. It's a muscle relaxant. And why is usage up this month? Are we doing more cases? Is there a problem with the batch?" - SP15*

This participant, a medical manager for a theatre complex, had to manage anaesthetic and surgical teams, and used his clinical knowledge as a platform from which to engage with clinical colleagues, who may otherwise not have had to account for their use of a particular, more expensive medication over alternatives.

Clinical experience also gave participants a broad understanding of the system they were managing:

> *Because I'm in managerial work as a medical manager it's really overseeing the operations of all the different units within the hospital for which medical care is provided. So it does require a clinical background to know how to organise a casualty… how to organise a triage system at casualty where people are coming in and know how to separate emergency cases from cold cases and using different codes, managing the queues and managing both the clinical and administrative [matters]. - SP16*

Being able to both understand how a system operates and how to prioritise within this system was shown here to be the result of clinical experience. Having worked extensively as a doctor in anaesthetics, this clinician-manager was able to make sense of a complex system and make changes within it. Her use of jargon, such as "triage", "cold cases", and "codes", signals her understanding of the work "on the

ground" (as others have put it). Meanwhile, her position as manager also allowed her to manage "operations" and "organise" care.

The clinical approach as a problem-solving tool

Some accounts went beyond acknowledging the usefulness of clinical experience in the managerial role. These depicted the clinical "method" or "approach" itself as a useful tool in management.

A South African guidebook on managing district hospitals, *The Guidebook for District Hospital Managers*, referenced by two of the participants, frames the work of the clinical manager using a clinical example:

> *The guidebook approaches the district hospital using the analogy of a patient who needs assessment and management. When a patient presents with a problem, the first task is to carry out a comprehensive assessment of the patient by gathering information. The second is to formulate a management plan which includes critical problems but also plans to address chronic or long-term issues. This process takes place in the health worker's environment and strives to provide quality care. (de Villiers M, Couper I, Conradie H, Hugo J 2005)*

The guidebook goes on to give detailed information on the management of a district hospital, including procedural as well as more informal advice, such as how to communicate with peers and subordinates sensitively. Here, however, the specific guidance in the manual is framed as falling into a two-step process: information gathering (akin to history taking, examination and investigations) and the formation of a management plan, which aims to address urgent and chronic problems alike.

One participant was more explicit about using the clinical approach alongside management approaches, and about the similarities between them:

> *I think that medicine really helps in management because… I still use the acronym …SOAP. I use the A and the P mostly, but literally all my notes that I*

> *keep on meetings is always … What is the summary of this the assessment and then what is the plan?...I use A and P all the time… What I have learnt …is that there isn't only one diagnosis. There isn't only one option…*
>
> *I actually find that it helps me. I think that clinicians have forgotten a lot more of the differential diagnosis and a lot of the options appraisal so these are a variety of differential diagnoses and then these are all the possible options of which doing nothing is always an option. – IP0B*

The participant IP0B's narrative on being a clinician-manager, specifically with regards to quality improvement, contains several allusions to approaches used in clinical practice and healthcare management.

SOAP is an acronym used by clinicians to assist in structuring their evaluation of patients, as well as subsequent documentation. The letters stand for Subjective, Objective, Assessment and Plan. Under "Subjective", one would record the history reported by the patient. "Objective" would record any findings from vital signs or physical examination, as well as any special investigations. "Assessment" requires the clinician to list possible diagnoses in order of likelihood (as well as other important diagnoses which should be considered even if they are less likely). "Plan" would include the required next steps to address the patient's problem, including further investigations, testing and other activities such as patient education and counselling (Podder et al. 2021).

Differential diagnosis is a term used to describe ranked hypothetical diagnoses which clinicians construct in order to come to a diagnosis. For example, a patient complaint of chest pain, followed by a history, examination, and special investigations, may yield a differential diagnosis which includes possible diagnoses such as a myocardial infarction or pulmonary embolism, ranked in order of perceived likelihood (Altkorn 2021).

Quality Improvement, which was the focus of this narrative, involves the development, evaluation and implementation of changes with the aim of improving the healthcare environment. The PDSA cycle is a widely used model and this abbreviation refers to four steps: Plan, Do, Study and Act (NHS England (NHS-E) and NHS Improvement (NHS-I) 2020).

Using these concepts, this clinician-manager illustrated how clinical evaluation and reasoning might be applied to managerial problems. She also linked these clinical concepts to other practices in management, such as quality improvement.

At a more fundamental level, another participant likened medical work to that of a detective and offered a different narrative:

> *You can't think that your job as clinical manager is to make sure that patients get the right clinical care. It's got to be broader than that. You've got to be available to help problem solve because actually, I think as doctors we are amongst the highest trained problem solvers. That is effectively what medicine is all about anyway. People bring you a set of clues. It sets you off on a process of finding more clues and you try and create an answer… and put all the clues together. We are just highly trained detectives….*
>
> *Especially in the early days I was often called upon for my problem-solving ability, not my knowledge. I think as doctors we sometimes underestimate our problem-solving ability or we want to be doctors so we focus on the doctoring, "Don't bother me with the other stuff."*
>
> *But, then the other stuff doesn't work and the system doesn't work and we get frustrated and our colleagues get frustrated because the system is not working and everybody gives up … But, actually if you could just have got out of your consulting room and looked a bit more broadly around you and seen, "Oh yes, okay I will give some time and attention to that."*
>
> *It's got nothing to do with being a doctor… So there is very little that I don't think of that was in my job description.* - IP1

Invoking the comparison of medicine with detective work, which is one also used in other settings (Rapezzi et al. 2005), IP1 created a narrative which cast medical training and experience as an approach rather than simply a body of knowledge. He

emphasised the importance of a broad approach to any issues which may impact the “system” which is supposed to deliver healthcare. In the rest of the interview, IP1 related that he and his colleagues have had to help solve problems with the facility’s sewerage system and electricity supply as part of this approach. Importantly, he noted these problems may not have had anything “to do with being a doctor”, yet were still essential for the delivery of service and as such need to be solved by whoever has the skills – and that is where the medical detective is called upon.

The limitations of relying on knowledge and skills acquired as a clinician

However, not all participants shared this view and some emphasised the importance of actually acquiring knowledge about management rather than relying on existing knowledge and skills:

> *What I would say ideally, is that managers are there to apply the clinical method to the system. So it is the exact same thing you've done as a clinician. You want to improve your patient outcomes. You want to treat as many people as possible. And the way you do that is by taking a history, doing an examination, coming up with a management plan, and following up over time.*
>
> *But to be able to apply that to the system...You need to know what in your history is important, what kind of indicators to follow. As [for] an examination, what does that mean? Often as managers that means going to the floor, asking questions, understanding the pressures that people deal with on the ground. Coming up with the management plan is always difficult on a systems level, because you need to first come to a common understanding of what the problem is. And you need to choose your indicators to measure over time. It's not like diabetes where you can just pull an HbA1$_{C}$ and measure it. You have to decide, “Okay, we want to look at headcount. We want to look at time in theatre that we are using efficiently.” And you have to follow it up over time, which means you have to have buy-in from the team. That this is the indicator that is important to us and we wanted to improve no matter what the cost.* - SP15

Whereas this clinician-manager provided support for the idea that management can work by applying the clinical method to a system, he highlighted a few challenges which might not be faced in the clinical setting. Whereas many patients’ symptoms

and signs can be linked to underlying disease processes by studying and understanding pathophysiology, understanding why operating theatres are being underutilised might not be as straight forward. This illuminates why “understanding what the problem is” poses such a challenge.

Once the problem is grasped, the next hurdle was depicted as deciding on a solution and a strategy for monitoring progress. The clinician can rely on existing guidelines or best evidence once a patient’s diagnosis is made. For example, when deciding how to monitor a patient with diabetes one can request a specific blood test known as an HbA1c. However, as SP15 pointed out, there are not necessarily agreed upon analogues to this in management. The negotiated, and possibly contested, nature of management “diagnoses” and treatment plans undermines the notion that clinicians can apply a domain agnostic problem-solving approach to managerial problems.

Another participant noted that while many clinical conditions and scenarios have protocols or guidelines for treatment, “it doesn’t always work that way in management” and that one might have “basic principles” in management, but can seldom rely on stepwise approaches.

Formal learning

Having established the use and limitations of a clinical approach, one can turn to participants’ accounts of learning. Clinician-managers had made use of both formal and informal learning opportunities, with some emphasising the former or the latter. Many participants, however, made reference to both. Although these paths are entangled in reality, they will be considered separately to aid discussion and understanding, starting with formal learning.

Discovering the “gap” in one’s training can be a frustrating experience:

> *The university is training you purely to be a clinician. You don’t really get a comprehensive understanding of what it means to run a clinical service…*
>
> *For me that was the gap, and I spent my time as a clinician trying to figure out what it is that is going wrong in the system. It just was not working. It was just frustrating. And you would hear this abstract term of management and you wouldn’t really understand what these people do... You go through a process and somebody’s got to teach you the correct way of being a manager.... Because we get taught very well how to be a clinician, but nobody really teaches you on how to be a manager unless you go into public health medicine. – SP17*

Here, a public health medicine registrar and manager was comparing her training for clinical work, to her training as a medical manager (which is part of the registrar programme). There is according to her, a “gap” between clinical and managerial training. She also emphasised that learning management is, similar to medicine, a “process”, where one must be apprenticed and shown the “correct way of being a manager”. One also sees how one specialty, public health medicine, can lay claim to management as one of its domains of expertise.

Seeking “help” through the “tools” of management

The narratives encountered around formal management training were varied and nuanced. As a whole, some form of training was seen by participants as being useful, but not a guarantee of good management. Instead, some participants emphasised the need to apply what was learned in formal training and to combine the knowledge gained with experience and “wisdom”.

Having spent much of their careers in some form of training, interviewees appeared to be open to the value of formal training for undertaking new tasks. One participant framed it as:

> *I think that management has got a certain amount of literature. A certain amount of tools… You don't have to reinvent the wheel for everything. And I think clinicians are disregarding that to a certain extent. – IP11*

This clinician-manager, a surgeon, placed high value on training as a tool to aid in her new position as head of department. In the rest of her narrative, she emphasised how valuable this training had been for her, whilst noting that it did not automatically allow one to be an effective manager.

Reflecting the varieties of experiences and settings included in this study, participants made use of a wide array of learning resources as part of their transition into clinician-manager positions. (Some of these are listed in the table below.)

One participant related that she found herself “basically running the hospital” at an early stage in her career and that she pursued further training in order to seek “help”. After specialising in public health, she noted that she had “outgrown” her role as district hospital superintendent and she moved on to managing larger facilities. This also illustrates how training can be tied to mastering immediate challenges, as well as career progression for some.

Table 8: Formal training courses and programs mentioned by participants

Specific to a profession?	Course or Programme	Provided by
Profession-specific	Specialty program in public health medicine	Tertiary education institutions, departments of health
	Specialty program in family medicine	
	Various nursing management courses at different career stages	
Non-specific	Master of business administration (MBA)	Universities
	Master's degree in public health (MPH)	Universities
	Oliver Tambo Fellowship (Health Leadership Training Programme)	University of Cape Town
	Various other: Advanced health management courses Technology literacy courses Conflict resolution courses Managerial leadership development programs Coaching programmes	Various governmental, non-governmental and private providers

Theory versus practice: the application of management knowledge

Although participants who had undergone formal training for the positions found formal training valuable, they and others expressed caveats, noting that:

> *It's not like if you've done an MBA, you are necessarily a good manager. – IP8*

This participant, a clinical manager who had not done formal management training, expressed ambivalence about this qualification among medical managers in particular. Despite his doubts, he conceded that an MBA might make someone already possessing "leadership qualities" a "better" manager.

Another participant emphasised the need for "implementation of the training", explaining that:

> *You could go to maybe a course that isn't so good but if you take what you learn a little bit and you implement it you could be better than someone who does and MBA and never ever uses it. - SP6*

Thus, the actual training, in her estimation, makes less of a difference than the ability and skill of the participant to apply what they've learned.

Some of the more senior participants described the "wisdom" or "softer skills" which were acquired through informal means, such as experiential learning, mentorship, and vicarious learning.

A head of a clinical unit provided a complex narrative, weaving together the clinical and the non-clinical, as well as formal and informal training:

> *I think most doctors, most clinicians don't read any management literature. When I was in [another hospital] 21 years ago, I did a diploma in health service management and also for a while [was] acting superintendent by default.*

> *I made a mess of [being a manager] before that in a small rural hospital. [Another manager] asked me to and it didn't go very well. I actually had a bit of burnout… because I was obviously all energy and passion and no knowledge and wisdom. I'm a clinician. I can be on call every second night. I can do ectopic [pregnancy surgeries], anaesthetics… and I've got energy. But that is not enough. You need to use your resources, discover your rhythm...* IP9

IP9 lamented clinicians' overly clinical orientation and knowledge base, and the difficult process through which "wisdom" is won. He, like several other participants, was placed into a management role "by default" at an earlier point in his career. The result of his clinical approach, which was "all energy and passion", was that he "made a mess" of being a clinician-manager when first given the opportunity to do so. Despite being a skilled clinician, able to run an emergency department, do specialist surgeries and to exude "energy", he noted his own limitations.

Learning to "use your resources" (as he went on to do a diploma in management following his first foray into management) and "discover your rhythm", was part of the "knowledge and wisdom" of being a clinician-manager, a complex mix of clinical and managerial experience, as well as formal and informal learning.

Another former hospital superintendent further reflected on the practical aspect of management, noting that the "theory is different from the practice". Discovering this through practice is the topic of the next section.

Informal learning

The informal means of learning included learning by doing, learning from others, and mentorship.

Sink or swim: learning by doing

When one former clinical manager, a family physician, was asked about the preparation he had for his role, he answered:

> *Absolutely none… The first hydrocoelectomy [I did] I just basically spoke to the surgeons they spoke to me over the phone and then I went and did that … which is not happening … like that anymore, but that is pretty much how we approached admin also…*
>
> *And I think as family physicians we are more and more trained to do these things as part of our training. [They] teach the principles [of management and leadership] and hopefully in your training, working in the hospital… over time [you] get given more and more leadership roles and that is kind of how you practice what you get taught, and that is pretty much the same way administrative management skills are grown.*
>
> *But, in the old days it was just like sink or swim. – IP2*

This narrative offers a glimpse into how clinical training once took place, and to a certain extent still takes place, in South Africa. When asked about his training as a manager, IP2 responded by saying that he had none, but was quick to add that he also had limited training as a surgeon, yet was still expected to perform procedures (such as a hydrocoelectomy – a non-trivial surgical procedure) he was not trained in. He then made explicit that in a context where clinical work is approached in a "sink or swim" (sometimes phrased as "see one, do one, teach one"), it is no surprise that management work (or "admin"[7]) is learned similarly.

In this vein, as clinical skills are nurtured through trial and error, and junior clinicians gradually become senior through experience, so too are administrative skills "grown".

[7] Terminology such as "admin", "politics" and other informal ways of referring to management work will be explored in chapter 5.

This departs sharply from notions about formal training, and this narrative shows why: for some, much being a clinician is learned “on the job”.

The emergence of formal, credentialed training for clinician managers (sometimes as part of certain medical specialties) in South Africa may come into conflict with the above process of learning, as another participant explained:

> *You can end up with difficult dynamics. The medical manager has less training than the family physician who they are managing. So the family physician reports to the clinical manager who reports to the CEO or medical manager.*
>
> *So although you are also in a sense collegially trying to lead this thing actually at the end of the day the clinical manager is the family physician’s boss and a lot depends on how the clinical manager sees things and often they [clinical managers] are career medical officers. They may have a lot of resentment of the family physician - this younger person who has done this fancy degree and thinks that they are better than them or knows more than them then there can be a degree of friction…*
>
> *If you have been trained as a health professional, what do you really know about managing resources, rational planning, budgets, supply chain, all this stuff? - SP5*

This narrative contrasts the growth view espoused by IP2, one which is decidedly informal, with the newer, formalised model of management which is implicitly or explicitly endorsed through various training schemes.

The friction described by SP5, a family physician trainer and academic, arose from the contested nature of management in these narratives. One, clinically grounded, narrative is that management is learned gradually “on the job”, whereas another holds that management, like many skills in healthcare, can be taught. Even here, IP2 conceded that the “principles” need to be taught if one is to apply them as one learns by “working in the hospital”.

These accounts do not necessarily need to be in conflict, but as SP5's account shows, organisational structures which place the formally and informally trained together might lead to "friction". One family physician, who was also an acting clinical manager, shared her contract and job description with me, which contained the following passage:

> *Depending on the experience/seniority of either of the Clinical manager and Family physician, the line of communication will be more horizontal, with close co-operation between the two. The principle is that the Family physician's line manager is the Clinical manager.* (Excerpt from family physician contract)

Even in the facility organogram, the hierarchy is a conditional mixture of formal qualifications, experience and appointed position. The expectation that there will be "horisontal" communication, but that the clinical manager will be the family physician's line manager, with the caveat that "seniority" be taken into account, is an instance of the above two developmental narratives competing at an organisational level.

Learning "on the job" can be frustrating, and "trial and error" (as put by another participant) can have serious consequences for the facilities managed in this way. Therefore, participants also relied on other means of acquiring knowledge.

"Re-enact" what "others have done": Learning from others

Participants emphasised the various ways in which they learned to manage from others. This included observing others:

> *You do pick up from other managers around you, you see examples of bad management and good management and try and learn from that. – IP6*

Implicit in this quote from a clinical manager is the need to judge what other managers were doing as good or bad and then try to distil lessons from these instances.

It was useful to have interviewed more junior staff, who could elaborate on this:

> *It is… like watching what other people have done and how has that worked…So I suppose it's… like trying to figure out what aspects I can… re-enact. – SP1*

In this account, the junior clinician and occasional acting manager (when her manager went on leave) is explicit about learning from her superiors, but trying to identify effective strategies to "re-enact" based on their outcomes.

Participants did not only learn from senior staff in their own discipline. When placed into management teams with non-clinicians, some participants reached out to these colleagues to learn essential skills from them. The narrative below, from a former facility CEO and later clinical manager at a different facility, shows the complexities of learning to manage:

> *When you come in you don't have a person that is going to sit you down and say, "This is the structure of clinical management, of medical management, and these are the expectations. This is what needs to be done. The type of meetings that we have."*
>
> *And so what people have tried to do, especially doctors that are in these positions, is to have doctors shadowing them all the time, for instance when they go on leave, they know that they leave one particular person who's going to be looking after the department when they're gone. In that way that stimulates an interest into management and also facilitates the process of handover when they leave and stuff like that...*
>
> *You need to identify people with interests in management and start introducing them to this so that they can start also acquiring the skill of knowing exactly what is expected from the medical management. And I think that it is a skill on its own to identify people who you think would be able to have these skills to be able to perform better. But otherwise, most of the people that I know have learned through doing and then the expectations at work. And most of them have never undergone any form of training*

whatsoever, and so they learned these things through reading, maybe some standard operating procedures or policies of the department…

That's what I did when I started as a CEO. I had no background as a CEO. So … I went to a computer and I found all the policies of the department. And I started reading and I used to lock myself up. If I don't understand something I'd say "give me time. I'll come with an answer tomorrow." I go to my office. I read up on the policies and I come tomorrow… I think that if you don't have courage to do that, it becomes a very complicated exercise…

When I had to run a cash flow meeting… I never learned anything about finances of how to run a hospital… and I said… to the finance manager: "You've been doing this for so long, you will be the chair of this meeting. Today I will observe." And I learned from her doing these things, starting from the beginning to the end of day three. Then I was able to stand and say I'm going to [chair the meeting]. I'm going to be asking relevant questions because I've already seen somebody doing it and therefore I'm in the better position to run through the process. But if you just come in, you look like a fool in front of people who expect you to know more. – IP12

This longer quotation spans the breadth of this section, and shows how various portions of the chapter relate to one another in a single narrative. As IP12 was not only describing his own experiences, but also the experiences of others, one is given contrasting or reinforcing accounts at different steps.

He noted that one might not have expectations or roles made clear at the start of one's time as a CEO or manager. His own experience was that of starting in the CEO position with no preparation, and having to learn while working.

However, other managers might designate a subordinate to take over their position and get this person to "shadow" them in various management roles. His role at the time of the interview exposed him to numerous other managers in clinical and non-clinical departments, where he could observe various mentoring processes and acting managers at work. He emphasised how most of the managers he knew, however, had undergone no training for their roles.

He outlined two strategies for overcoming this: one is to read guidelines and standard operating procedures provided by their department of health or facility. This was an effective strategy in his narrative as he could learn in this solitary manner. The second strategy was learning from peers with expertise, through asking for help or even delegating some tasks and watching how they perform them. Clearly, this strategy requires cooperation from one's peers as well.

Within a few paragraphs, this quotation takes one through a complex journey of learning in the life of a clinician-manager. The improvised and highly variable nature of this education is a striking feature throughout the narrative, with very limited formal processes present. The informality of learning "through doing", and the various guises of this form of learning stand in stark contrast to the comparatively regulated and formalised world of clinical work (even granting the haphazard "growing" of clinical skills related earlier).

Mentorship and coaching

Several participants raised the concept of mentorship to explain how they coped with the transition to being a clinician-manager. Some clinician-managers, who did not have mentorship opportunities in their own process of learning, were deliberate about providing this to others, framing it as mentorship or coaching.

The absence of mentoring can compound the difficulties of being a manager, as one participant put it:

> *I don't think there is any mentoring, in my experience, of people who have taken that role to… say, "Hey… these are some of the things you are going to deal with and navigate through and understand."*
>
> *Certainly, most of my experience was on the job. I tried to then share that with other people, but… I learnt mostly the hard way and I was fortunate I was in a*

> *network… When I was at the level of a medical superintendent, not so much when I was [at another facility]. There was a network of hospitals that worked together and my fellow medical superintendents, we used to talk a lot about issues and give that support, so I think that support is an important part of actually being able to manage the role. - SP11*

This former medical superintendent's own experience was that of learning "the hard way", without the benefit of someone to tell him what he needed to "navigate through and understand" as a superintendent. Eventually he was also able to rely on others in the same post at nearby hospitals for support. Even this, however, was absent at one of his postings. Where he did have the benefit of peers, he came to understand that this support was essential to being a clinician-manager. This and other participant narratives showed how a difficult process of learning could be translated into a desire to pave the way for others and make their transition into management easier.

Some of the knowledge which has to be acquired by clinician-managers is procedural, such as how to manage leave among staff, appoint new staff, maintain an adequate supply of medication and equipment and similar matters. This might be learned from reading, as IP12 related in his narrative. Some of the situations, however, are more fraught and challenging to manage.

Dealing with impaired or absentee staff was a topic returned to, particularly in one region. IP5 was a district family physician, whose role was to support the district's health facilities. She supported numerous managers without being their direct manager. Although she noted that some clinicians in management were "wise" and "manage situations so well", others only wanted to "manage the hospital and do the clinical stuff" without having to address more difficult matters. Her role would then be to help clinical managers to "tackle" complicated problems such as these.

Mentors were also cited by some as having encouraged their transition into management, through supporting specific training or applications for management positions. This, noted SP7, helped her to "see the value" in herself.

However, when mentorship was absent, this created an additional challenge for some clinician-managers to overcome. One, a surgeon who was not selected to be mentored as a manager but later went on to head her division, sought out formal management training instead:

> *So I never really received much mentorship or guidance in terms of management skills. I was never really earmarked for my position of taking over the division of general surgery. So I wasn't groomed to do that. I think it was the previous person who was the head of division, I knew him very well… He didn't see me as the person who would take over the division of surgery when he retires. So I don't really think he specifically tried to pull me in or mentor me or give me guidance. Not really.*
>
> *Whereas, clinically, working in surgery, [and in my research field]. I have very strong mentors and I have people who helped me and guided me and really showed me how to do things, but in managerial skills I would say I almost had no mentors. And I think it's the result of the clinical reality.*
>
> *So I don't think as clinicians we prioritise managerial skills as something that have to be taught or learned or developed. We… presume people will take on these roles and they will know what to do and they will do it in a sensible way. But we don't really presume that when we teach them to do surgery or to publish research. So I actually ended up registering for an MBA…*
>
> *It wasn't that I can't do the job, but I thought I could possibly do the job better [than I otherwise would]. … So I ended up doing an MBA… that has given me a lot of tools… So I do believe… that was of value for me. But to be honest, I think most clinicians, when I told them I'm doing an MBA, they all thought I was completely mad. – IP11*

The first paragraph of IP11's narrative reveals a downside to the informal processes of leadership and manager development. If one is not identified as a successor, then one will not receive mentorship. This person could contrast the strong mentorship and guidance she had received as a surgeon and researcher with the paucity of guidance she received to become a manager. She speculated as to the causes, one

possible reason being the demands from a service delivery vantage. As a woman in a specialty previously dominated by men, it is noteworthy that she did not mention gender as an influencing factor. As both surgeon and researcher, she was someone working in the field under the tutelage of others, which has allowed her to develop those skills. For management, however, the transition was not as gradual in that people were expected to "know what to do in a sensible way" despite not having the preparation afforded to trainees in surgery or research.

This contrast influenced IP11's decision to enrol for an MBA, which she framed as providing her with "tools" and "resources", as well as developing her thought processes. In spite of this clear value, however, she revealed that other clinicians may have thought she was "mad" for doing so. On the one hand this may reveal a more widespread prejudice against non-medical qualifications in general among clinicians, in favour or medically oriented ones. Alternatively, it may reflect a preference for more informal means of learning (or "growing") management, as explored in this section: relying on clinical approaches, learning "on the job" and relying on peers and mentors.

IP11's narrative is even more interesting for the explicit way in which it compares her learning journeys in the other domains of her professional life. To her, it was in contrast to her development as specialist surgeon and researcher that her management mentorship appeared so inadequate.

Summary: strategies utilised by clinician-managers to fulfil their managerial roles

The heterogeneity of the accounts described above is explained by the very diverse paths medical clinicians took into management. Some followed a set path, rising in

position until they were full- or near full-time managers. Others engaged in management in an unplanned manner, sometimes by necessity, stepping into the role either because no-one else was available or willing, while carrying on other clinical roles.

Doctors took different approaches to fulfilling their roles as managers. This can be framed as learning, as much of this pertains to overcoming novel situations faced in management. All of these can be considered as strategies to enact a managerial role.

Although the three approaches were described separately, they are each closely related. Clinical approaches on their own may be useful in some situations, but may prove to be inadequate or poorly suited to some managerial problems. These must then be supplemented through a combination of formal training and informal learning. The two approaches appear to be complementary in practice, with formal training obviating the need to “reinvent the wheel” and providing essential administrative knowledge. Informal learning (learning by doing, by watching others or through mentors) allows clinician-managers to deploy both their clinical knowledge and approaches, as well as formally gained knowledge in an effective manner. This, framed as “wisdom”, brings together the components described.

However, this harmonised depiction of the components conceals certain tensions. Clinical approaches in management may oversimplify or mismanage certain situations. Formal training may vary in quality or largely serve a credentialling purpose. This may clash with a developmental approach of “growing” managerial skills which exposes the healthcare system to unacceptably high levels of consequential mistakes as part of “trial-and-error” learning.

Theorisation and discussion: three different lenses

Clinicians in South Africa entering managerial roles find themselves unprepared for the task of managing (Parbhoo 2020, p.64). The HPCSA's Undergraduate Education and Training Committee has adapted the CanMEDS framework as part of its accreditation of undergraduate medical programmes (van Heerden 2013). One South African university lists "Leader and Manager" as among its six graduate attributes (Stellenbosch University 2013). On a national level however, it is unclear whether management (or "admin" as described later in this thesis) skills are being imparted as part of medical training. As this participant cohort's dates of graduation range widely over the past decades, it is not possible to infer the current state of undergraduate medical education with regards to non-clinical work. It would fall to curriculum planners to evaluate their current learning outcomes in light of these and previous findings.

Postgraduate training for doctors, particularly specialty training, is heterogenous in this regard. Some specialty programmes (public health medicine and family medicine) are cited by participants as having management or governance components to their curricula. Specialised courses and diplomas also exist which aim to impart management skills.

It may be possible, as certain undergraduate courses have indicated, to aspire to impart management skills across the profession. However, this might be challenged on the basis that these skills would only be actively used by a small proportion of medical graduates. In the absence of structured management experience accompanying theoretical instruction, it is unclear what the impact of such training would be in preparing graduates or specialists to actually *do* the work.

One can, in turn, consider each aspect of the findings by using a functional, power, and institutional approach. This allows for a richer analysis than might otherwise be achieved through a single approach. The applications of these lenses are included in table 4. This section returns to several earlier quotes and views them through the different lenses.

Varying transitions into management

The multitude of paths clinicians find themselves taking into management roles is, from a functional perspective, the consequence of their being well suited to management. Owing to a professional logic (or professionalism or leadership qualities more broadly) which acts as a countervailing force to balance bureaucratic and market forces in healthcare, clinicians in management are regarded as important drivers of patient-centredness (Martin et al. 2017, p.115), of quality care (Imran et al. 2021) sustainability and cost-efficiency (Berghout et al. 2017). A functional perspective justifies the placement of clinicians who are inexperienced managers into positions of management, by virtue of other important traits they possess. Consider a quote from earlier:

> *Where I was working [at a small hospital], we went from nine doctors down to two, so I became the medical superintendent. We [played rock paper scissors.] Who wants to be in charge? - SP13*

A functional lens, focused on the positive traits of clinicians, may portray this as less problematic. Clinicians understand the needs of patients and the healthcare system more broadly, and this should be the primary consideration in appointing them to management positions. However, this traits-based model which justifies the autonomy and authority of the professions, and by extension the presence of medical professionals in management positions, is now dismissed as “ahistorical”

and based on an “idealised view” of the professions (Muzio et al. 2020, p.10). Indeed, as another participant put it:

> *If you have been trained as a health professional what do you really know about managing resources, rational planning, budgets, supply chain, all this stuff? SP5*

Turning to the power lens, the rock-paper-scissors quote is viewed more problematically. Critical scholarship may not readily accept the claim that certain healthcare management positions should automatically be occupied by clinicians. With this lens, clinicians entering into management are seen as accumulating power and position themselves as an elite among clinicians and managers (McGivern et al. 2015) and this is facilitated by claiming that they alone are qualified for this role.

However, this was not the narrative encountered among participants at all. Rather, the accounts above depict a spectrum of hybrid clinician-managers, including the willing, incidental, reluctant and ambivalent (McGivern et al. 2015; Nzinga et al. 2018b).

From an institutional point of view, this can be understood as a result of the liminality of healthcare management – a space between institutions, namely medicine, nursing and management. At present, in South Africa and elsewhere, the role of healthcare manager can be contested, but the institutional pillars favour clinicians for these roles. Under the regulative pillar, these roles are sometimes reserved for clinicians or persons with further qualifications in a field (such as a specialist surgeon) (National Department of Health 2012) or as the potential scope for a medical specialty (Dudley et al. 2013).

Normatively, health workers are, by virtue of professionalism and professional values, seen as acting in patients’ best interest (Michalec and Hafferty 2013).

Clinicians are explicitly and tacitly favoured as candidates who would act appropriately in these positions. Through an institutional lens, the above quotation is interpretable in a manner which is kinder to clinician-managers themselves: they are forced into management positions due to factors beyond their control or even awareness.

Applying the "clinical method": Relying on pre-existing knowledge and skills

Here, some participants articulated a functional perspective of what a medical professional's contribution to a management position might be:

> *I think as doctors we are amongst the highest trained problem solvers. That is effectively what medicine is all about anyway. People bring you a set of clues it sets you off on a process of finding more clues and you try and create an answer that and put all the clues together. We are just highly trained detectives. -IP1*

This hypothetico-deductive model of medical problem solving is well-described (Trimble and Hamilton 2016; Rapezzi et al. 2005). In this account, clinicians' training has prepared them for problem-solving and logical thinking more broadly.

This is explicitly articulated in several of the accounts, and in the guidebook for clinical managers. If this is read as a justification of clinicians' suitability to management roles, this can be another example of traits-based, idealised views of clinicians. However, these quotes also demonstrate a functional view of the clinical method itself. The clinical approach is painted as a broad problem-solving tool, characterised by systematicity and decisiveness in the face uncertainty or limited information.

Even in the participants' own accounts, however, there are problems with translating the clinical approach to management. On the one hand, clinical methods may need

to be distilled to such a conceptual level so as to lose all distinctiveness, as seen in the two-step approach outlined by the handbook for clinical managers. When the specific steps of the clinical approach are followed, however, the problem may be finding appropriate equivalents to various stages of clinical evaluation. What counts as a thorough history or valid special investigation? Finally, even if a diagnosis or differential diagnosis is made as part of the assessment, multiple participants indicated how ill-defined management solutions could be when compared to evidence-based or protocol-driven actions sometimes required in clinical practice.

The functional view, therefore, contains within it the seeds of a more critical view through the power lens. One could critique the accuracy of the hypothetico-deductive model in medical reasoning. One way of doing this would be by showing the prevalence of bias or non-systematic reasoning in real-life clinical decisions (Saposnik et al. 2016; Stolper et al. 2011) thus calling into question whether this really is a skillset clinicians do bring to management.

The focus on the "clinical method" might also be a rhetorical tool, further aimed at justifying the presence of clinicians in management roles, and as a reassurance that clinicians will remain primarily loyal to their profession (and by extension – their patients). Drawing on the tools of Bourdieu, one might view the healthcare setting as a social space, or field, and then understand how clinicians don a medical habitus even in a managerial space (Witman et al. 2011, p.481).

Witman and colleagues note both descriptively and normatively that clinicians in leadership positions must act both as "wise men" and "spokesmen", steering both clinical and managerial activity in the domains they have influence, having to act in a two-way facing (or "Janus-faced") manner. Clinician-managers therefore blend the

clinical and managerial logics in the two main fields they find themselves (Witman et al. 2011), but function largely as clinicians.

This process of mediation between roles can also be understood using Lipsky's notion of street-level bureaucracy (Lipsky 2010), specifically as it has been applied to doctors in the South African public healthcare sector (Gaede 2016). Gaede found in South Africa that "the merging of the roles of the health professional and the bureaucrat" is a necessity to function effectively in this system, and that it may be difficult to disentangle which role is influencing decision-making at any point (Gaede 2016, p.1). Although street-level bureaucracy is often framed as "undermining" top-down policies, Gaede's analysis also shows how clinicians can deviate from guidelines and "translate the clinical information into required steps within the healthcare system to assist the patient" – navigating the healthcare bureaucracy on behalf of their patients (Gaede 2016, p.5). When analysing clinician-managers in Kenyan district hospitals, Nzinga also concluded that they acted as street-level bureaucrats (2016, p.30).

Relying on clinical knowledge and approaches in a management role (reverting to the medical habitus), is the reciprocal of guiding clinical decisions at the "street-level" using managerial imperatives (donning a managerial habitus). Gaede's description of ordinary doctors as street-level bureaucrats can therefore be augmented to describe some clinician-managers in this study as bureaucratic-level clinicians. This adds detail to the complex manner in which those involved in service delivery shape policy, which includes action not just at the "street-level" and requires sympathetic, role-spanning allies such as clinician-managers. The figure below illustrates the different levels at which clinician-managers must function.

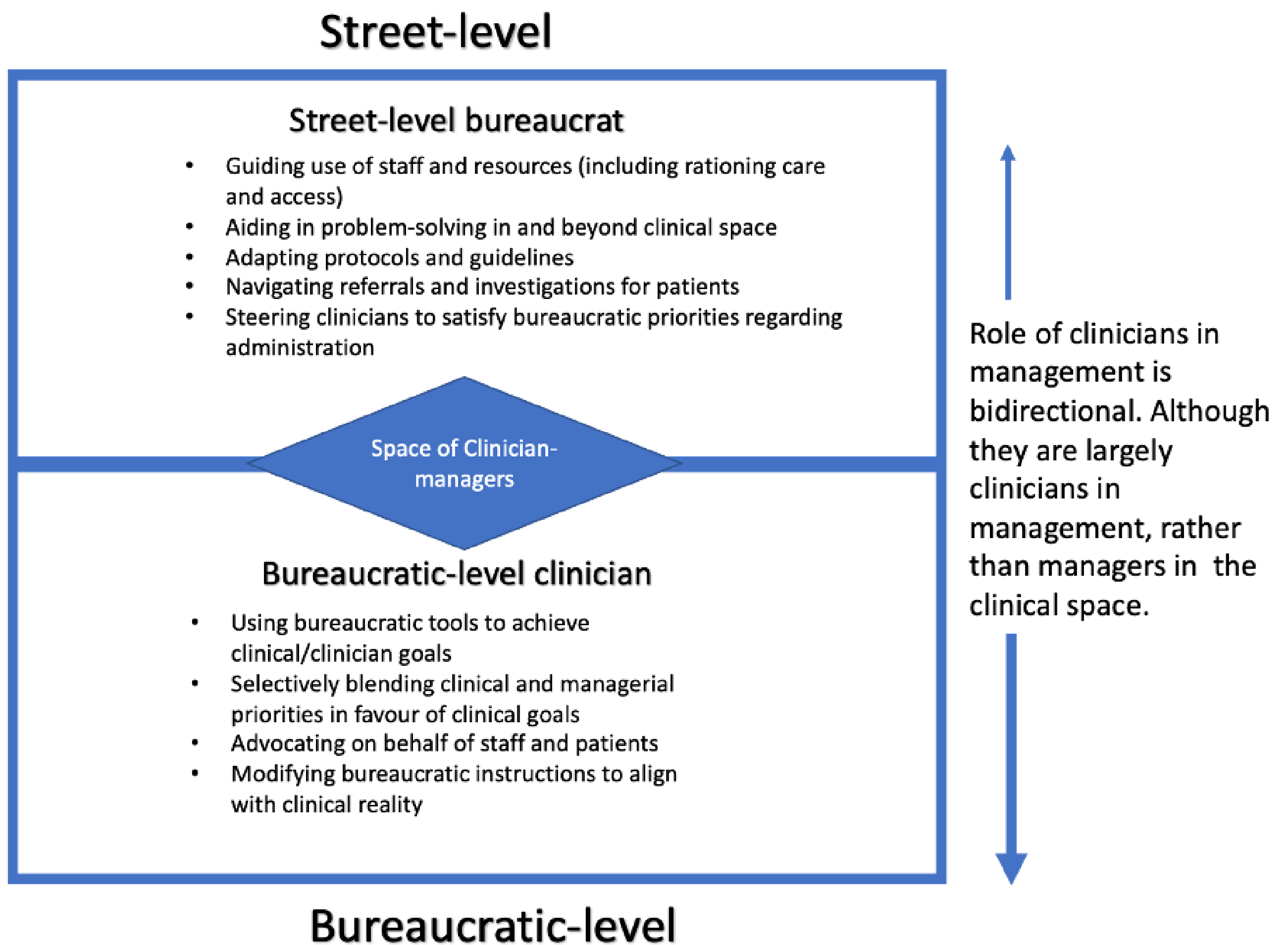

Figure 4: Clinician-managers' activities in the street-level from Lipsky (2010) and bureaucratic levels (from this analysis), respectively.

One area which Gilson identified as requiring further research was that of street-level bureaucrats’ line managers (2015, p.11). Gilson has cited the work of Evans (2011) (who studied the role of social workers’ managers in the UK) and Brewer (2005) (who studied frontline supervisors in several of the United States’ federal agencies) as examples of this work. Clinician-managers, who often function as line managers for frontline workers (and sometimes are frontline workers themselves), can serve as important facilitators, assisting and supporting policy adaptation (or obstructing these efforts). I will advance this further in the next chapter.

Both the concepts of the medical habitus and the street-level bureaucrat span the functional and power interpretations of clinicians' actions in management roles. Functionally, as shown in the discussion and diagram above, clinicians can wield managerial power to serve patient needs. However, a power lens forces one to note that clinicians might also benefit their own profession through opposing managerial reform which might impinge their autonomy – and that managerial authority assists in this project. The result may not always be to the betterment of patient care and service delivery.

From an institutional perspective, the cultural-cognitive pillar can be seen as supporting the tacit reversion of clinician-managers to a clinical approach in the face of emerging problems, largely in an unconscious or symbolic manner. The normative pillar reinforces clinicians' notions of what the "right" thing to do in a situation is, be it clinical or managerial.

Formal training

As this study did not look at formal training methods directly, an evaluation or survey of the contents of the numerous formal training routes used or referenced by participants is beyond the scope of this thesis. However, the manner in which formal training is perceived and utilised deserves to be analysed in detail.

Some participants gave a functional account of formal management training. That is, as a course of study which enhances one's ability to act as clinician-manager.

> *So I ended up doing an MBA… that has given me a lot of tools… So I do believe that that was something that was of value for me. – IP11*

Here the MBA is viewed as a source of valuable "tools" and this is judged by an individual who has many years' experience receiving and providing advanced

training in other fields. Other participants noted how their further training in management had benefited their ability to fulfil their role as manager:

> *…We get taught very well how to be a clinician, but nobody really teaches you on how to be a manager unless you go into public health medicine. – SP17*

This quote also introduces one of many points of contention in this section. Note how medical management or clinical governance is regarded as the territory of certain professions or specialties, such as public health medicine or family medicine. Certainly, this could be explained in functional terms, citing specific expertise or experience, but other participants were sceptical about the value of credentials alone:

> *It's not like if you've done an MBA, you are necessarily a good manager. – IP8*

A critical view, focused on how power is accumulated by the professions, must point at efforts in South Africa and internationally to professionalise management in healthcare. For example there have been efforts to professionalise management in South Africa and the United Kingdom by means of specific qualifications, standard setting or training programmes (Dudley et al. 2013; Clark 2021). If the skills required of medical managers were truly specialty or profession-specific, this has serious implications for the broad field of what is sometimes called "amateur management" (Ham et al. 2011; Stewart and Wolvaardt 2019) where clinicians without management training serve as managers. This also undermines the traits-based claims made implicitly earlier in this chapter, and calls into question the value of drawing from a limited pool of clinicians to manage healthcare in the first place.

The power lens further informs an institutional analysis. If formal qualifications begin to serve a credentialling purpose (even informally, as candidates begin to compete

with one another), this can also be seen as a step towards occupational closure, whereby a certain area of professional work is closed off to outsiders, establishing a "quasi-monopoly" (Muzio et al. 2020, p.13; Freidson 1994, p.83). This is one way to understand the subtle tensions observed between those with and without management training, as well as between different specialties which lay claim to aspects of management expertise. One participant noted the "friction" which may arise between a specialist family physician and a non-specialist clinical manager, who may be senior in years and experience. As explained, even the organogram introduces ambiguity into this relationship. This illustrates the state of flux which healthcare management finds itself in with regards to credentials.

These tensions were also explored in one qualitative study of stakeholders regarding the status of public health medicine in South Africa. The appointment of public health medicine specialists (doctors with a four year specialty) to positions of management was favoured by some stakeholders to the "generic managers" who did not hold medical or specialty qualifications (Zweigenthal et al. 2019, p.7). However, it is important to note that this study focused on the future of this particular medical specialty in South Africa, which the authors concluded was "vital" (Zweigenthal et al. 2019, p.1). Evaluating the merits of their claims are beyond the scope of this section, but it is useful to view such studies as part of professional projects which reinforce the normative and regulative pillars of the medical institutions – particularly as it encroaches into the management and political space.

An institutional analysis can further enrich one's understanding of these accounts by pointing out that healthcare management falls on the boundary between different institutions, namely medicine, nursing and professional management. Indeed,

numerous studies point out that clinician-managers serve boundary-spanning roles between clinical and managerial institutions. (Ainsworth et al. 2009; Croft 2015, p.418)

The South African setting, in this sense, represents an outcome where clinicians have been successful at closing certain organisational roles to non-clinicians, and are now in the process of restratification (through credentialling processes), creating a new "administrative elite" within the clinical professions (Numerato et al. 2012; Möller and Kuntz 2013, p.88).

Informal learning

An important finding in some of the accounts was the manner in which "learning by doing" was viewed as a normal means of acquiring competence in a field:

> *Over time [you] get given more and more leadership roles and that is kind of how you practice what you get taught, and that is pretty much the same way administrative management skills are grown.*
>
> *But, in the old days it was just like sink or swim. - IP2*

Even this developmental, gradual approach to "on the job" learning is contrasted to the "old days" or the "hard way" in which other clinician-managers had to learn to fulfil their roles. A functional interpretation might emphasise that much of the work of a clinician-manager is to act with "wisdom" and that this is best learned experientially.

Learning to be a clinician-manager vicariously, such as through observation of others and mentor or peer networks, have the added benefit of bridging the "gap" between theory and practice alluded to by some participants. The strategies or approaches learned in this way might to a greater extent be valid for the particularities of a

specific region or administration (such as a provincial department of health) and these would be invaluable resources for a new clinician-manager. Mid-level clinician-managers in Kenya were found to rely on “practical norms” which may conflict with professional or managerial norms, but allowed clinician-managers to enact their roles (Nzinga et al. 2018b). However, as Nzinga and colleagues also noted, practical norms may also deviate from professional or managerial ideals in a manner which benefits certain groups.

In this more critical view, the informal means by which management is learned serves a central purpose – to retain professional power and discretion. This mirrors critiques of the hidden curriculum as it exists in medical education (Michalec and Hafferty 2013; Mahood 2011). Applied to clinician-managers, the lessons clinicians might learn during this gradual process may diverge from those which might be agreed upon when establishing formal role expectations as part of a curriculum or professional framework. As with the medical hidden curriculum, the clinician-manager’s learning process, which includes learning by doing, by observing others, and through mentorship, may privilege certain values above others. In clinical practice these lessons may, for example, emphasise the autonomy and authority of the medical profession.

Some of the more alarming accounts related by participants, such as those concerning impaired clinical staff, might be viewed as features of this process rather than aberrations. To deal effectively or “tackle” these problems require the clinician-manager to act primarily as manager in following set protocols for disciplinary procedures, and act against a fellow clinician. The expectation that a manager should be understanding of frontline staff and not be “too harsh” in following “the

rules", is another aspect of practical norms explored by Nzinga and colleagues (Nzinga et al. 2018b).

Although none of the participants in question appeared to justify inaction in the face of an impaired clinical colleague, they perceived it as common enough to mention it in their own interviews. Indeed, some participants related that they had to leverage their considerable influence as both clinicians and managers in order to address these and other problems – showing a willingness to act in a managerial capacity. The moral aspects of these instances are explored in chapter 6.

The informality of mentorship networks as related by participants, might also mean that incumbent managers can exercise a large amount of discretion in terms of supporting or withholding support to other managers:

> *[The previous head of division] didn't see me as the person who would take over the division of surgery when he retires. So I don't really think he specifically tried to pull me in or mentor me or give me guidance. – IP11*

As related in IP11's narrative, the judgement of a senior colleague – whether one is seen as a future manager – plays a large role in a setting where much of the preparation for a management is informal. If these skills are to be "grown", then withholding mentorship is a way of stunting a junior person's managerial development. IP11's narrative, where she seeks out formal training as an alternative route to acquiring expertise, also illustrates another source of tension. If the discretion of incumbent managers can be circumvented through qualifications, then these degrees and diplomas could be seen as a threat, and indeed that is what was described in some interviews.

Viewed institutionally, the multitude of learning paths (both formally and informally) trod by participants reflect the boundary status of healthcare management. With a

minimally developed regulative pillar, which mostly reserves certain management positions for clinicians, the process of acquiring competencies represents a less defined terrain. Clinicians therefore have to rely on the normative pillar, learning through others what a "good" clinician-manager must do. The conception of "moral leadership" in healthcare frames the challenge for clinician-managers as reconciling clinical and managerial priorities or "virtues" (Shale 2011; Dawson 2009) and as this is an informal process, one which relies on experience and peer learning. An analysis of these normative frameworks will be the focus of chapter 6. This theorisation section is summarised in the table below.

The value of theory in this analysis

This discussion section has applied two overarching theoretical analyses to the findings and used these as starting points to engage with literature relevant to the various aspects of the findings. With this in mind, it is useful to reflect on the role theory has played in furthering the analysis of this chapter with regards to the research question.

As Muzio and colleagues point out, the three lenses (functional, conflict and neo-institutional) "follow the historical evolution of theory and research on the professions" (Muzio et al. 2020, p.7). Furthermore, the commonality between these lenses is a view of the professions as part of a particular ideology (although each lens differs on what that ideology entails or means) and how the professions organise and shape work. As Scott noted in one publication outlining the three lenses, the functionalist lens allows one to focus on a particular occupational group and the claims it makes, whereas a conflict lens draws the researchers' attention towards the "population ecology" level (Scott 2008, p.221). As the above analysis

shows, some participants advanced functionalist arguments for the role of clinicians and the usefulness of clinical skills in the managerial space, and the conflict lens served a valuable function in directing my attention towards the inter-occupational implications of these claims – such as the proposed exclusion of non-clinical (or even non-medical) managers, even if my primary data source remained individual interviews. The institutional lens further allowed me to examine the so-called pillars undergirding a particular professions' role as encountered within the data, such as normative claims, taken-for-granted assumptions (relating to the cultural-cognitive pillar) and references to regulative frameworks. Both the conflict and neo-institutional lenses have the effect of turning the research perspective outward and helping me to shape an agenda for future research. This is further discussed in chapter 7.

Table 9: Using various lenses to understand the processes by which clinician-managers learn to fulfil their roles

Component of findings	Functional lens	Conflict / power lens	Institutional lens
Variety of pathways into management	Clinicians inevitably find themselves in management positions, as they are the most appropriate choice for these roles due to their experience and value to healthcare organisations.	Non-clinical managers, or subordinate clinical professions, are prevented from entering or remaining in management positions by more dominant professions (medicine and nursing). Clinicians fill these vacant positions wherever they arise.	Healthcare management lies within a contested boundary between the well-establish institutions of medicine and nursing, and the newer institution of management. Legislation and regulation embed clinicians into healthcare management (regulative pillar), and it is expected that clinicians will act appropriately in these positions (normative pillar).
Reliance on clinical knowledge and skills	Clinical approaches are effective problem-solving strategies and clinicians are highly trained problem-solvers. This allows them to align managerial priorities with clinical reality.	Clinicians use inappropriate strategies in management positions because they are ill-equipped for management roles. The use of these approaches also serves to legitimate the presence of clinicians in management to other clinicians and laypersons. This, in turn, allows them to expand and protect professional discretion and authority.	Clinicians make sense of the world through the clinical approach (cultural-cognitive pillar), and are expected to act primarily as clinicians in other settings as well (normative pillar).
Formal Training	Formal training, informed by evidence, can enhance the quality of clinician-managers' work and reduce the time it takes for them to become effective in their roles. Training also reduces the likelihood of costly mistakes in healthcare, and could in future act as an indicator of expertise.	Formal training which is recognised by participants and organisations is either profession-specific, part of specialty training, or an elite postgraduate qualification. The heterogeneity of the training paths calls into question how specific the requirements to be a clinician-manager are. Serious consideration is to be given to the opportunity cost of removing a clinician from the workforce, compared with training a manager from another discipline.	As healthcare management is a contested field, several institutions lay claim to this space. Management does this through discipline agnostic approaches (such as the MBA). Nursing possesses its own management subdiscipline. At least two medical specialties (public health and family medicine) claim to have expertise about some aspect of management or leadership. Credentialling is one of the first steps towards occupational closure. This may be part of the creation of an "administrative elite" in order to resist managerialisation (reverse colonisation and restratification).
Informal learning	As clinical knowledge and experience can be gained effectively through an extended apprenticeship, management can also be learned in this way.	Formalising the curriculum and requirements for healthcare management might undermine the claim that a clinical background is necessary for this role. Informal learning pathways also empower incumbents with high degrees of discretion to support or undermine incoming or potential clinician-managers.	Lacking clear formal requirements (under a regulative pillar), much of the work of a clinician-manager is reliant on the expectations of what a competent or "good" manager might do (normative pillar), as learned from others, or through experience.

Conclusion

This research has yielded results which provide a framework for understanding the multiple, nuanced narratives encountered on the topic of clinician-managers' preparation for their role. These analyses can also serve as the basis for future research at organisational and regulatory levels.

Through the functionalist lens, the learning journey of clinician-managers was viewed with the supposition that professionals are largely self-effacing public servants and that clinicians are most suited to the management of healthcare. However, this lens was undermined by admissions from participants that the clinical method they brought to their role as clinician-manager, was not necessarily effective. The critical lens brought into question whether clinicians are indeed suited to management in healthcare, by emphasising the difficulties and inefficiencies entailed in the transition from clinician to clinician-manager. Finally, the institutional lens drew attention to the cultural-cognitive, normative and regulative pillars which undergirded both the creation and ongoing existence of clinician-managers, and of the relative success of certain groups (such as doctors or nurses) in claiming managerial roles within the healthcare system.

Each analytic lens provides useful and complementary insights into the empiric findings. The imperfect fit of each lens alone reflects the evolution of these bodies of scholarship in conjunction with trends in organisational studies and the sociology of the professions. The next chapter analyses the individual clinician-managers' task of choosing between or combining two distinct logics of work.

Chapter 5: Clinical-managerial logic: assimilating management into the clinical logic

Chapter summary

This chapter describes clinical-managerial logic among clinician-managers in South Africa. Using the concept of institutional logics, I describe both clinicians' professional, clinical logic as well as their how they perceive managerial logic which influences the bureaucrats and administration they engage with as part of their role. I then describe how clinician-managers function within an assimilated logic, where clinical logic assimilates aspects of the managerial, rather than adopting a new logic altogether. As part of the institutional logics framework, this chapter contains descriptions of the vocabularies of practice, narratives, frames and theories which clinician-managers rely on to understand their working environment and their work itself. I then compare my findings with similar research conducted in in a range of settings (such as South Africa, the United Kingdom and Kenya). These results and theorisation are also compared to those used by other researchers and shown to be complementary to and compatible with other approaches.

Summary of literature relating to this chapter

The logics of work

One theoretical approach to understanding hybrid professionals has been to frame professionalism and management as competing "logics" in an organisation (Giacomelli 2020, p.1631; Shale 2019, p.15).

In relation to health services, an institutional logics framework is particularly relevant. Thornton and Ocasio (1999, p. 804), drawing on earlier work by Friedland and Alford (1991), define institutional logics as:

> *socially constructed, historical patterns of cultural symbols and material practices, including assumptions, values, and beliefs, by which individuals and organsations provide meaning to their daily activity, organise time and space, and reproduce their lives and experiences.*

Put differently, institutional logics can also be described as setting the "frames of reference" which shape, enable and constrain an individual's decisions, sense-making and sense of self and identity (Giacomelli 2020, p.1631).

Institutions were introduced in chapter 4 and they are taken to be enduring social structures which are stable over time and which include the activities, resources and symbolism related to an aspect of social life (Scott 2014; Muzio et al. 2020, p.16). In this chapter, clinical professionalism (with a particular focus on medical professionals) is described as an institution, as is management, to describe the social structures relevant to the health bureaucracy. Where professional is used in this chapter, it refers to clinical professionals.

Writing at a similar time to Alford, Friedland, Thornton and Ocasio, Eliot Freidson used the term "logics" to describe three different models of labour market organisation (Freidson 1990). These he referred to as the logic of the "perfectly free" market, bureaucratic logic and the professional logics of organisation. His subsequent work, *Professionalism, the Third Logic* further advances the notion that professionals represent an alternative form of arranging economic activity to markets and bureaucracies (Freidson 2001).

As free-market logic emphasises “price and profit”, its application to this study, which mostly focused on the public healthcare system, is indirect. The bureaucratic labour market, according to Freidson, emphasises reliability in the delivery of services, and relies on hierarchy and regulation to achieve this (Freidson 1990, p.436).[8] The professional labour market, on the other hand, is regulated by an occupation and is “somewhat protected” from those who pay for it (users or employers), as well as from competition from those outside the profession. The insight which is important for this chapter is that professional logic does not emphasise price or procedure, but rather “the quality and virtuosity of work irrespective of cost and even outcome” (Freidson 1990, p.437).

Freidson’s logics each operate with reference to a central preoccupation (profit, procedure, or professional work) and these constitute the material practices and assumptions, values and beliefs which individual actors in an organisation rely on and reproduce. Thornton and Ocasio cite Freidson in constructing professional ideal type logic within their interinstitutional system (Thornton et al. 2012).

Ideal types, a concept taken from Max Weber, refer to abstract representations of concepts which are used to analyse or measure phenomena (Wooten and Hoffman 2017, chap.19). These are not meant to be definitive or normative frameworks and the term ideal does not denote desirable. Instead, ideal type representation, in this

[8] In this study, an emphasis of price was only indirectly operational through bureaucratic mechanisms. Thus, at the individual level of this research, references to spending and costs were largely focused on various administrative procedures set in place to control these, rather than a preoccupation with profit.

case of a particular logic, allows observations to be theorised and analysed (Thornton et al. 2012, p.15).

The concept of field, also important to this chapter, is developed from the work of Bourdieu, DiMaggio and Scott, and for the purpose of this chapter is understood as "the locale in which organisations relate to or involve themselves with one another" (Wooten and Hoffman 2017, chap.2). Studying the field level means attending both the effect of the field on individuals, as well as the relationships between individuals within the field. The field which was studied as part of this research, through participant interviews, was the setting in which they worked. It is important to note that the field is more than just the healthcare facility, but rather a conceptual space where several organisations are involved. Some of the organisations which interact in this space include the facilities themselves (hospitals, clinics), the department of health, various unions or professional organisations and other groups. Multiple logics can operate within a given field and this chapter focuses on clinical and managerial logics, as well as clinical-managerial logics.

This conceptualisation of logics, based on Freidson as well as Thornton and Ocasio, is the theoretical perspective which informs the analysis of this chapter's findings. This is also part of the synthesis which is advanced by Noordegraaf in describing a "hybrid professionalism" (2015), which is a particular kind of field-level logic.

In order to contrast logics, Noordegraaf proposes analysing them in terms of how work is coordinated, where authority stems from, and what are regarded as core values. Professionalism can be said to rely on coordination based on skills and norms, authority derived from expertise, and values which prioritise quality. In contrast, managerialism is coordinated through a hierarchy, derives authority through

systems of accountability and values efficiency (Noordegraaf 2015, p.190). As part of this framework, Noordegraaf suggests a managed or hybrid professionalism which is coordinated through cooperation (between management and professionals), derives authority from reliability, and values efficient quality (2015, p.201).

Institutional logics are interpreted and enacted in myriad ways in real-world settings through these field-level logics. A specific emphasis is placed on their "vocabularies of practice", narratives, and the "common language" used to guide decision making in practice (Thornton et al. 2012, p.149). Some of the key terms for this framework are defined in the table below.

Table 10: Key terms and concepts for understanding institutional logics

Component	Definition from Thornton et al. (2012, chapter 7)
Logic	"Socially constructed, historical patterns of cultural symbols and material practices, including assumptions, values, and beliefs, by which individuals and organizations provide meaning to their daily activity, organize time and space, and reproduce their lives and experiences."
Theory	Symbolic representations of the world which "contain their own internal coherence". They rationalise and provide "principles and explanations" for institutional logics. They "need not reflect the actual organising practices" and can serve as "political instruments" to organize support for an institutional logic.
Frame	Framing which allows for the diagnosing problems or challenges, prognosticating about possible outcomes and motivating others. It is "inherently political and rhetorical".
Narrative	A story which "organizes events and human actions into a whole" and assigns them meaning
Vocabulary of practice	The words used by a group, along with the meanings the group assigns to them, which "guide attention, decision making and mobilization" and provide the group with "collective identity".

Thornton and Ocasio propose that logics can be combined in different ways, citing various examples from fields outside of healthcare. They suggest that these changes can be either transformational or developmental. One study of quality improvement practices among clinical professionals in the UK found that a variety of influencing and persuasion strategies were used among clinicians in pursuit of their goals. The authors noted that several features of managerialism were being incorporated into clinical logic (Martin et al. 2015, p.393). These processes are described as the "assimilation" or "blending" of logics. Assimilation is a form of developmental change where one logic remains dominant, whereas blending is a more transformative change which leads to a new logic altogether (Martin et al. 2015; Thornton et al. 2012).

Another UK study of clinician-managers described the narratives among medically qualified managers as drawing on clinical and managerial logics in different ways. Some individuals saw their own role as representing or protecting professionalism, whereas others sought to challenge or audit their professional peers' practices (McGivern et al. 2015). One lesson that can be drawn from this is that clinician-managers do not combine logics in a uniform manner.

An aspect of institutional logics which has not been emphasised in previous scholarship on clinician-managers is the question of what is interpreted and produced as legitimate work according to different logics. This is particularly important for individuals who must transition from exclusively relying on one logic (that of a clinical professional), to operating within structures which rely on a different logic (management positions within a bureaucracy). Applying the frameworks above

to my dataset, this chapter describes a clinical-managerial logic which is clinical logic that has assimilated aspects of managerial logic.

Description of findings

The findings presented in this chapter rely on the participants' own interpretations of these adjacent logics which the clinician-managers must combine. It is illuminating to consider each of these logics through the perspectives of participants, not because they provide an accurate depiction of managerial logic, but because they give insight into the theories, narratives (including how actions and events are rhetorically depicted), anticipated outcomes and motivations to act (frames), as well as vocabularies deployed as part of clinical and clinical-managerial logics.

Managerial logic according to clinicians

As the participants were all clinicians, most of whom were medically qualified, they spoke of certain managerial directives and goals to emphasise the impact that these had on clinical service delivery. In one example, a former hospital manager recounted how budgetary management was communicated in one province:

> *I remember seeing a letter on the desk addressed to the CEO …of the hospital… stating… that [if] their facility has been found overspending [the budget], [they] will be charged with financial crimes and that was from leadership above the CEO and that whole approach had me quite disturbed.*
>
> *So that led to the CEO telling me I shall not ask for certain blood tests. I am not allowed to do that. I must ask for individual tests I can ask for potassium or creatine but I can't ask a full U&E [a combined blood chemistry panel]. – IP0B*

This clinician-manager is describing a chain of influences, stemming from a managerial level above the hospital, and how it affects his ability to deliver what he considers to be quality care. The notion that an overspent budget may carry with it

the possibility of a criminal charge (whether this was the actual substance of the letter or not) “disturbed” this clinician and influenced various aspects of his practice, such as what he could prescribe and how long he could admit patients. On the one hand, this could be understood from a logics perspective: in that a professional will resists means of coordination (hierarchy and coercion) as well as values (cost-effectiveness), which are different from his own (coordination by expertise and placing a high value on quality of care). There is also an ethical perspective, through which the clinician perceives their duty towards the patient being violated by a managerial injunction – which itself functions according to a different ethical framework. This is further explored in chapter 6.

Another participant explained that he had always had a “clinical focus” and that he was the most senior member of his clinical team as well as the clinical manager. His relatively inexperienced team of doctors required his input and involvement on a day-to-day basis. However, as a clinical manager, he was expected to engage with his province’s administrative structures:

> *The tension of doing clinical work and then having to go to meetings… it just drove me nuts. If they [the district or province] phone you three days in advance and tell you to go to a meeting that will take a whole day and then suddenly you have to pull out of the clinical team.*
>
> *Seeing [the clinical team] suffer was basically what drove me up the walls because then you suddenly leave for a whole day. They’re not going to be able to cope. It’s going to be just a train smash and you’ve got young inexperienced doctors that you basically throw to the wolves, and that was very difficult to see happening all the time… There was just like no way that the planning was ever going to work out and there wasn’t a big enough team to absorb the blow every time. – IP2*

The expectations created by his role in management created a “tension” which he was not able to resolve: he was required to be highly managerially *and* clinically involved. This participant is explaining a series of possible outcomes. One outcome,

that preferred by his employer is compliance with a command to attend a meeting, which would lead to a “train smash” and throwing junior staff “to the wolves” and to reduced quality of care at his facility. The other outcome is to be insubordinate, refuse to attend the meeting and to work clinically, as is his preferred focus.

Of note is the highly colourful metaphorical language that this (and other) participants deployed when speaking of instances where clinical and managerial priorities conflicted. In particular, these refer to clinical consequences: delays in seeing patients, inexperienced staff working without supervision, or in other cases, clinicians being sucked into a management work “vortex”. With regards to symbolism, this reinforces the notion that the two domains of work (and their underlying logics) are in opposition in the perceptions of some. Furthermore, this illustrates a vocabulary of practice within clinical logic.

For those clinicians who had both clinical and managerial duties, such tensions were a recuring narrative. Managerial work tended to require a great deal of time and energy – limited resources for senior clinicians, or even those who were full-time managers at facilities.

One clinical manager characterised his engagement with his managerial role as that of engaging with bureaucrats:

> *A bureaucrat is somebody who never says yes when they can say no… Which is actually one of the best definitions I have ever heard. – IP1*

IP1 attributed this definition to one of his own mentors. Given this narrow role for bureaucrats in the healthcare system, he came to see his role in a particular light:

> *One of the things that I tried to deliberately teach myself is to think like a bureaucrat. I don’t ever actually [want to] be a bureaucrat who thinks like a*

bureaucrat... but, to understand… the mindset of someone who just deals with paper and not with people. – IP1

This paragraph depicts managerial logic as practiced and elaborated on by "bureaucrats": people who "never say yes when they can say no" and who deal with "paper and not with people". As with the previous quotes, managerial logic which undergirds this rigidity, the threats of criminal action, and the commands to attend meetings is depicted as something which threatens clinicians' work. The rhetoric deployed here dehumanises the non-clinical actors with whom clinicians must engage. Non-clinicians are also presented as being unreasonable to the more typical clinical means of persuasion, such as appeals to quality and safety. The table below outlines managerial logic as it has been depicted by clinician-managers in this study.

Table 11: The managerial institutional logic according to some clinicians

Aspect of institutional logic	Managerial logic as viewed by clinicians[9]
Frame	Diagnosis: healthcare is expensive and prone to overspending its budget. Prognosis[10]: if this tendency is not resisted, there will be significant negative repercussions. Motivation to action: controls (such as denials or delays of requests wherever possible) and, if necessary, threats of disciplinary action must be instituted.
Narrative	Healthcare is a bureaucracy which requires close management, through budgetary and administrative control.
Vocabulary of practice	Budgets, finance, meetings.

To understand this interplay between the demands placed on clinician-managers by their perceptions of the clinical and managerial logics which they function between, the next section focuses on the vocabularies of practice available to clinician-managers to describe their work situation.

Doing "work": the sacred and the coalface versus the "admin stuff"

The vocabularies used by clinician-managers were a revealing avenue for analysing clinical-managerial logic. Participants expressed that clinical work was their "passion", something that they "loved", or would like to do more of:

> *The most clinical managers... they love clinical [work] and so the clinical managing part becomes a bit of a side thing. -IP5*

Multiple participants expressed a preference for clinical work over managerial work, with full-time managers also reflecting positively on clinical work. The result, as

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[9] It is very important to emphasize that this is not necessarily an accurate portrayal of what is likely to be the managerial or bureaucratic logic one might encounter if doing ethnographic or interview research in health departments in South Africa. Rather, this table summarizes the clinicians' perspective of this logic.

[10] The terms diagnosis and prognosis are used by Thornton and Ocasio in laying out the aspects of a logic frame. This may cause some confusion in the medical context, where diagnosis and prognostication have very specific meanings. Diagnosis here refers to a decision on what the core problem or challenge is according to the framing, whereas prognosis refers to the potential consequences perceived by those operating within the logic.

observed by some participants in themselves, clinician-manager peers or former superiors, was the relegation of non-clinical work to a secondary position (a "side thing"). The perceived importance of clinical work was reinforced through various references to it as "real" or simply "the work".

Clinical work was largely defined as a being involved with patient care (either at the bedside or in support of this through documentation, diagnostics, consultation or treatment decisions), while all other activities were deemed non-clinical and therefore not the domain of clinicians. The nurses interviewed also made this distinction between clinical and non-clinical work, but appeared to regard their managerial workload as part of their roles, whereas the doctors expressed more varied and ambivalent views, ranging from an embrace of non-clinical work, to a reluctant tolerance thereof or outright contempt for it.

Instead of viewing their managerial role as a source of authority and status, some participants related negative responses from clinical peers. One doctor related incidents of medical colleagues who appeared to regard her career transition into management with derision and puzzlement:

> *People tell you… 'Do you like paper pushing, do you enjoy all the admin? Don't you want to get back to do real work?' - IP0B*

In comparison with the "paper pushing" and "admin", some participants used symbolic language to refer to the "real" clinical work, such as "frontline" or "coalface". These terms both denoted the physically involved nature of clinical work compared with work which would be remote from patient interaction. Participant narratives, metaphors and similes emphasised the centrality of clinical work to the functioning and purpose of healthcare and, by comparison, the peripheral nature of other activities.

Clinician-managers who were in a position to do so, used certain strategies in order to continue with some form of clinical work. They did this by working after hours at the facilities as clinicians (doing “calls”) or having a non-negotiable clinical day, as articulated by one participant:

> *My clinical day is sacred. I have one clinical day where I have patients booked. … in my district office they would say there is a meeting on this day and I say, ‘I am very sorry, I have patients booked.’ -IP5*

The use of the term “sacred” further illuminates the various layers of meaning which are attached to clinical work. In addition to the religious connotations of the term, this and other figures of speech attach certain qualities to clinical work. In contrast, non-clinical work could either be secular or even profane. The symbolic language referring to clinical work both elevates it above other work, and places non-clinical work into a subordinate or threatening category.

Whereas some participants referred to administration, management, clinical governance and leadership as distinct entities, others simply referred to clinical work and “admin”.

Although not universally employed, “admin” (and sometimes “administration”) provides a title for the extensive non-clinical domain and allows for further exploration of clinician-manager perceptions. What was consistent throughout was the distinction between patient-facing (clinical) and non-clinical work, and implicitly between legitimate and illegitimate work.

When participants were pressed for a definition (after they used the term “admin” or “administration”), some provided a broad definition:

> *[Administration] entails having regular meetings with the staff. Each Friday morning we had a meeting with all the district staff with the mobile clinics. It*

involved also quite a bit around the budgets the yearly budgets and then things like they were planning to renovate the hospitals involved with that as well. Obviously the normal things of duty rosters and organising the doctors working out where they work… -SP4

Whereas some participants listed specific activities, others defined admin as the work which managers did:

So I think admin is the work that you do to be a manager. It's not a technical term I am using. It's like they are all interchangeable, but they aren't really. But, the admin is just a short way of [saying], 'I am going to sit down and write this stuff and get it done with.' And by doing that I'm managing it. -IP2

This definition highlights again the notion that admin is the work of a manager, compared to a clinician who does patient-facing, clinical work. There is also the admission that this is an informal term which describes a variety of non-"interchangeable" activities. The definition is also imperfect, as the implication is also that patient-care essential documentation (such as medical notes or requests for investigations) do not fall within this definition. However, the distinction of admin, a sedentary, remote activity (for which you "sit down") away from the "frontline", clinical work was also consistent throughout these definitions. The various non-clinical activities regarded as "admin" or the "job" of a manager by various participants are listed in the table below.

Table 12: Terms and definitions of non-clinical work

Terms used to describe non-clinical work	Select participant definitions or activity lists

o Admin
o Administrative procedure
o Administration
o The admin or management side
o The “job” of a manager
	As a domain
	• The work and knowledge required of a manager
	• When a manager works, they are doing admin
	On an organisational level
	• Strategic thinking/planning
	• Setting an enabling organisational culture
	• If correctly done, as a prevention for:
	  o Chaos
	  o Strikes
	Broad or generic activities
	• Office-based/seated
	• Meetings
	• Writing emails and reports
	• Sitting down and finishing something
	As specific activities
	• Monitoring and evaluation
	  o Ward statistics
	  o Occupational health and safety
	  o Adverse event reporting
	• Engaging with administrative systems:
	  o Travelling to head office for signatures
	  o Staff appointments
	• Finance management
	  o Budgets
	  o Ensuring staff salaries are paid correctly
	• Staff management
	  o Duty rosters and placements
	  o Appointments, interviews
	  o Discipline of the staff
	  o SPMS (Staff Performance Management System) paperwork
	  o Leave, absenteeism, overtime
	  o Enabling others
	  o Prioritising relationships
	• Facility based
	  o Arranging maintenance/repair of buildings
	• Implementing policy
	  o Such as “National Core Standards” or “Ideal Hospital”
	• Procurement:
	  o Ordering of stock and equipment
	  o Serving on procurement committees
	• Assisting with clinical problems:
	  o Arranging medication and after-hours clinical services
	  o Finding bed spaces for patients
	  o Arranging additional staff for shifts
	  o Protocol development
	• Medico-legal matters
	  o Road Accident Fund reports
	  o Engaging with and responding to legal enquiries or investigations

From this table, one can see that “admin” incorporates a vast array of activities at various organisational levels. The main thing these activities have in common is that they don’t involve patients directly. The implication is that there is a zero-sum interaction between clinical work and “admin” with regards to the time they take from the individual.

From an institutional logics perspective, the clinician-managers are operating within the healthcare field and must reconcile conflicting demands from two logics which predominate. Each logic demands time, attention and expertise of which they have a limited amount. However, as they operate with clinical logic, they must reluctantly sacrifice some or all of their clinical time in order to comply with the demands created by managerial logic.

When one clinical manager (a doctor in a district hospital) was asked about how much clinical work he did, he answered:

> *Not as much as [the other doctors]. Not as much as I want to. – IP4*

This quote illustrates the impact that managerial roles have on senior clinicians’ work and how this differs from this participants’ expectations that this role would be a 50/50 split. In the field, the work of a clinician-manager cannot be so easily bisected into two roles. Instead, they are drawn into management during the working day. This participant also expressed the wish to be involved more clinically, as they found themselves removed from direct patient care.

Among participants who had to balance clinical and managerial work, this posed a significant challenge as it was impossible to “stay ahead” or do “both hundred percent”.

Some participants also shared the perception that administrative processes had "skyrocketed", becoming more detailed and demanding over time, particularly in some provinces. The manner in which these audit-style processes are intended to foster accountability (Nxumalo et al. 2018, p.11) reflects differences in clinical and managerial logics. Whereas managerial logic exerts control though hierarchy and increasing procedures, clinical logic frames these attempts at control as a threat to the quality of service delivery.

The result was that "admin" tended to take up more time:

> *A clinical manager usually is 80% [administrative]. I think they are doing at [another hospital] 80% admin, 20% clinical. So just a little bit of a clinical function… I think basically so that they don't lose their skills, but I was the other way around and that was just not enough. – IP2*

Contributing to the challenges of clinician-managers were the difficulties in delegating or handing over management work, compared to clinical work which could often be done by a skilled colleague. This seems counter-intuitive, but reflects two other factors within the healthcare system. Only a few participants had a clinical colleague to whom they could delegate management tasks, and the nature of clinical logic meant that this may have been a difficult thing to do, as such colleagues did not view this "admin" as more pressing than clinical work. In addition, some participants expressed that they were compensating for skills deficits among administrative staff, or even for deliberate obstruction from their regional offices, such as delays in appointments of staff in order to cut costs. According to both clinical and clinical-managerial logics, as onerous as such tasks may be, they should be done by a clinician in order to ensure that clinical priorities are served. Over time, this logic meant that more time was devoted to "admin" than clinical work, and this became a "vortex" which sucked clinician-managers in.

One participant offered two possible paths for the clinician-manager – one as a manager with progressively less clinical involvement and deteriorating clinical skills, and the other as a clinician reluctantly doing the "admin" which they disliked and which was not valued the same as clinical work. The risk in this case is that clinician-managers or clinical teams as a whole, neglect the parts of "admin" which are essential for clinical service delivery, relegating this work to a "side thing".

The clinician-manager must decide whether to do the activities seen as legitimate according to clinical logic, or to do the work which is required by managerial logic. As they operate within clinical logic, such a move is difficult and to a certain extent threatening to the values of clinical logic. This results in a compromise: clinical-managerial logic.

For some, seeing a superior or other manager fail to engage with matters outside of clinical, work was the impetus for their own move into management. For others, this engagement with management was seen as a necessity for functioning in resource constrained settings:

> *There is a core need from each individual to make sure that the working area is good. I know a lot of clinicians. A lot of them are very good at administrative things. Because when you put systems right when you help an organisation in that capacity...You are still helping the society and the community. - SP14*

For some clinicians, if they expect to be successful in their clinical goals, they must become "good at administrative things". Although this might mean spending time away from patients, this might still be regarded as "helping society and the community", which is part of how some clinicians see the impact of their work with patients. The result is that clinicians must "come up with a plan", as this participant later put it, and this entails engaging with the health bureaucracy. This is a process by which clinicians come to incorporate certain aspects of managerial or

bureaucratic logics into their own logic. Crucially, this is done in pursuit of clinical goals, such as quality of care, rather than considerations of cost containment or procedural correctness. The next section will illustrate how the clinician-managers adopt a new narrative, frame and vocabulary in service of their and their colleagues' clinical goals of quality healthcare.

Assimilated logics: incorporating bureaucratic procedure into everyday clinical work

The preceding sections have described the clinicians' view of managerial logic, (rather than a direct observation of how this logic was enacted), followed by a detailed description of a vocabulary which makes an emphatic distinction between clinical "real" work and "admin". This is a vocabulary which belongs to both clinical and clinical-managerial logic, which has assimilated aspects of bureaucratic procedure in pursuit of clinical goals.

Clinicians rely on the acquisition of resources, such as salaries, equipment, and consumable stock. The South African healthcare system places senior clinicians in a position to influence this process, and the pathways they followed were considered in the preceding chapter. These clinician-managers must engage with non-clinical activities, or "admin", in order to procure these resources. Failing to do so would mean that clinicians might be denied the means to perform their work. This was sometimes described as a balancing act between the clinicians' desire to adhere to the clinical focus on quality ("the type of doctor you want to be"), against the demands of their environment ("the type of doctor that the system needs"). This required some adaptation from clinician-managers.

For some, this meant reframing the way they engaged with their departments of health. The participant who spoke of learning to "think like a bureaucrat", expanded on this notion by further illustrating his perception of the managerial logic as well as his strategy for engaging with it:

> *…To learn to play their game when it comes to appointments [of staff] or the way you write things or the way you present your argument…*
>
> *My agenda is better healthcare for my community. The method of getting that might be more staff or more drugs or more equipment… but a bureaucrat in [regional head office], their agenda on one hand might be better healthcare in the province, but actually their primary task in the job that they are appointed to do, is to make sure that we don't overspend the budget.*
>
> *…Remove the reason to say no. Eliminate the possibilities. Learn to speak the language of the person controlling the budget… So that you can help them meet their job requirements.*
>
> *That is a helpful way of thinking about life as well. What do you need out of this transaction? Okay, you need to be able to tick this box. Okay, I can show you how to tick those two boxes by helping me and that is also politics. …*
>
> *It's playing the game… - IP1*

This quote illustrates the assimilated logic. This participant is preoccupied with the clinical priority of "healthcare for the community", and has come to see the administration he relies on, as chiefly concerned with the departmental budget. He therefore engages in a "game", where he tries to understand the priorities and constraints of his administrative peers. This highly transactional "game" is, by this participant's own admission, quite "cynical". Yet, this quote also shows a move beyond the highly oppositional "resistance" offered by some clinicians to bureaucracies (Numerato et al. 2012). This is explored further in the discussion.

Other participants spoke of their own realisations regarding the role they might play in pursuit of clinical goals. The acquisition of surgical sutures was an example used by more than one participant:

> *There was a time where somebody decided that it's a good idea to save money on suturing material… so they changed the brand to a much cheaper brand…*
>
> *And we ended up sometimes with a... needle that was so blunt … that I couldn't get through the skin … That was quite disturbing…*
>
> *I was fortunate that the medical CEO was doing the anaesthetic while these events happened so she could not hide. – IP0A*

This participant then related how the matter of the blunt, low-quality sutures was escalated through the healthcare bureaucracy and ultimately resolved. Essential to this process, according to this participant, was having his superior, the CEO, faced with the clinical consequences of this batch of sutures. This meant that the clinical consequences of a budgetary decision were now being faced by the entire surgical team, and possibly affecting the patient's outcome.

For another participant, a similar experience was the moment where she realised her value in management meetings:

> *You get into a supply chain management meeting, and you think, oh, I don't know anything about supply chain. Really, I don't know why I'm in this meeting. And then, boom! They are talking about which sutures to buy. And the only thing that they care about is the price, as the finance and admin people.*
>
> *But since you are a clinician you know, that no, it's not about the price, it's the type of sutures, the quality of the sutures. It's about what it's going to be used for. – SP16*

This quote once again tells a story where non-clinical personnel aim to take decisions based on cost alone. It is, according to both of these narratives, the role of clinicians who have input into these processes to guide decisions towards the outcome which would serve clinical needs.

Both of these accounts feed into a frame, within an institutional logic. This is explored in the table below. Each component forms a justification for clinician

involvement and authority and in management, and also forms part of this assimilated logic. Importantly, each aspect maintains the goal of clinician autonomy and quality of service, and uses this to justify involvement with “admin”, such as meetings or procurement procedures.

Table 13: Frame, narrative and theory of clinical-managerial logic

Aspect of institutional logic	Elaboration within clinical-managerial logic (clinical logic which has assimilated aspects of managerial procedure)
Frame	Diagnosis: Without clinicians to guide decisions, non-clinical personnel will focus only on price when acquiring equipment and goods for healthcare facilities. Other decisions may also fail to account for certain clinically important factors, such as the need for laboratory investigations. Prognosis: The result will be the proliferation of low-cost, low-quality equipment and consumables which imperils quality of care, or restrictions on clinician autonomy. Motivation to action: Clinicians can prevent this by serving in clinical-managerial roles and giving input when these decisions are made, such as in procurement meetings and protocol development.
Narrative	"Admin" is a time-consuming activity which takes clinicians away from clinical work. However, clinicians can use the procedures and opportunities provided by engaging in non-clinical activities in order to protect the quality of clinical work, and reassert their autonomy from the "bureaucrats". By following the rules of this game, clinicians can achieve their clinical goals.
Theory	Clinicians possess special insight, without which clinical work cannot be coordinated. Clinician-managers must partially or completely depart from the clinical domain in order to realign bureaucratic actors, who are primarily preoccupied with finances and cost, and secondarily with outcomes.

The managerial logic which clinicians perceive themselves engaging with is likely a highly simplified depiction of the theory, narratives and frames relied on by non-clinical administrative personnel working in health bureaucracies.

The process of assimilation, whereby clinician-managers learn to "think like a bureaucrat" is not without its challenges, and some may never achieve this. Having been educated and trained within clinical logic, several participants spoke of their difficulties with leaving busy clinics to attend meetings. Superficially, this may seem an ordinary, practical requirement, but some clinician-managers viewed this as abandoning patients and clinical colleagues, and others were challenged by these parties when they did so. The process by which one participant came to balance the clinical and managerial workload was a dynamic process over time, which included several training courses and "practice".

With regards to the resistance that some faced from clinical colleagues, who continued to regard non-clinical work as an unworthy activity compared to a clinic for patients, SP6 gave this account:

> *I was down at [a clinic] and was seeing the patients and I had to come to a meeting at the district office…*
>
> *[Then a colleague said], "Yes, there goes the doctor again… she only sits in meetings."*
>
> *In front of all the patients…*
>
> *I was new on the job so I turned to her [and said], "Can I explain what I'm going to do? I'm going to show them the stats, and explain why we need more money for blood tests…"*
>
> *The colleague actually came the next day and said thank you.*
>
> *And I said, "No. Thank you. Because I had never thought I need to explain what I do."*
>
> *And now it is something I tell all my new family physicians. – SP6*

Although the preceding quotes have focused on the changes in clinician-managers' own perceptions, this quote highlights the role that clinical peers might play in hindering or facilitating this transformation. An individual clinician-manager might come to adopt clinical-managerial logic, which regards "admin" as a legitimate activity, as long as it advances quality of care. Their clinical colleagues, however, might not. The above extract illustrates the conflicts which might arise from this. Other participants spoke of pressures they faced from other clinicians to "push queues" (see patients rapidly in a clinic) rather than attending meetings. This shows how clinical-managerial logic can come into conflict with clinical logic. This is outlined in the table at the end of this section.

Given the pressures described, it is also possible that clinicians appointed to managerial roles continue to regard "admin" as an obstacle to be overcome in the

minimum amount of time, to free them and their team to work clinically. Comparing his own clinical manager to regional peers, SP2 offered an explanation:

> *We go into medicine thinking, "I want to be a doctor," and when you think of doctor, you think of managing patients. And so people who have a desire to do desk, office, bureaucratic-type jobs do not end up in medicine…*
>
> *I think that is why you will find that at most of our level [district] hospitals in our region: the clinical managers have very little power because they want to see patients they are in the clinical manager role because there is no one else… So they will do whatever they need to do to just keep the show on the road but they are not pushing… for a bigger vision or a bigger change agenda They are just basically keeping the show on the road so they, as an individual and their team, can see patients. – SP2*

This longer quote provides several possible outcomes for the development of field-level logics, as well as speculating about the causes and consequences of these divergent outcomes. This participant was part of a team which functioned within an effectively assimilated clinical-managerial logic.

The clinical manager (or the acting clinical manager) was expected to address numerous non-clinical matters as part of their role, even if this meant that they engaged in little clinical work. This was accepted by both the manager and the rest of the clinical team. The wider perception within the team (several of whom were interviewed for this study), was that this was a legitimate way for a senior clinician to spend their time, and that this provided numerous benefits to the clinical team.

"Managing patients" is contrasted to "desk, office, bureaucratic-type jobs". The string of adjectives here encompasses widening areas of work, ranging from the desk, to the office, to the entire domain of bureaucracy. This is yet another illustration of the clinical work/admin dichotomy and how extensive the latter domain can be. The quote also contrasts a reactive approach to "admin" to a more proactive one, which requires one clinician to "sacrifice" (in the participant's words) their clinical role.

The bureaucratic “game” is characterised as something that requires both skill and patience in order to achieve “positive change” (for the health of the community and the clinical team which serves them). The reward, as this participant later put it, was the "golden signature” – the authority to procure or request certain resources, or at least influence these processes. Within the context of this quote, this forms a justifying narrative for clinicians to engage in bureaucracy or “politics” – in order to attain a certain amount of power within the system. Because clinicians do not perceive the work as legitimate and may lack necessary skills, it is not always done well.

This willingness to engage in non-clinical work (“admin” or “bureaucratic-type work”), along with the justifying narrative and frame, is part of the assimilated clinical-managerial logic: clinical goals (quality and autonomy), sought through a game-like engagement with the managerial role. The alternative approach, alluded to throughout this chapter – is to disregard non-clinical work as far as possible and to do the bare minimum. The result, sketched in both this and preceding quotes, is disempowering to clinicians and potentially compromising to quality. Therefore at least one person on a clinical team must adopt clinical-managerial logic to pursue a “bigger vision” of quality and autonomy from bureaucracy (as far as possible).

Viewed as a description of a frame within an institutional logic, this quote offers diagnosis, prognosis and motivation to action for some of the field-level logics this chapter has encountered. These logics are summarised in the table below.

Table 14: Components of field-level logics as it relates to managerial work or "admin" as encountered in this chapter

Logic	Clinical logic (as described by clinician-managers)	Managerial logic (as described by clinician-managers)[11]	Assimilated clinical-managerial logic
Theory	Clinicians must primarily concern themselves with patient care and must be provided with the resources to do so. Non-clinical activities are a misuse of their time, especially when these compete for clinical time. This is a functional view of clinicians, as benevolent, independent, highly skilled professionals acting in patients' best interests.	This theory in itself was not directly encountered. It is likely to follow an amalgam of market and bureaucratic logics, emphasising price and procedure.	In order to achieve clinical goals of quality and autonomy, a certain amount of non-clinical work needs to be done well, preferably by someone with an understanding of clinical work, i.e. a senior clinician. This allows clinical work to be done unimpeded and prevents negative impacts of managerial mismanagement or the divergence of managerial and clinical priorities.
Frame	Diagnosis of a problem: senior clinicians are required to take time out of the clinical sphere in order to do "admin". Prognosis: The above will lead to a "train smash" or various calamities for patients and healthcare workers. Motivation for clinicians involved in "admin": "desk, office, bureaucratic-type" work must be dispatched as quickly as possible to allow the clinician to return to the bedside.	Diagnosis of a problem: deviation from procedure, overspending, underspending, fruitless expenditure, irregular expenditure Prognosis: legal ramifications, bankruptcy for the province or department. Motivation of others within the logic: it is important to have strict procedural and financial controls, extensive documentation and systems for applying for any action or expenditure.	Diagnosis of a problem: clinicians require resources (salaries, consumables, facilities) to do work as they see fit. The provision of these resources require engagement with non-clinical work. Prognosis: If this work were to be done by a clinician, the resources are likely to be delivered. If managerial work were done by an outsider, the resources might be withheld or fail to be delivered due to divergent priorities or incompetence. Motivation: senior clinicians are to become involved in various managerial tasks (formally and informally) to ensure the acquisition of clinical resources and to maintain clinician autonomy.

[11] As this field-level logic was not directly observed and as this is merely to serve as a clinicians' perspective, however inaccurate, I have had to infer the details of the theory, frame and narratives from participant interviews. The vocabulary is taken from descriptions provided by participants, who were all clinicians.

Narrative	Clinicians just want to “manage patients” and “keep the show on the road”.	Healthcare expenditure needs to be carefully controlled to ensure a form of distributive justice, given limited national and regional resources.	To resolve issues, clinicians must be involved beyond only the clinical aspects of healthcare.
Vocabulary of practice	With reference to patient-facing, clinical work: “real work”, “coalface”, “bedside”, compared to “admin”, “administration”, “politics” or “bureaucrats”.	Budget, overspending, irregular expenditure, waste, financial crimes, procedure.	The same vocabulary as the pure clinical logic, but with a different narrative around the utility of non-clinical work.

Discussion

This chapter has described a clinical-managerial field-level logic among predominantly medical clinician-managers in South Africa. This logic is distinct from the clinical and managerial logics which are also present in this setting, but were not studied directly. Rather, this distinction is understood through clinician-managers' own accounts of their interactions with clinicians and various aspects of the health bureaucracy. The components of this logic, such as its frame, narrative, vocabulary and theory, have been described and listed in detail.

Clinical-managerial logic as a form of hybrid professionalism

Clinical-managerial logic is a form of hybrid professionalism. As proposed by Noordegraaf, these clinician-managers are tasked with "managing quality" and must do so whilst functioning between logics (Noordegraaf 2015, p.195).

Using this concept further, and paying attention to how work is coordinated, where authority lies and which values are being pursued, the field-level logic can be described in greater depth. Using Noordegraaf's framework (2015, p.201), one can attend to clinical-managerial logic's organising principles, as depicted by clinician-managers.

The means of coordination was reliant on cooperation between clinical and administrative staff, facilitated by clinician-managers themselves. In this sense, they became the conduits for clinical, as well as administrative directives. The source of authority was a mixture of professional and bureaucratic. On the one hand, clinician-managers relied on their professional status and expertise to exert control in both directions. On the other hand, they also relied on their hierarchy position and

authority to exert influence upwards into the health bureaucracy. The guiding values within clinical-managerial logic can also be said to be a combination of professional commitments to quality, as well as bureaucratic pursuit of efficiency and cost-effectiveness, resulting in "efficient quality" (as Noordegraaf describes it).

Describing this field-level logic is a first step towards understanding how professionalism, particularly the work of clinicians, may change over time. These changes may be confined to certain instances of clinical professionals, such as those studied here, or they may spread to the discipline more widely. This can be the first steps in a process of professional restratification, explored in the previous chapter (Numerato et al. 2012; Möller and Kuntz 2013, p.88). In practice this would mean the establishment of a new specialty or expansion of existing specialties into this space.

The position of clinician-manager (whether this is called clinical manager, medical manager, chief executive officer, head of clinical unit or something else) offers one clinician the opportunity to become "very good at administrative things" and engaging with the managerial logic, while freeing their clinical peers to do "real clinical work". This may insulate their clinical colleagues from managerial demands and preserve a clinical logic which values quality and autonomy. However, this requires a transformation from the clinician-manager. Research among Kenyan clinician-managers found that clinician-managers drew on clinical norms which they and fellow clinicians knew and viewed as legitimate, in order to fulfil their roles (Nzinga et al. 2018a, p.183). The development of these "practical norms" could also be reinterpreted as the emergence of a clinical-managerial logic which uses management tools to the advantage of clinicians.

Clinical-managerial logic is a distinct field-level logic which assimilates aspects of managerialism. In particular, aspects of proceduralism and clinician-participation in the broader health bureaucracy are embraced as a means to maintaining or achieving clinical quality and autonomy for clinicians, a form of “reverse colonisation” (Waring and Currie 2009, p.774). This is a form of developmental change to the field-level logic of clinicians, as it incorporates “external dimensions” (Thornton et al. 2012, p.164), such as budgetary awareness.

In high-income settings, researchers have described transformational changes in professional logics. In Finland, among health social care workers, Olakivi and Niska described the “overlapping discourses” between professionalism and managerialism, emphasising their commonalities (2016). Case studies within the NHS, describe nurse consultants as blending clinical and managerial logics (Currie and Spyridonidis 2016).

In a time where administrative requirements “sky-rocketed”, clinicians in certain positions had to become skilled administrators with limited or no clinical components to their work. Their thwarted desire for more clinical work was a source of ambivalence for some participants, as well as a source of conflict with clinical colleagues who expected clinician-managers at the bedside, and administrators, who expected them in meetings. The ongoing clinical role for managers has been described in other settings, as clinician-managers’ need for a “reality check” (Ham et al. 2011, p.116), or as a means of retaining legitimacy within the organisation (Clay-Williams et al. 2017). In addition to responding to clinician shortages and high patient loads, the participants in this chapter likely also used ongoing clinical involvement for similar instrumental reasons. However, the institutional logics framework adds an

additional reason that clinician-managers might choose to remain clinical: it is regarded as inherently more “real” or worthwhile than managerial activities – both by those operating within clinical logic, and the emergent clinical-managerial logic.

Clinical-managerial and street-level bureaucracy

Writing about various “audit-style accountability” mechanisms for front-line managers in South Africa and Kenya, Nxumalo and colleagues noted that these systems may contribute to conflicting requirements from managers and may negatively impact healthcare delivery (2018, p.2). The narratives in this chapter also support their and other authors’ assertion that professionals may respond to such bureaucratic controls with “creative compliance” or efforts to “play the system”, which may defeat the purposes of the directives (Nxumalo et al. 2018, p.2; Nzinga et al. 2018b, p.183).

Notions of “gaming” the system or “playing the game” in previous research has sometimes focused on how clinicians undermine management directives to their own advantage. With regards to healthcare targets in the NHS, gaming has been defined as a form of “reactive subversion”, which could take the form of “hitting the target and missing the point”, or otherwise “reducing performance” in the absence of regulations (Bevan and Hood 2006, p.521). The narratives in this chapter are presented as less self-interested. Clinical-managerial logic, for these individuals, is about using or undermining regulations or procedures to create space for agency. In the Norwegian setting, gaming practices which benefit patients have been described among health and social care workers (Strandås et al. 2019). In Kenyan hospitals, similar practices were said to create “space for gaming”, and allow a “wider repertoire” of possible action for individuals to choose from (Nzinga et al. 2018b, p.175).

One way of understanding this is by returning to Lipsky's notion of street-level bureaucrats. If one study is to be generalised, South African front-line doctors already engage in considerable discretionary interpretation of health policy in order to deliver services (Gaede 2016, p.7). Some participants in this chapter depicted themselves as professionals using their positions as bureaucrats to undermine cost-saving initiatives to maintain service quality. This returns to the notion of bureaucratic level-clinicians, which I introduced in the previous chapter. These narratives, along with Gaede's own findings, depict professionals as compensating for policy failures, rather than simply undermining them. Further ethnographic observations of clinician-managers would be required to observe these accounts in day-to-day practice.

As Gilson noted, the behaviour of street-level bureaucrats is influenced by their organisational and institutional environment (Gilson 2015) and as such the institutional logics perspective presented in this chapter is highly complementary to this approach. In particular, an understanding of field-level logics offers an explanatory theory to understand how street-level bureaucrats' behaviour is shaped by underlying narratives, theories (as a form of rhetorical justification), and vocabularies of practice. This framework also provides an additional entry-point for interventions which might challenge the underlying components of these logics.

Using the concept of a field-level logic, the relationship between clinicians, clinician-managers and bureaucratic procedures is also further elucidated. This is particularly with regards to the highly simplified, zero-sum clinical/"admin" dichotomy observed. This chapter reveals the challenge posed by clinical and clinical-managerial logics when clinicians are required to engage with top-down directives, such as those aimed at containing cost or ensuring compliance. Understanding this may allow

policy implementors to reframe certain aspects of managerialism as aligned with clinical goals and values.

Clinical-managerial logic, leadership and power

The developmental changes to clinical logic described in this chapter can be seen as individuals' or networks of individuals (described in the previous chapter) responding to changes. Some of these changes stemmed from their environment, such as high patient loads, new policy directives or conflict with peers. Other changes could be said to be related to their position as clinician-manager, requiring a new perspective on legitimate work, themselves and their role in the organisation. Importantly, the transition from clinical to clinical-managerial logic took place within an organisational context, and influenced by peer responses and attitudes.

Distributed leadership is an approach which views leadership as a "collective practice embedded within a wider constellation of relations between leaders, followers and context" (Nzinga et al. 2018a, p.ii28). In Kenyan public hospitals, the development of distributed leadership practices were found to be influenced by the structure of organisations, as well as professional norms, with professional power and politics seen as a barrier (Nzinga et al. 2018a, p.ii32). A separate investigation into South African hospitals advocated for a "crossing over of perspectives", where clinicians and managers align their goals (Doherty 2014, p.31).

Understanding both the challenges and successes of leadership practices through the lens of field-level logics has the potential to demystify aspects of policy implementation. The norms, structures, and perspectives alluded to in these studies are parts of underlying logics, which merit further study. Distributed leadership as a

lens moves the focus from the individual to a wider consideration of actors and relationships within an organisation, but this can be further augmented by focusing on the logics which determine available courses of action. In the same vein, an understanding of logics can aid in understanding how power is wielded by clinician-managers within organisations through everyday political processes.

Gilson describes the “leadership of everyday politics” in a healthcare settings as the exercise of “political skills in balancing and managing the relationships among people and resources that influence services on an everyday basis”, which is done to “maintain services and ensure good quality care” (2016, p.190). This is similar to the organising principles for clinical-managerial logic described at the start of this section, such as the means of coordination and sources of authority.

Framing these balancing acts as complex negotiations between field-level logics offers an additional avenue for understanding the challenges of health policy implementation and management. Logics can be viewed as an alternative description of the “invisible power” (Gilson 2016, p.191) or mindsets (Spehar et al. 2014) that shape the behaviour of individuals within healthcare settings.

The institutional logics framework also brings a different understanding to how organisations adjust to various challenges. Consider the developmental changes to clinical logic, particularly in the adoption of certain procedures or priorities from managerialism, which resulted in a new clinical-managerial logic. These developments could also be framed as changes in cognitive and behavioural capacities, to use terms from everyday health systems resilience, which allow new challenges to be met (Gilson et al. 2017, p.2). An institutional logics lens may reveal the specific narratives and vocabulary which signal a predominance of a particular

logic, which could prove inappropriate to the circumstances. This may be useful to explaining variations in resilience encountered in different settings.

Drawing on the theoretical work of Lukes on different kinds of power, Barasa and colleagues analysed resource allocation practices in Kenyan hospitals, noting that power operated in three ways: concrete decisions (compelling others to do things), hidden (removing options or preventing their consideration), and through socialisation (2016, p.2). In their study of Kenyan hospitals, however, they observed that clinician-managers were failing to exercise power over priority setting and resource allocation within their organisations, absenting themselves from key meetings. One reason given for this was that clinicians did not think that “budgeting and planning were part of their roles as professionals” (Barasa et al. 2016, p.7). Attending to the logics active within this field would likely yield a similar finding to this study: that clinicians with management responsibilities cannot continue to operate with clinical logic alone. In addition to the solutions proposed by these authors, a focus on the language and narratives employed by individuals or groups may provide an additional avenue for intervention.

Implications of this research

Taking the above into consideration, it is clear that the institutional logics approach can productively reframe several areas of scholarship related to clinician-managers with the aim of improving the management of health facilities. Owing to the limited nature of the dataset, this chapter lays the groundwork for further research into the field-level logics at work within the healthcare setting. A more detailed analysis of each of the proposed logics, the clinical, managerial and clinical-managerial would

be possible with longitudinal ethnographic work and documentary analysis in both clinical and managerial settings.

Using ethnography, education researchers in the UK described distinct “patterns of leadership” (public-facing, meeting-based and “gambit[s] of compliance”) enacted by individual leaders which changed based on the setting (Kelly et al. 2006, p.195). In developing the concept of hybridity, Fulop has drawn on Kelly and colleagues’ findings to suggest their application to healthcare (2012). Specifically, ethnographic work has the potential to observe clinician-managers who have both clinical and managerial duties alternating between clinical and managerial environments. Using the content of this chapter as sensitising concepts, observation can focus on changes in the language, rhetoric and goals for clinician-managers in different settings (for example, at the bedside compared to a regional meeting) and also observe the communication of other members on the clinical team.

A separate, but related, question concerns the emergence of dominant institutional logics. These processes are likely dynamic and unfold over longer periods. If a future project specifically studied institutional logics by the above method, some of the inquiry can focus on *how* certain logics come to dominate in particular settings. Once these questions are better understood, interventions to foster specific, adaptive logics would be the natural next step.

Expanding interviews to include non-medical and full-time clinicians would broaden an understanding of clinical-managerial logic. Martin and colleagues propose a case study design for this, where multiple individuals are studied across different settings where different logics predominate (Martin et al. 2017, p.124). Interviews with lay

managers and administrators would also allow for a detailed, emic description of managerial logic.

Conclusion

This chapter has presented an analysis of field-level logics based on a series of interviews with clinician-managers and key informants. These provide an empiric description of clinical and clinical-managerial logic within the South African healthcare setting. Given the limitations to fieldwork posed by the pandemic, I have also provided an outline for research to expand on this work. The results presented here could form the basis of an additional avenue of research to understand and respond to challenges in the management of healthcare facilities. This would be highly complementary to some of the established approaches considered in this chapter.

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Chapter 6: Normative aspects of clinician-managers' work

Chapter summary

The work of clinician-managers has important normative dimensions – that is, it has an ethical aspect.[12] As clinician-managers may face dilemmas different from those confronted by solely clinical professionals, understanding their accounts as moral narratives is an important analytic approach to grasping the challenges they face. Suzanne Shale's framework for moral leadership in medicine, with a focus on fiduciary, bureaucratic, collegial, inquisitorial and restorative proprieties (practices of responsibility), is one way of understanding these challenges. This framework allows for a more nuanced understanding of the tensions within the narratives of clinician-managers. It may also be an important tool for clinician-managers to understand, and deliberate on, their own actions.

Summary of literature relating to this chapter

During thematic analysis of the interview data, it became clear to me that several categories had normative connotations, such as "what makes a good manager", "recollections of bad managers" or even the more colourful "making a mess of it". Here participants made value-judgements with regards to their own and others' actions at the junction between the clinical and managerial worlds they inhabited. I have called these normative as they mostly contain a conception of what one *ought* to do in a situation. I have used norms and normative in the following sense:

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[12] As this chapter uses specialised language (such as moral, normative, propriety and more), this summary relies on definitions contained in the literature review section below.

> *'Norms' either signify behaviours that are more or less prescribed and desirable, in which case we consider the norm something we 'ought' to do; or they signify behaviour that is more or less prohibited and undesirable, in which case we consider it something we 'ought not' to do.* (Shale 2011, p.66)

In this view, norms, morality and ethics refer to "conventions or conventional behaviours that particular group treats as 'good' or 'correct'" (Shale 2011). This is the understanding with which this chapter approaches these terms.

Making sense of participants' value-laden utterances posed several challenges. Whereas the prior empiric chapters in this thesis had not needed to frame the results in terms of right or wrong, these findings required that I reproduce (and thereby amplify) normative statements by participants, but also to contextualise and challenge them. I have aimed to relate the findings faithfully without being overly credulous, overly critical or presenting myself as an arbiter of morality.

The second, related, challenge was that of narrative. The codes mentioned earlier were mostly extracts which formed part of longer stories that ran through interviews. Whereas thematic analysis had allowed me to find meaning *across* interviews, I now had to return to the original interviews in order to find the meaning *within* participants' own narratives.

The third challenge was to use a language and conceptual framework appropriate to the interface at which these clinician-managers found themselves. One might, if foregrounding the clinical aspect, rely on somewhat abstracted introductory ethical frameworks such as deontology or utilitarianism, or the more applied ethical "guidelines" (which are more akin to rulebooks) provided by the Health Professions' Council of South Africa (HPCSA) or various professional bodies (Health Professions Council of South Africa 2019). If one focuses on the managerial role of clinician-managers, one might refer to the Code of Conduct for the Public Service (Office of

the Public Service Commision 1997), or the *Batho Pele* ("People First") Principles for the Transformation of the Public Service, which the South African government has also published (Department of Public Service and Administration 1997).

However, as the research question is about how clinician-managers combine their roles as clinicians and managers, and as this research is constructivist in its approach, I elected to focus foremost on what they actually said and to apply theories which provided the best descriptive and explanatory fit.

Guidelines, rules, legislation and resolving ethical dilemmas

Participants did not usually reference any particular framework or guidance which they, as clinician-managers, relied on. Some participants did reference certain legislation or broader ethical principles when speaking about certain scenarios. I have sought to summarise the ethical guidance which clinician-managers might be expected to comply with, both as managers and clinicians. The intention is not to be exhaustive, but to outline some constraints placed on their decisions and behaviour when faced with dilemmas. Ethical dilemmas are taken to mean situations where more than one ethical rule or moral framework conflict with one another (McConnell 2018)

Public sector doctors are public servants, employed by one of the provincial departments of health. The government of South Africa has published guidance on the principles which should guide their behaviour. These are known as the Batho Pele Principles and they are listed in the text box below.

As others have put it, the Batho Pele Principles are person-centred and aim to ensure the provision of "the right services at the right time in the right place"

(Walmisley 2018, p.9). Although the principles might make reference to values, they are chiefly focused on the delivery of service to “clients” or end-users.

The Batho Pele (“People First”) Principles from the White Paper on Transforming the Public Service

1. Consultation: Citizens should be consulted about the level and quality of the public services they receive and, wherever possible, should be given a choice about the services that are offered
2. Service standards: Citizens should be told what level and quality of public services they will receive so that they are aware of what to expect
3. Access: All citizens should have equal access to the services to which they are entitled
4. Courtesy: Citizens should be treated with courtesy and consideration
5. Information: Citizens should be given full, accurate information about the public services they are entitled to receive
6. Openness and transparency: Citizens should be told how national and provincial departments are run, how much they cost, and who is in charge
7. Redress: If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy; and when complaints are made, citizens should receive a sympathetic, positive response
8. Value for money: Public services should be provided economically and efficiently in order to give citizens the best possible value for money

In contrast, the Code of Conduct for the Public Service is written with clearly ethical intentions:

> *The Code should act as a guideline to employees as to what is expected of them from an ethical point of view, both in their individual conduct and in their relationship with others. Compliance with the Code can be expected to enhance professionalism and help to ensure confidence in the Public Service.* (Office of the Public Service Commision 1997)

The code of conduct contains five domains. Three of these focus on a different relationship the public servant might have: with the executive and legislature, with the public and among employees. The last two domains concern the public servant’s duties and their private interests. Among other items, the code outlines that public servants should not engage in discrimination, corruption, or nepotism. As a whole the code is meant to “promote exemplary conduct”, but it is also emphasised that violations of the code would make individuals guilty of misconduct according to the

Public Service Act of 1994 (Office of the Public Service Commision 1997, p.3). However, the code was not mentioned by any of the participants and subsequent correspondences with some participants did not make reference to them either. Instead, when ethics were mentioned, broader principles of medical ethics were used.

The Health Professions' Council of South Africa (HPCSA) is a statutory professional council for doctors and some other health professionals, but not including nurses. The council was created in 1974 by an act of South African parliament (Health Professions Act 1974). Nurses are regulated by the South African Nursing Council, also with authority granted by separate legislation (South African Nursing Council 2021). Both councils provide extensive guidance to the professionals they regulate. As the majority of this study's participants were medically qualified, and with this chapter chiefly based on interview data from interviews with this subgroup, only the guidance from the HPCSA will be considered here.

The preamble to the HPCSA's Guidelines for Good Practice in the Health Care Professions describe "The spirit of professional guidelines" in the following way:

> *Practice as a health care professional is based upon a relationship of mutual trust between patients and health care practitioners. The term "profession" means "a dedication, promise or commitment publicly made"* (Pellegrino 2000)*. To be a good health care practitioner, requires a life-long commitment to sound professional and ethical practices and an overriding dedication to the interests of one's fellow human beings and society. In essence, the practice of health care professions is a moral enterprise.*
>
> *In this spirit the HPCSA presents the following ethical guidelines to guide and direct the practice of health care practitioners. These guidelines form an integral part of the standards of professional conduct against which a complaint of professional misconduct will be evaluated* (Health Professions Council of South Africa 2019, p.i).

This preamble espouses an explicitly functional (see chapter 4) view of the professions with reference to their “promise” which has been “publicly made” and that the practice of healthcare is a “moral enterprise”. Secondly, the guidelines are also presented as “standards” against which breaches of conduct are to be measured.

The council provides 17 booklets on good practice. The first considers general guidance, particularly with regards to the duties of professionals, as well as a framework for resolving ethical dilemmas. The second considers statutory rules to which health professions are bound by legislation. The remaining books consider specific areas of practice, ranging from confidentiality, to the development of chemical weapons.

The background to these guidelines is further elaborated in the first booklet:

> *Being registered as a health care professional with the Health Professions Council of South Africa (HPCSA) confers on us the right and privilege to practise our professions. Correspondingly, practitioners have moral or ethical duties to others and society. These duties are generally in keeping with the principles of the South African Constitution (Act No. 108 of 1996) and the obligations imposed on health care practitioners by law* (Health Professions Council of South Africa 2019, p.1).

While the guidelines aim to provide “value-oriented principles” for professionals to subscribe to, the authors also note that it would be “impossible” for the council “to develop a complete set of specific ethical prescriptions” for all scenarios. Practitioners are thereby instructed to “work out for themselves” what actions “can be defended ethically” and that this requires “ethical reasoning” (Health Professions Council of South Africa 2019, p.3). The “core ethical values and standards” required of health care practitioners include are reproduced in in the table below (Health Professions Council of South Africa 2019, p.9).

Table 15: The thirteen "core ethical values and standards" for health professionals, according to the HPCSA (Health Professions Council of South Africa 2019, p.9)

Value or standard	Explanation
Respect for persons	Health care practitioners should respect patients as persons, and acknowledge their intrinsic worth, dignity, and sense of value.
Best interests or well-being	Non-maleficence: Health care practitioners should not harm or act against the best interests of patients, even when the interests of the latter conflict with their own self-interest.
Human rights	Health care practitioners should recognise the human rights of all individuals.
Autonomy	Health care practitioners should honour the right of patients to self-determination or to make their own informed choices, and to live their lives by their own beliefs, values and preferences.
Integrity	Health care practitioners should incorporate these core ethical values and standards as the foundation for their character and practice as responsible health care professionals.
Truthfulness	Health care practitioners should regard the truth and truthfulness as the basis of trust in their professional relationships with patients
Confidentiality	Health care practitioners should treat personal or private information as confidential in professional relationships with patients - unless overriding reasons confer a moral or legal right to disclosure.
Compassion	Health care practitioners should be sensitive to, and empathise with, the individual and social needs of their patients and seek to create mechanisms for providing comfort and support where appropriate and possible.
Tolerance	Health care practitioners should respect the rights of people to have different ethical beliefs as these may arise from deeply held personal, religious or cultural convictions.
Justice	Health care practitioners should treat all individuals and groups in an impartial, fair and just manner.
Professional competence and self-improvement	Health care practitioners should continually endeavour to attain the highest level of knowledge and skills required within their area of practice.
Community	Health care practitioners should strive to contribute to the betterment of society in accordance with their professional abilities and standing in the community.

How these values are to be reconciled is not explicitly discussed, but this is implied in the guideline's consideration of duties. The authors define a duty as "an obligation to do or refrain from doing something". They further elaborate that, "duties may be ethical, legal or both at once, and operate in the personal, social, professional or political spheres of our lives" (Health Professions Council of South Africa 2019, p.11). The HPCSA states that doctors have particular duties to their patients, their colleagues, society, their profession and the environment.

While duties might be general or specific to one's profession, institution or a specific law, the guideline does state the "no duty is absolute" and that "any classification of

duties is arbitrary". The indefensible position, according the guide, is if a duty is violated "without justification" and this is regarded as the basis for possible sanction (Health Professions Council of South Africa 2019, p.12).

These guidelines represent the standards and rhetoric employed in the training and continued development of doctors. I have quoted them extensively not to provide a rubric by which to grade participants, but rather to build an understanding about what is considered "normative" or "ethical" in the South African healthcare setting.

Ethical frameworks, ethical fragments and theories of virtue

Discussions of morality or ethics in healthcare can take the form of listing various contrasting approaches to moral philosophy. These approaches include consequentialism (usually in the form of utilitarianism), deontology and virtue ethics. Sometimes other approaches such as "prima facie" ethics (in the form of Beauchamp and Childress' four principles) are also included (Shale 2011; Papanikitas 2015).

Table 16: Commonly used ethical frameworks in medical ethics. From Papanikitas (2015, chap. 1)

Ethical framework	Explanation
Deontology	"Act only on that maxim through which you can at the same time will that it should become a universal law". One can discover what is ethical by asking whether acts satisfy the categorical imperative.
Utilitarianism	The moral act is one that results in "the greatest good for the greatest number". In practice, this is often applied as rule utilitarianism, where individuals are expected to follow rules which have been made with such considerations, rather than trying to predict the consequence of every action.
The four principles (these principles constitute a "guideline" for discussion rather than a coherent ethical theory)	Autonomy: "respecting the decisions made by those capable of making decisions." Beneficence: doing good. Non-maleficence: to refrain from doing harm. Justice: "ensuring fairness and equity in the distribution of risks and benefits".
Virtue ethics	Ethics is analysed not in terms of what a person does but in terms of what kind of a person one is, and especially the person's virtues (e.g. integrity, courage, altruism) and vices (e.g. dishonesty, laziness). See text for further detail.

Ethical guidelines published by medical councils (or as enshrined in pieces of legislation), as considered above, are deontological through their use of words such as "duty" or "rules". Public and community health, on the other hand, have utilitarian objectives through resource distribution decisions which weigh the needs of the individual against the needs of a wider community.

These frameworks allow for dilemmas to be articulated, but do not necessarily offer a means by which to reconcile tensions between incommensurate approaches. Deontology, utilitarianism, and other modern approaches may come to different conclusions and "ethical reasoning" frameworks may not resolve these tensions. Alasdair MacIntyre refers to these conflicting ethical frameworks as "fragments" of the virtue tradition (MacIntyre 2007, p.55).

Below, I will provide the essential terms which require further definition. Although the process may appear laborious or overly detailed to the first-time reader, this is a necessary step if one is to understand concepts used by later writers whose work

form a key part of this chapter's analysis. MacIntyre's work has been highly influential, and the concepts of practice and internal goods as they relate to virtue offer a nomenclature for understanding the clinical-managerial space.

The definition of virtue, according to MacIntyre is:

> *'an acquired human quality, the possession and exercise of which tends to enable us to achieve those* ***goods which are internal*** *to* ***practices****, and the lack of which effectively prevents us from achieving any such goods'* (MacIntyre 2007, p.191)

One difficulty of MacIntyre's framework is the manner in which definitions are interrelated. Thus, the very definition of virtue requires that one defines a practice and internal (and therefore external) goods.

A practice is defined as:

> *any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realised in the course of trying to achieve those standards of excellence which are appropriate to, and partially definitive of, that form of activity, with the result that human powers to achieve excellence, and human conceptions of the ends and goods involved, are systematically extended.* (MacIntyre 2007, p.187)

Toon summarises the concept of a practice (by which he means a professional practice) in his own work, in order to argue that healthcare is a practice (Toon 2014, p.29). I summarise and elaborate on Toon's own list in the table below:

Table 17: Characteristics of a professional practice, adapted from Toon (2014, p.29)

Characteristic (as identified by Toon)	**Explanation and elaboration**
Using technical skills as a means to achieve an outcome	Technical skills are considered necessary but not sufficient to constitute a practice, rather these must be used to strive towards internal goods.
Involves "standards of excellence"	It should be apparent to peers that someone who participates in a practice may excel in that practice, to be known as a "good" doctor, lawyer, clergyman, etc.
These standards are "transmuted by the history of the activity"	The goals of practices are not fixed, but may change over time. The "goals" of medicine, for example, have evolved as the profession has changed over the centuries. Consider the contested nature of the purpose of medicine, depending on whether one asks patients, specialists, public health practitioners and others.
Practices are "cooperative"	Although some practices are team-based, even those which can be done in a solitary fashion (Toon uses the example of painting), can be developed, discussed and debated in a community of practitioners.
Practices have a history or form part of a tradition	MacIntyre states that "to enter into a practice is to enter into a relationship not only with its contemporary practitioners, but also with those who have preceded us in the practice, particularly those whose achievements extended the reach of the practice to its present point."

Internal and external goods are best understood through comparison. Once again, Toon's summary provides a useful basis (Toon 2014, p.30) for the table below.

Table 18: A comparison of internal and external goods, from MacIntyre (2007), quoted in Toon (2014, 30)

Internal goods (Goods of excellence)	**External goods (Goods of effectiveness)**
"Their achievement is a good for the whole community who participate in the practice".	When achieved "they are always some individual's property or possession".
These are not zero-sum/finite	"[T]he more someone has of them the less there is for other people".
These are not characteristically objects of competition.	These are "characteristically objects of competition".
Can only by achieved by participating in a practice in an attempt to "achieve excellence" (quotation from Toon) according to the rules (explicit or implicit) of the practice.	Can be achieved without engaging in a practice.
Examples include: Knowledge, happiness, love, wellbeing.	Examples include: money, material resources, power.

Toon argues that healthcare is a practice and therefore that everyone who participates in healthcare are working towards realising the internal goods related to it: health, happiness, and human flourishing. This includes doctors, nurses and patients as "co-producers of health" in a "struggle against suffering and incapacity" (Toon 2014, p.34). Within this definition, all other persons facilitating this process

(including managers and hospital maintenance staff) are also participating in this practice. Implicit in this definition is also the possibility that the practice produces external goods, such as money, power, and other resources which do not contribute to the cultivation of virtue, but are nonetheless real outcomes and essential for survival (at least in the case of income).

To summarise: in this framework virtues are acquired human qualities, which are the result of participating in practices (such as healthcare), with the aim of advancing internal goods, such as health and wellbeing. In contrast, therefore, participating in healthcare for the pursuit of power or resources is not the cultivation of virtue.

One might further develop this argument in several directions, but for the purpose of this chapter, I will focus on two questions: what are these virtues in healthcare and can clinicians cultivate them whilst acting as managers?

What are the virtues in healthcare?

Writing about medicine in particular, but noting that their work would have application for nursing and other health practitioners, Thomasma and Pellegrino sought to present the virtues which could be cultivated through medical practice. In *The Virtues in Medical Practice*, they use MacIntyre's framework to argue for eight virtues: fidelity to trust, compassion, phronesis (practical wisdom), justice, fortitude, temperance, integrity and self-effacement (Pellegrino and Thomasma 1993).

The internal and external goods are not to be considered as polarities, but rather as two important categories of outcomes which practitioners realise through their practice. However, the actions of an individual can be judged as virtuous based on which category they are preoccupied with cultivating. Consider if a doctor defies

management by providing a treatment which has high costs. It is possible to use all of the above frameworks to view the doctor as actively cultivating virtue in the pursuit of better health outcomes for their patient, and to condemn the manager for their preoccupation with the external goods – budgets and resources. However, the manager may also be displaying particular managerial virtues, only at a larger scale than the individual doctor-patient relationship. The reasons for managerial concern with budgets or even their own status in the organisation may stem from both virtue and vice. It is also possible that a doctor may believe themselves to act virtuously in one situation, but to undermine the well-being of a large group of others in this same action.

Writing about this tension from an organisational perspective of the UK healthcare system, Dawson identifies six possible managerial virtues which may conflict with clinical professional virtues: courage, managerial competence, innovativeness, responsiveness to customer, restraint and market awareness (Dawson 2009). If one compares these to the Batho Pele principles, and the public servants' code of conduct one finds that there is clear overlap with regards to financial prudence and the delivery of services to customers.

To understand both how clinical and managerial virtues are identified, and how the tensions between them are resolved – Dawson emphasises the role of narrative in organisational ethics (Dawson 2009, p.96). Furthermore, he claims that for different "traditions" (that is medicine and management) to understand one another, they must not only understand one another's "language", but also become fluent in it.

Achieving this bilingualism at the level of the individual clinician-manager, however, is one of the challenges this thesis set out to study. According to Dawson (and in

turn, MacIntyre) the challenge of management as a practice in itself, is its preoccupation (at least in the usual story told about it) with the external goods of healthcare: resources and their efficient acquisition and management (Dawson 2009, p.105). However, if the above virtues were practiced in pursuit of health and patients' well-being, they would certainly constitute true virtues.

This is where Toon offers a more hopeful view by suggesting that healthcare as a whole is a practice, where clinicians, patients and, indeed, managers might cooperate to achieve the internal goods of practice and thereby cultivate virtue (Toon 2014, p.104). In this sense, a virtuous organisation can consist of virtuous doctors, nurses, patients and managers.

The role of narrative

Dawson's emphasis on narrative is one shared by Shale (2011, 212) and Toon (2014, 51), in turn influenced by MacIntyre (2007, 217) and Bruner (1990), among others. Greenhalgh and colleagues (2005), drawing on Aristotle, list the defining characteristics of narrative in social science research as chronology (taking place over a period of time), emplotment (relating happenings in a manner which implies causality or relatedness), and trouble ("harm or the risk of harm").

Shale (2011, 211) draws on Mishler (1995) to outline three ways in which narratives might, in turn, be analysed for meaning: in terms of content, structure or the role the narrative performs. Gabriel further elaborates that stories in organisations can serve multiple functions, such as entertainment, stimulating imagination, offering reassurances, justifications, explanations, as well as moral instruction (Gabriel 2000). For the purpose of this chapter, the role of this organisational story repertoire,

as told by participants, will be used to understand the moral dimensions of clinical-managerial work. This approach still fundamentally relies on thematic analysis of the participant content, but uses narratives to illustrate the main threads in this chapter.

Moral leadership in medicine

In *Moral Leadership in Medicine*, Suzanne Shale provides an in-depth exploration of the normative dimensions of the work done by clinical directors (doctors in management positions) in the United Kingdom's National Health Service. Theoretically, the work relies on various ethical frameworks, with a particular emphasis on the works by Mary Urban Walker (2006) and Alasdair MacIntyre (2007), as well as the ethical guidance provided by the General Medical Council and various bodies within the NHS. Empirically, the framework is grounded in a series of qualitative interviews with medically qualified senior managers in the NHS.

The result is a framework for organisational ethics, with an emphasis on narrative and the "proprieties" of moral leadership. Moral leadership, as Shale puts it, is:

> *being astute to the moral connotations of all that is involved in providing care, determining where action is needed, identifying situations where action is needed to improve or maintain the moral quality of care, and orchestrating the activity of other people to provide a morally appropriate response when one is required* (Shale 2011).

Thus, moral leadership in medicine is identifying the potential for conflicts between norms (specifically those related to quality of care) and conducting, directing or facilitating the "morally appropriate" actions – either oneself or through others. Shale examines the narratives around these instances of recognition, decision and action. The aspect of Shale's work which is most applicable to this thesis is her attention to the particular series of actions clinical managers must take in order to provide the "morally appropriate" response to situations.

Proprieties

Shale distinguishes between “general practices of responsibility” and the “specific practices of propriety” through which a “moral narrative” can be enacted (Shale 2011). She uses the term propriety to indicate these specific practices and impropriety to note their absence. As she points out, “the moral tension” for medical managers is that each propriety has a different priority, which may conflict with the others in a specific situation.

Table 19: The five proprieties of moral leadership (Shale 2011)

Propriety	Definition	“First priority” to…	Example
Fiduciary	Promoting the interests of a beneficiary,	… the patient.	Advocating on behalf of an individual patient, perhaps for a specific treatment or access to a service.
Bureaucratic	Prioritising the needs of the organisation and in so doing, the needs of patients and professionals collectively.	… the “medical corporation”. In the short term this may mean the users/clients, but in the long term, this means the organisation itself.	Transparently following the procedures set out by the organisation in order to safeguard the collective interests of all concerned.
Collegial	Acting in a way which promotes cooperation based on goodwill and collegiality, rather than hierarchy.	… fellow professionals (the “collegium”).	Persuading colleagues to adopt a protocol or treatment based on the evidence rather than by command.
Inquisitorial	Investigating “misconduct, misbehaviour” and “mistakes”. This requires objectivity from the inquisitory, as well as “candour, regret and confession” where appropriate.	… justice and fair procedure.	Undertaking investigations or commissions of enquiry following adverse events and allowing all sides to be heard.
Restorative	To restore moral relations after harm.	… moral relations.	Transparency in the wake of events that have caused harm. Restorative gestures such as apologies or remuneration.

Despite the similarity between the proprieties with virtues, Shale argues that whereas virtues are the “manifestations of deep character”, the proprieties are

responses to particular scenarios. She further clarifies that these responses need not be internalised or become part of the individual's character – indeed, individuals demonstrating the appropriate proprieties may feel that the acts conflict with their character (Shale 2011, p.190).

A normative framework for clinician-managers

This section has provided an overview of normative theories which have been used to understand the tensions faced by clinicians in managerial roles. I have explored the use of virtue ethics as a possible means to provide a more coherent framework, particularly as explored by Toon and Dawson, as well as Shale's framing of the proprieties expected of clinicians in management. I have also considered specific concepts, such what constitutes a practice, the question of whether healthcare (including medicine and nursing) and management are practices, how a practice can result in internal and external goods, and how this relates to the cultivation of virtue and flourishing.

A final topic which requires introduction is that of moral injury, the "violation of deeply held moral commitments leading to emotional" distress (Cahill et al. 2022). The term originated in descriptions of military veterans and since has gained popularity in healthcare and psychiatry (Wiinikka-Lydon 2019, p.176). For the purpose of this chapter, I will draw on two insights from Cahill and colleagues, which are that the ethical norms individuals are expected to adhere to are shaped by "moral communities", and that moral injury occurs when an individual's agency is limited (Cahill et al. 2022, p.2). Clinician-managers may find themselves departing from their original moral community, that of fellow clinicians, and find themselves isolated. At

the same time, they may realise that their ability to act is constrained by a number of explicit or implicit norms.

Findings

The findings presented below are divided into four sections. The first considers the normative role played by clinician-managers when they advocated on patients' behalf at managerial level, providing what they called "clinical insight". The second analysed how clinician-managers weighed organisational goals against individual patient care, and the ambivalence this may engender. The third section unpacks how participants resolved tensions between the clinical-managerial obligations when conflicting with expectations of special treatment from colleagues and their duty to investigate harm or wrongdoing. The final section describes the deliberative work done by some clinician-managers in making the, largely implicit, tensions described above more explicit and working through them.

The normative role of being a clinician in management

During an interview with a senior manager at a private hospital group, one participant with an extensive clinical background reflected on how his decision-making role had changed since moving into management:

> *I think my current role as I said is much less in a way of quick snap decision-making. I think somebody… who has done management has management experience and done official management courses might actually be better at some of the things, being more systematic in their approach. But if they don't have a clinical background and they are in a clinical management role… they may lack the clinical insight. – IP6*

The paragraph contains a reflective journey. First, IP6 compares that which is currently expected of him to his previous role: much less "snap" decision-making as at the bedside and much more slow deliberation. In this sense, he concedes that a

manager, possibly even a lay manager with the requisite training and experience, might be able to do “some things” better than he can. However, this is quickly followed by the statement that a lack of clinical “background” may translate to a lack of “clinical insight”.

At this stage, the notion of “insight” requires further clarification. Another participant, a former hospital superintendent, still involved in healthcare policy, reflected on the “tension” between the clinical and managerial space:

> *I think that it’s always a tension between the two and… as you get more senior I don’t think the tension diminishes because there are more demands on both sides… But, yes I think the issue for me is that it is absolutely essential to have clinicians in managerial roles.*
>
> *I actually was in a meeting … with colleagues in the [local] Department of Health and they were speaking about the difficulty… their head of health in the province and their financial controller [are having]. The chief financial officers [have] no understanding about health, so they cannot understand why it is a greater priority to pay the blood bank than to pay the security service. They pay the security service because they worry the union is going to strike and then the blood bank doesn’t get paid… or the lab or whatever… oxygen was the other example.*
>
> *They phoned Afrox [the supplier for medical gases] to say, “Your oxygen wasn’t delivered,”*
>
> *So [Afrox] said, “We can’t. We haven’t been paid.”*
>
> *“What do you mean you haven’t been paid?” – SP11*

This quote clarifies the importance of clinical insight and contextualises its meaning. Here he provides a cautionary tale of bureaucracy without clinical insight. With limited funds in their budget, presumably less than the payments owed to several service providers, the non-clinical provincial administrators, according to SP11, reasoned that a union strike would be most disruptive, so opted to pay the security firm ahead of other providers. Some other participants also raised the issue of service providers (such as laboratories or medical gas suppliers) refusing to provide

further services until debts were settled or assurances were made. The result for clinicians and their patients, however, was that the hospital stood to run out of oxygen. Global and local South African oxygen shortages received renewed attention due to the COVID-19 pandemic, but as this quote illustrates, the problem predates the pandemic.

A clinical manager from another region related a similar experience with, what might have seemed from his perspective, ineptitude:

> *I remember when we ran out of oxygen because somebody hadn't ordered it, in my rage I went and got the [non-clinical] admin manager and dragged him to the ward and said, "This short of breath patient is dying in this bed here because there is no oxygen. This is why we order oxygen". - IP1*

This excerpt surfaces two other strands. One is the patient orientation which this individual clinician-manager brings to their role – an orientation which is demonstrated through strong emotions ("rage"). The second is the translational role played by the clinician in management, who not only symbolically steers administration in the direction dictated by patient needs, but even physically brings administrators into the wards to demonstrate the impact of a missed oxygen order.

In the language of moral leadership, SP11 and IP1 were both demonstrating the impacts of improprieties. In SP11's slightly more complex example, a bureaucratic propriety (in the actions of the financial officers), aimed at reducing the disruption to healthcare services by union strikes, inadvertently led to fiduciary impropriety – neglecting to put the interests of patients first. IP1's narrative paints a picture of a more dysfunctional system, where one fateful indecision represents an impropriety in more than one sense. The administrative manager's failure to order oxygen is not justified or defended, rather is it is presented as a failure – an impropriety – which is

compounded by a fiduciary impropriety (a patient suffocating without oxygen), which the clinician-manager cannot prevent from occurring.

At this point, and at several other points in the chapter, it is important to note the limitations of the study material. I cannot present the alternative narratives by other actors, or those affected by these events in order to come to a fuller understanding of what happened. In addition to the content, one can note additional narrative elements: the form and the work the narratives perform. The narratives are descriptions discrete interactions with verbatim quotes – exchanges between characters as they were said to happen. This establishes actors in the moral narratives the participants are providing. The work these narratives perform, as I have summarised them here, is to foreground improprieties (fiduciary and bureaucratic) and to demonstrate how readily this takes place without the much-needed "clinical insight".

Continuing the quote from SP11, this is made explicit, alongside prescriptions of what the maintenance of clinical insight might require and what its role might be:

> *Clinicians in management are essential because of those kinds of understandings which I think your non-clinician managers don't always have. But, to be effective in that role one also still has to have a reasonable amount of clinical contact and clinical involvement otherwise one loses that value.*
>
> *Yes, one always has the more the clinical, the medical understanding but I think clinicians who become pure CEOs and pure managers… after a time they start losing some of that… Yes, they still have a broader understanding…[of] something like the value of oxygen, for example. But I think they lose some of the feel for what it is actually like in terms of clinical decision making that is impacted on by management. – SP11*

This participant articulates a frequently encountered sentiment, both in this research and elsewhere: that clinicians in management should maintain clinical involvement. This was not the unanimous opinion of participants in this study, though. Note how

the “understanding” and “value” which a clinician brings to management is contingent on a “reasonable amount” of clinical contact. As a full-time manager, one might maintain some understanding of clinical imperatives, but one would lose “the feel”, particularly of having to make clinical decisions whilst contending with managerial decisions.

This could be phrased as an injunction for clinicians to participate in the *practice* of medicine (or nursing), lest they lose the ability to cultivate the internal goods of healthcare. Alternatively, SP11 is arguing that one needs regular experience of how fiduciary and bureaucratic proprieties conflict at the point where they contact one another at the bedside.

IP1 adds a different perspective to this:

> *If you don’t actually know what good quality clinical medicine looks like, you can’t ensure that it is being provided and I think that is the critical thing there. – IP1*

Implicit in knowing “what good quality clinical medicine looks like” entails practicing it oneself. As a manager, one is not only making resource decisions, but also managing a team of professionals – and one requires insight into how those professionals are providing care. Quality assurance, then, is not abstracted but framed as an integral part of providing care as a manager.

The reasons for continuing clinical involvement, however, may be simultaneously symbolic and mundane:

> *I've remained involved in the clinical work around [my specialty field] and I haven't given up any of that and it's partly the reason for it is I think two-fold. The first reason is that I believe, that to be a more efficient manager, if you also do some work on the ground and in surgery if you don't operate you lose touch and to a certain extent respect from the people that work for you…*

> *The second reason is that… I'm not in a position where I can appoint another [specialist] so we are two full-time people at [the hospital] and it's too much work for one person on their own so I end up doing half of the work – IP11*

Here, a senior specialist and head of division adds complexity to the narratives above. Although she describes her motivations as two-fold, there are at least three reasons she continues with clinical work. Firstly, she states that doing work "on the ground" can help her be an "efficient manager". This will prevent her from losing "touch". Secondly, tacked on to this sentence is an allusion to "respect" from colleagues. This implies that the need is also to maintain a perception among subordinates and colleagues. This has been reported elsewhere as maintaining "legitimacy" (Berghout et al. 2017).

From a moral perspective, her example could be seen as a performative means of demonstrating dedication to the internal goods of healthcare, or a commitment to exercising fiduciary propriety. It may not be enough to *do* the right thing, one also needs to be perceived as having the right *priorities*.

The third reason she provides is a reminder of the context. In a resource-deprived setting, it would be an unaffordable luxury to shift a specialist to a non-clinical role. The result is that the clinician-manager still maintains a sizeable clinical workload out of necessity.

Organisational moral agents: adopting the bureaucratic propriety

The preceding pages have explored the ways in which clinicians in management positions might act as bulwarks against managerial impropriety, or appropriately weigh the fiduciary and bureaucratic proprieties when they do conflict.

There is another dimension to this, however. Clinician-managers are not simply called upon to be a clinical voice in the managerial space. They are also meant to represent a managerial voice in the clinical space. This, however, is interpreted in more complex ways.

In the language of virtue – virtuous clinicians are asked to cultivate managerial virtues, or to weigh the bureaucratic propriety more seriously. A narrative encountered in several interviews concerned limiting clinicians' use of resources such as prescribing, testing and equipment. This was framed both in ambivalent and righteous terms, signifying the variety of connotations and motivations which lay behind these actions.

Continuing with SP11's narrative, largely advocating for clinicians to be in management, he describes the role clinician-managers can play in pursuing goals which have trade-offs with individual patient care:

> *I think the clinician-manager can help medical colleagues to understand the impact of some of their decision-making. If you are going to send a full blood count and a urea and electrolytes [blood tests] on every single patient you see… [To then tell the medical colleagues]… "These are the consequences in terms of the budget. You need to think through that. And it is not bad medicine to be thinking through that."*
>
> *Whereas if an administrator said, "You can't do that"…*
>
> *[The clinicians] would say, "These guys [the lay administrators] don't understand everything," – SP11*

Here the former superintendent's (SP11) quote expands on the senior specialist's (IP11) narrative above. Whereas SP11 had started their narrative earlier in the chapter, emphasising the fiduciary propriety – ensuring that hospitals do not run out of oxygen and that patients receive care – largely a role of reorienting organisations

to the internal goods of healthcare, here is the first mention of a responsibility towards the external goods or, managerial virtue.

This is framed as "help" for medical colleagues – who might so closely focus on caring for the individual patient, that they neglect the organisation as a whole. If each doctor were profligate in ordering a wide variety of tests on every patient, then the testing budget would be exhausted and future patients might not have access to any testing, or another part of the service may need to be cut back. SP11 frames the role of the individual clinician-manager in terms of simultaneously explaining the budget "consequences" to clinicians, while arguing that it is "not bad medicine" to consider how the one uses resources as an individual clinician. This further contextualises the earlier calls for the clinician-manager to remain "in touch" or grounded.

Whereas the earlier section depicted the clinician in management as resisting inappropriate managerial directives, the opposite is also true: they must also curtail clinicians' autonomy in favour of the organisation. As above, some frame this as a process of reconciliation between the organisation's goals and evidence-based healthcare, to show how these objectives are compatible:

> *One of the other challenges with non-medics [in management positions is that] they tend … [to] defer to doctors… Whatever the doctor says isn't questioned…*
>
> *[Whereas I say], "No… that is rubbish… Let's go and look what evidence says." – IP0B*

IP0B, a former hospital manager in both public and private is referring to her experiences in the latter. She depicts lay managers, sometimes with a finance background, as not sufficiently resisting clinicians' decision-making in terms of equipment requests and prescribing. Her role as clinician-manager, as she describes it, is to "rubbish" those claims which are not evidence based, essentially defending

her opposition to clinicians as a peer rather than a manager, and her decisions as evidence-based.

The above examples depict well-delineated opportunities for the clinician-manager to exercise bureaucratic propriety without committing a fiduciary impropriety – harming patients or increasing the chances of harm. Another participant expressed serious ambivalence about this conflict, however:

> *My role changed with time so within a few years' time I was the senior doctor having to go and tell the [junior doctor], "Listen, you can't do liver functions on every patient. It is not going to help you and it's expensive. You can't do thyroid functions on every patient you have to think. Use your clinical reasoning.*
>
> *So although I hated it, I also took on that role eventually. [I had] mixed feelings. Because I knew some of [the reduction in testing] was appropriate and in our context we had to think about how we use our money and how to use it wisely, applying distributive justice. But I also felt irritated because sometimes it is important to do a wide screen and to not care about the budget, but to find the diagnosis…*
>
> *If you're constantly reminded that you are overspending then at some stage you do too few tests and the patient's care is compromised and whoops a day or two later, you figure out what is going on and then the patient suffered because of that. – IP0A*

This narrative firstly points out that, although resource awareness has been considered as a managerial responsibility until now, it is one that is shared by senior clinicians who may only be involved in resource decisions from a clinical governance perspective. In the second strand, reducing unnecessary testing is depicted as part of being a competent doctor who is capable of exercising "clinical reasoning". IP0A depicts this scenario as a confluence of two objectives which are therefore compatible: appropriate testing and distributive justice in terms of resources. Why, then, the ambivalence and hatred towards the role?

I identify two possible reasons: the one is the obligation for the senior doctor to play the role of curtailing others' autonomy, and the other is the possibility that an excessive concern with parsimony might lead to patient harm through doing "too few" tests.

Whereas in the previous chapter, this conflict would have been one between clinical and managerial logic, this chapter focuses on the ethical dimensions of the narrative. Furthermore, it illustrates one clinicians' balancing of bureaucratic propriety (judicious resource allocation) as well as the collegial propriety (respecting other professionals' autonomy) against fiduciary propriety (reaching a diagnosis as soon as possible). It is significant that the clinician weighs the latter more heavily.

The above quotes can also be understood in terms of the pursuit of internal and external goods, particularly when considering healthcare in its entirety as a practice. Clinician-managers are not expected to lose sight of the care of individual patients (the internal goods), but must attend to the budget (external goods). The concept of proprieties simply allows a more detailed understanding of competing priorities. The ambivalence expressed here and elsewhere, lends further credence to a focus on actions and a diminished emphasis on character, as would be important in a purely virtue ethics-based analysis.

In addition to the narratives' content, their stories depict clinician-managers as characters facing and overcoming various difficulties or "trouble" – all in the best interests of patients. Here, clinician-managers are moral agents seeking to align their organisations with the interests of their patients, and this requires them to make difficult decisions as managers or administrators. They are depicted as being "in touch" clinically and this is purported to be their first priority.

Another participant, speaking about various medical colleagues working in rural hospitals, frames their reluctant journey into management as a means to an end:

> *If the patient dies of a ruptured ectopic [pregnancy] where the shortcoming was an ultrasound machine to [detect] it in time... the joy of being in a small rural hospital is going to vanish… I know a lot of clinicians - a lot of them are very good at administrative things. Because when you put systems [in place]… When you help an organisation in that capacity...You are still helping the society and the community - SP14*

This quote shows how “administrative” tasks become a means to better patient care, such as securing an ultrasound machine to avert obstetric tragedies. As explored in the previous chapter, this indirect form of delivering patient care is an essential part of clinical-managerial logic. There is, however, a normative dimension in addition to the functional one. Demonstrating bureaucratic propriety by establishing “systems” or securing resources, is for these clinician-managers a way of prioritising patients and “the community”.

Framed in this way, for the clinician to act as a manager, absenting themselves from clinical work (either part- or full-time) in order to arrange for an ultrasound machine, is a way of providing care and is ethical from the *clinical* perspective. This is compatible with bureaucratic propriety – as it calls on the manager to exhibit a certain behaviour (to become “good at administrative things”). Management here, however, is not chiefly concerned with preserving the organisation or resources, and therefore it is difficult to regard this as a pursuit of external goods.

Clinician-managers can fail to make this shift, however, busying themselves mostly at the bedside. Returning to a quote used in the previous chapter, SP2, who had been an acting clinical manager, compared his own hospital’s clinical manager to what he saw in other hospitals in their region:

> *At most of [the district] hospitals in our region the clinical managers have very little power, because they want to see patients. They are in the clinical manager role because there is no one else and so they will do whatever they need to do to just keep the show on the road but they are not pushing… for a bigger vision or a bigger change agenda. They are just basically keeping the show on the road so they as an individual and their team can see patients and I think that has been one of the things that has been instrumental towards our changes that [our clinical manager] was willing to sacrifice… his clinical [involvement]. – SP2*

This paragraph further illustrates the links between clinician-managerial logic, a conception of organisational power, and the prospect of effecting change. Initially, this too may seem to be a quote about practical matters: how clinicians in management should act in order to accumulate power and execute a “vision”. However, this paragraph illustrates a normative pitfall. Clinicians in management might commit the bureaucratic impropriety of neglecting “admin” and thereby forego the fruits of effective management.

Shale describes the “comportments” of bureaucratic virtuosity - specific behaviours visible when exercising bureaucratic propriety (Shale 2011). Because her participants did not have to balance a clinical and managerial workload (as some participants in my own research had to), they did not demonstrate one which I have identified here: the comportment of clinical restraint. This is restraint in the sense that the clinician-manager must occasionally act as a manager first and a clinician second. To do the minimum amount as a manager, just to “keep the show on the road” and to keep seeing patients, is to exercise a bureaucratic impropriety – depriving one’s team of a trustworthy clinical ally in management.

SP10, a former superintendent, related how she was called upon as a manager in order to make decisions regarding the withdrawal of life support in her hospital’s intensive care unit. She had to devise a strategy to exercise clinical restraint:

> *Tough decisions were when it had to be decided to withdraw active treatment and the clinicians already felt that decision should be made, but no one wanted to make the final decision to say, "Now we withdraw [treatment]".*
>
> *It was very difficult if I saw the person — if I sat in my office and I had the file, all the information, the clinicians who gave me the full picture, it was easier to say it. But the moment I walked into an ICU and saw the person in bed, then it's as if your primary training, your clinical focus, kicks in heavier than pure management principles. – SP10*

This quote vividly illustrates the conflicts between a fiduciary and bureaucratic propriety, but also the importance of having a clinician in management who is capable of exercising clinical restraint. SP10 was being called upon by colleagues who knew which decision needed to be taken, but could not exercise clinical restraint in the face of other considerations: futility, resource constraints, the needs of other patients. Therefore, the superintendent had to step in, be briefed on the "full picture", and make the necessary decision. Crucially for her, as an individual, she had to remain physically removed from bedside to prevent her training or "clinical focus" from impacting the decision.

Compare this to IP1's story of bringing the lay administrator to the ward to show the impact of a missed oxygen order – a suffocating patient. Whereas SP10 was trying to reduce her "clinical focus" as a manager, IP1 was trying to inculcate some degree of clinical awareness in an administrator precisely through clinical exposure.

The examples in this section illustrate conflicts between the different normative expectations under which clinician-managers labour, and how they make sense of these. These narratives have not only provided content for analysis, but have shown participants grapple with the — sometimes incommensurate — demands of being a clinician and manager. Their stories depict themselves and others as moral agents attempting to overcome challenges and, even when they describe themselves as successful, as doing so with considerable ambivalence. Not all normative

challenges, however, directly involve individual patients pitted against organisational needs. Sometimes managers must face their clinical and managerial colleagues to resolve conflict and prevent harm.

Colleagues and inquisitors: soft power, hard power, and "extremely stressful" processes

The attitudes of some clinician-managers to various non-clinical work have been explored in the previous chapter. However, the one aspect of this which some participants highlighted as particularly unpleasant, was managing other clinicians, particularly doctors:

> *The big stress was managing the doctors…*
>
> *There was one particular doctor. It was an elderly doctor who worked there and he was actually schizophrenic and so every now and then he would do quite strange things and was not very responsive to any measures we took. I mean I was at the point where I felt he was unfit for a doctor and had to follow that procedure and then he went away fortunately. But that was extremely stressful. -SP4*

Multiple participants shared the admission that managing others, was a source of "stress" or difficulty. Whereas one participant spoke about the organisational "politics", and another spoke of the "drama" entailed in being a manager of professionals, the most striking examples were those concerning impaired colleagues or malpractice. As with SP4's example, his experiences with a colleague suffering from a serious mental illness led him to doubt this person's fitness to practice medicine – triggering several steps to report the doctor to their professional body. Although he was following "procedure", he still found the experience difficult.

It is not clear from this narrative where this stress emanates from, and it is not spelled out in the interview. It may be a concern for patients, the additional workload required by the procedure, personal animosity from the person under investigation or

something else entirely. Another impaired colleague, a missionary doctor, which SP4 had to discipline, labelled the process as “ungrateful” for their work.

This example concerns a serious mental illness and, given the information provided by SP4, few would object to the steps he took. However, in less extreme examples, taking action against a colleague may violate some clinicians’ perception of collegial propriety – that is disregarding goodwill and informality in favour of a more rigid, hierarchical and bureaucratic response. This response is characterised by “procedure” and, in other interviews, by “paper trails” and distressing slowness.

IP5, a district specialist, provided an extensive narrative around the reporting of malpractice and impaired colleagues or subordinates. Her account encapsulated some of the challenges articulated by other participants. Although her examples may be more extreme than those encountered elsewhere, they are highly illustrative. This may also be the result of her role in moving between facilities and supporting managers with difficult problems. Below is an extended series of quotations from IP5.

As a junior doctor, she noticed a colleague injecting a potentially toxic medication (gentamicin) into patients’ spinal canals during lumbar punctures. This procedure had no evidence base and carried significant risk for patients. She reported this colleague to her manager:

> *It was a [foreign trained] doctor who said he was a neurosurgeon, and it was very trying to work with [him]. As a fairly junior doctor I didn’t know all the paper work and the processes to follow… to either employ someone or to un-employ someone.*
>
> *I think that insight has changed slightly now and so my… initial sense of frustration - it was just like, “He’s doing this, - [I’m going to] go to the clinical manager.”*

It was very interesting, the approach [the clinical manager] took. – IP5

IP5 explained that the manager waited until the next ward round. When the doctor in question presented a patient on whom they had performed a lumbar puncture, the manager confirmed whether the doctor had given the unproven treatment in question, taking a “non-adversarial” approach. The participant explained how, although she was puzzled by this approach initially, she now understood:

> *[The manager] was actually collecting all of these examples and discussing with this doctor and discussing with whoever… appointed him or employed him through the [regional administration]… and one day [the doctor in question] just left … From that I realised that you need to follow procedures. You need to have paper trails. – IP5*

More senior and with some oversight responsibilities for others, IP5 had now been in the position of responding impaired healthcare workers or dangerous practices, and reflected on how her early experiences influenced her approach. She explained that she was involved with several disciplinary cases. In one, where a staff member provided substandard and dangerous care, she explained how she used extensive documentation of previous complaints to initiate the necessary procedure to have them dismissed.

> *It has got to the stage now where he actually needs to be dismissed from work and I said to [the rest of the team], “We’ve got all this paper work. We have shown what we have done along the way.” -IP5*

However, she noted that things were seldom as simple, as documentation was often inadequately preserved:

> *Unfortunately the process is often not followed very well and… the records are lost or there are not good records that are kept and so when it comes to the final… hearing… people drop away…[and the hearing cannot continue].* - IP5

In one case, IP5 stated that she had kept such thorough documentation about one doctor's malpractice that she could print out a "wad" of documentation, which could be used as evidence in a hearing.

In her role supporting other managers in her district, she had found that they avoid going through these "difficult" processes, hoping for the healthcare worker in question to "go away":

> *When we go to hospital now and… you are talking to the clinical manager and they say … "I am so glad so-and-so [a doctor]… left."*
>
> *And I said, "Why?"*
>
> *"No, they've got a drinking problem."*
>
> *I said, "Did you ever report it?*
>
> *"No, they were so close to the end of their time. We just decided to let them go [of their own accord]." -IP5*

Due to her role in reporting some of these cases, she was sometimes called upon to testify at hearings, and the regional administration had told her that they had difficulty finding persons willing to do so. She noted that people responsible for reporting might feel "intimidated" by the process. In one particular case, she had provided extensive documentation, evidence that one healthcare worker was drunk at work, but had heard nothing back after laying the complaint. However, many months later, she was called to a hearing and could then provide the necessary evidence.

Her careful documentation of incidents had provided the basis for a case, and this was how she managed to get the other managerial staff to participate at the hearing. Reflecting on the process, IP5 speculated as to why these processes were so challenging for clinicians in management:

I think it is not a strong part of our training [as doctors]... It's something that I think clinicians discover by default and often the first time you discover it is when there's a situation in your hospital… you suddenly now start floundering as to what to do…

This relates to earlier findings reported in this thesis – that the learning pathways for clinicians in management are highly variable and that some have to "learn on the job". Yet, this unfamiliarity with procedure does not fully explain the difficulties faced by IP5. As noted by SP14 above, many clinicians become competent administrators in pursuit of better patient care. How is initiating a disciplinary procedure different from acquiring an ultrasound machine? IP5 added additional dimensions to the dynamic:

You are sometimes seen as the bad guy…

But to be a good manager means you need to have the guts to follow through and organised enough to be consistent. So it wears you down and that is the whole thing about people who don't want to be in the system: they weigh you down and they look for gaps…

It is so exhausting to write the first warning and to collect evidence and the second warning … You need to have the tools available. You need to be able to feed it up to the right people and then you need to have a commitment of the right people and often that is where your system fault is. That when it gets to the district manager or something then it just peters out and then people get disillusioned. -IP5

The narrative above provides a detailed understanding of how clinician-managers must balance two additional proprieties alongside patient care (the fiduciary propriety) and doing the necessary paperwork (bureaucratic propriety). They must act as inquisitors when they learn of mistakes or malpractice, and balance this against tacit expectations of collegiality towards fellow doctors.

In the first example IP5 gave, she was frustrated that her manager did not immediately act in defence of patients by dismissing the offending doctor. However, she only later learned that the manager was balancing this fiduciary duty against

bureaucratic, collegial and inquisitorial expectations. The table below illustrates this in more detail:

Table 20: Possible responses, according to proprieties, to reports of malpractice or medical errors

Propriety	Possible response dictated by this single propriety:	Response conflicts with:
Fiduciary propriety	If there is a risk to patients as a result of malpractice, the alleged perpetrator(s) should be removed from clinical practice as soon as possible.	Bureaucratic propriety: there is a procedure for dismissal which must be followed, including warnings and documentation. Collegial propriety: this would not respect the clinicians' autonomy to practice and would resort to hierarchy for influencing practice. Inquisitorial propriety: the clinician-manager must gather evidence about what has happened and afford the accused the opportunity to respond to allegations.
Bureaucratic and inquisitorial propriety	The incident must be documented according to procedure and escalated appropriately. There must be an inquiry into what happened, which hears from all parties.	Fiduciary propriety: allowing unsafe or impaired practitioners to continue practice endangers patients Collegial propriety: this would not respect the clinicians' autonomy to practice and would resort to hierarchy for influencing practice.
Collegial propriety	Recognise the challenges entailed in provision of healthcare and approach the colleague, affording them an opportunity to explain their actions in a non-adversarial setting. There is also the possibility of not proceeding with any further confrontation at all, respecting the colleagues' autonomy, especially if they are senior.	Fiduciary propriety: allowing unsafe or impaired practitioners to continue practice endangers patients. Bureaucratic propriety: if only this approach is taken, this may violate set procedures for responding to possible patient harm. Inquisitorial propriety: this collegial approach risks not weighing the impact of malpractice or mistakes on other parties, especially patients, their families and other health workers.

The purpose of this table is not to dictate the correct response, but to lay out the conflicting courses of action available to the clinician-manager.

One thread which requires further elaboration is the reluctance of various managers, in IP5's account, to engage in such processes at all. Whereas the section above lays out the conflict of proprieties – behaviours which are each appropriate according to their own priorities – the narratives above also suggest certain improprieties. It is one thing for a manager to defer to collegiality when evaluating an incident and to decide to do nothing further. It is another thing entirely for the same manager to decide to do

nothing because they would resent the paperwork or “admin” involved. The former may be defended as collegial propriety (however objectionable), whereas the latter is simply bureaucratic and inquisitorial impropriety without a redeeming narrative. Consider also the HPCSA’s guidance which states that violating a duty “without justification” is unethical (Health Professions Council of South Africa 2019, p.12).

IP5’s account refers to poorly kept or lost documentation, and inquiries which “peter out” after extensive effort. These instances may simply be fiduciary, bureaucratic and inquisitorial impropriety – the absence of morally called-for behaviours – without deliberation.

Part of the clinician-manager’s “floundering”, not knowing how to act appropriately when faced with a problem, as IP5 suggests, may be due to an overly clinical approach to management, which neglects to equip clinician-managers with the necessary systems knowledge. However, as she later expands, another explanation for these improprieties may also be the absence of the necessary fortitude (or “guts”) to see difficult processes through, or disillusionment with the processes which would need to sustain these inquiries.

The above narratives may serve the purpose of depicting the protagonists as moral agents overcoming various forms of trouble. It would appear that one commonality to these stories is a reluctance or a difficulty for clinicians to engage with problems as managers rather than clinicians.

Another participant alluded to this balance when speaking about their role as a manager in a specialist department:

So what I find a bit unnerving… there's a lot of power that goes with management. If you choose to use it you can use it, and you can do a lot of good things. And you can do a lot of damage….

From my side we build relationships… We work far more on soft power, rather than hard… decision-making power…

And so it shouldn’t be the first thing you jump to, but after a process of deliberating, getting people’s opinions and views, at the end of the day there must be a decision resting with one person otherwise it’s chaos and we’re inconsistent in the way we manage things. So after that process and if you’re not able to get buy-in on something then you do have to go to hard power and then you have to make decisions, and when you make a decision you can’t satisfy everyone…

There’s not always time for deliberating, especially like we found with Coronavirus and closing wards here and pulling people from their departments to help somewhere else, you still have to draw on that hard power – the quicker you need a decision or the higher up you are in the organisation. So you’ve got it [hard power] and you always have to let people know that you can use it, but you shouldn’t use it first. – SP15

SP15, who manages a specialist department but holds a management qualification, states that he finds the “hard power” and one’s ability to use it for both “good things” and to do “damage”, an “unnerving” situation. On the surface, this may simply be a reckoning of what the responsibilities of healthcare workers are in general. However, viewed with proprieties in mind, and in context of the rest of the narrative, one realises that the “damage” chiefly refers to relationships between professionals.

Shale describes one aspect of the bureaucratic propriety, a commitment to collective decision-making, as “corporate comportment” and that is largely what SP15 is describing here as a “process of deliberating”. This also aligns with the collegial propriety insofar as fellow professionals are consulted with regards to their preferred routes of action.

Viewed in this manner, the successful reliance on soft power means exercising bureaucratic and collegial propriety. If, after extensive consultation, a solution can be

found which satisfies colleagues and a viable decision is reached, the clinician-manager can be said to have exercised both proprieties.

However, matters are seldom so simple and SP15 points out that in order to avoid "chaos", a manager may have to make a decision which cannot "satisfy everyone" or may even harm relationships. An example he gives is that of disrupting service delivery and reallocating staff due to the coronavirus pandemic. This exercise of "hard power" represents a collegial impropriety – as it relies on hierarchy to legitimise a decision. This must be done in order to act in the organisation's best interests and ultimately that of patients. Although this is far from the "corporate comportment", this is an expression of the "comportment of accountability", which Shale identifies as "perhaps one of the most fundamental moral responsibilities that it falls on leaders to discharge" (Shale 2011). This is similar to the need for health workers to act paternalistically in a life-threatening or public health emergency, where they must override a patients' autonomy in the interest of the patient or the community (Hershey 1985).

In this manner, some situations may require the clinician-manager to prioritise one propriety over another, and to treat colleagues as subordinates – so that the organisation can achieve its aims. SP15 also notes that these trade-offs, in his experience, become more likely as one ascends in the ranks of the organisation. It is no coincidence that this ascent sees clinician-managers drift further away from the clinical environment. However, this distancing can serve a function, as SP10 showed in her own interview, allowing the clinician-manager to exercise clinical restraint.

Learning, relationships and "making explicit some of the implicit stuff"

The scenarios given by clinician-managers above demonstrate the, otherwise implicit, normative aspects of clinical-managerial work. Prioritising certain service providers for payment, keeping "in touch" with one's clinical area, and ensuring judicious use of resources may, to the reader, present obvious courses of action. However, as participants' narratives, and a deeper analysis of expectations reveal, many of these cases occur at the nexus of several "oughts". By contrasting the differing courses of action, each prioritising a different beneficiary or group, this chapter makes these intersections visible.

Given these tensions, it is no surprise that some participants spoke of the personal cost that the clinician-manager role had extracted from them. Becoming sensitised to this, and alerted to the need for caution, was itself a process of learning for some participants.

> *I suppose it's a lot of trial and error a lot of getting frustrated with the system and sometimes handling that well and sometimes not handling that well and trying to learn from both. I think to start with… If I look back at myself I think "wow I was like a bull in a China shop to start with". – IP1*

IP1, a district hospital clinical manager who had held the post for more than a decade, was able to reflect on his own journey in the role. As chapter four has already showed, he had to learn by "trial and error", and this entailed a great deal of frustration and difficulty. However, what he emphasises is his own response to this difficulty. Being faced with difficult decisions and lacking the insight to proceed along the correct path – not deciding which parties to prioritise causes him to reflect that he was indelicate. A "bull in a China shop" describes the clinician-manager as someone

who breaks things – perhaps trust and relationships, perhaps committing improprieties without realising it.

Returning to an earlier quote by IP9, one is reminded that this process of sensitisation carries a cost:

> *For a while [I was] acting superintendent by default. I made a mess of it… It didn't go very well I actually had a bit of a burnout… because I was obviously all energy and passion and no knowledge and wisdom. - IP9*

Here, IP9 reflects on his foray into management "by default" and how he "made a mess" of the endeavour. He ascribes this to him deploying "energy and passion" instead of the "knowledge and wisdom". This framing is interesting as it matches Thomasma and Pelligrino's conception of phronesis, or practical wisdom, as being the most important virtue in medical practice. As they put it, phronesis is "an intellectual virtue that disposes one habitually to choose the right thing to do in a concrete moral situation" (Pellegrino and Thomasma 1993, p.21). Choosing the "right thing" is what the clinician-managers describe themselves as striving towards in these scenarios.

One participant described herself as making the trade-offs implicit in these "concrete moral situations" more explicit through conversation:

> *Most of the time the decision-making is between bad and bad or bad and worse or hardly ever between good and good, but those are the dilemmas that you are facing so lots of it is about really kind of challenging and about making explicit some of the implicit stuff.*
>
> *Part of the space is having that… open conversation… But those require skills to have difficult conversations that retain dignity. - IP0B*

The "skills" required of a manager, according to IP0B, based on her experience as manager in both the private and public sector, is to "have difficult conversations that retain dignity". These conversations would revolve around the "dilemmas" which this

chapter outlines – and take place in a way which makes the implicit tensions explicit. This is a crucial element of the normative work of clinician-managers: recognising the moral components of their work.

This strongly resonates with Shale's definition of "moral leadership", which entails "being astute" to the "moral connotations" of a situation, deciding on the appropriate action to take, and driving a "morally appropriate" response (Shale 2011)

Furthermore, in some of the more ambivalent or overtly negative narratives introduced above, participants are relating two of the factors that Cahill and colleagues identify as being associated with moral injury: finding themselves in a different ethical community (that of the healthcare bureaucracy) and limited agency (in terms of the options available to them) (Cahill et al. 2022). This is one way of understanding the negativity contained within these accounts.

Personal values and faith

Given that individuals' personal value systems are likely to have influenced several of the narratives in this chapter, it is perhaps surprising that concepts such as personal faith or community values did not feature more prominently. This is not to say that some participants did not mention religion at all. For example, one participant spoke of her background prior to becoming a nurse:

> *Missionary work was my background…[But] I had a dad who said, "First get a professional qualification then you can do a job so you have something to fall back on." – SP8*

In this quote, the participant acknowledges the importance they attach to a religious mission ("missionary work"), but one that seems to have been subordinated to (and is contrasted with) a professional career. There is reference to the role of a parent in

making this decision, but the interviewee does not return to the notion of religion in her narrative, so it is not possible to unpack this narrative further. Another participant noted that his role as a clinician in a rural hospital was motivated by a religious conviction:

> *…I felt a very strong calling to rural health… – IP1*

The notion of a religious "calling" being answered through a career in healthcare, particularly in settings which others might deem as less desirable (such as rural health), did feature in some participant biographies, and one participant also mentioned doing "bible study" with their clinical colleagues, suggesting that some clinical teams comfortably embraced religion. Another participant volunteered to do the interview in their local church hall (which was put to other uses during the week).

However, for the most part, participants did not frame moral narratives in religious terms. Instead, as has already been noted, narratives made reference to clinical duties towards patients, standards of care and broader ethical principles. This is further explored in the next section.

Discussion

This chapter has explored four key areas in which clinician-managers presented themselves as performing work, which must reconcile multiple normative pressures. The first area concerns work which must weigh priorities of what ought to be done: acting on behalf of patient interests at the organisational level. The second area sees them placing the interests of the organisation (including its resources and procedures) before other priorities. In the third, they must balance perceived obligations towards colleagues and the inquisitorial process with one another.

Finally, they have the difficult task of making all of this explicit through conversation and relationships.

Although the theoretical frameworks drawn upon in this chapter are based on research which emphasises the normative aspects of clinical-managerial work, this is not to suggest that the rest of the existing research on this group is value neutral. Indeed, in this section I will demonstrate how readily these findings map onto the moral aspects of clinician-managers' in other publications.

The normative role of clinician-managers

A 2010 literature review of ethical dilemmas faced by managers of healthcare organisations arose from three kinds of conflicts. Those within the healthcare organisation pertained to the care of patients, the management of staff and the resources in the organisation. Dilemmas at the national level concerned policy, access to healthcare and the consultations around these. Finally, the interface between the "political and local" level saw conflicts regarding resource allocation to the healthcare sector by government, obligations placed on professionals and financial incentives provided for certain kinds of care (Žydžiunaite et al. 2010, p.4). Although this study has not explored all of these aspects, it is clear that other authors also frame the management of healthcare as a morally fraught endeavour. However, with other authors the ethical dimension may be implicit.

In other South African research, introduced in chapter 3, clinician-managers who described themselves as "passionate about patients" moved from full-time clinical work to part- or full-time managerial work in order to "have a voice" at "higher levels" (Parbhoo 2020, p.36). Here they could impact a larger number of patients in an

indirect fashion. A study among nurse managers in South Africa also found that some considered their clinical background enabled them to asses care quality and to "advocate for patients" (Daire and Gilson 2014, p.ii90). In Sierra Leone, a study on doctors in leadership positions, many of whom were clinician-managers, reported the perception that the leadership of these individuals play an important role in determining the quality of patient care (Johnson et al. 2021, p.1649). In higher income settings, Berghout and colleagues' systematic review on medical leadership (which included multiple studies focusing on clinician-managers) reported that much of the organisational-level work of these leaders were to "safeguard both the quality and efficiency of care" (2017, p.12).

Although none of the above studies analysed their findings in these terms, it is possible to reframe these pragmatic considerations as distinctly moral problems. Clinicians in management (or leadership) roles can exercise fiduciary propriety in their organisational role. Doing so is not merely an act of "balancing", as several authors phrase it, but of choosing moral action. These individuals are called upon to cultivate the internal goods of healthcare, and to realign the organisation in that direction. That this patient-orientation is framed in such matter-of-fact terms further shows how implicit the moral narratives in this field of research are.

However, this section only makes sense if an alternative course of action is available to clinician-managers. The implicit message here is that, while some do pursue the internal goods of healthcare, others may lose sight of this and become preoccupied with external goods (narrow adherence to rules in pursuit of resources, status and power), to the detriment of patient care.

Adopting the bureaucratic propriety and focusing on the external goods of healthcare

Some researchers frame the move from clinical to managerial work for practitioners explicitly in terms of career progression and the accumulation of organisational power. One study of Norwegian clinician-managers noted that some participants took on the role due to a desire for control over their surroundings and because they "liked the feeling of power" (Spehar et al. 2012, p.4). These pursuits may be framed as the cultivation of the external goods in healthcare, as may considerations of career advancement for their own sake. However, a narrative understanding, which sees managers use these positions to benefit patients, may cast these ambitions in a more positive light.

As the exercise of the bureaucratic propriety can be viewed as the exercise of organisational power, it is important to consider by what measure something is judged to be a propriety or impropriety. Erasmus and Gilson suggest that the "perspective, context and criteria" of the decision-maker be taken into account and judgements about the "good" exercise of power be tied to whether they achieve goals such as "health equity" (2008, p.367). In this regard, I would argue that a consideration of whether a decision serves the pursuit of internal goods, as described earlier in this chapter, serves as a measure of bureaucratic propriety or impropriety.

Another study of priority setting and resource allocation (PSRA) in Kenyan hospitals, showed that positions which provided authority could be used by senior managers to exclude mid-level managers from decision-making, and that this might allow the misallocation of resources (Barasa et al. 2016, p.6). While the authors describe these outcomes as possibly constituting corruption, this chapter would view these

managers as pursuing the external goods of healthcare or committing bureaucratic impropriety. Within this framework, the failings and misconduct of clinician-managers can be understood. Righteous conduct, a fine balance between internal and external goods, and the judicious enactment of the appropriate propriety is the course which may be most difficult to achieve.

The same study also found that clinician-managers, the heads of departments, saw PSRA processes as “wasted time” and thus removed themselves from these meetings for the most part (Barasa et al. 2016, p.7). This reiterates findings from the previous chapter in this thesis, but also demonstrates how clinician-managers can fail to grasp the significance of bureaucratic processes to influence their practice. The clinicians here may be said to eschew the pursuit of external goods in favour of internal goods. However, this does not account for the possible negative impacts of their absence: decisions made without clinical insight that harm patients. It may be more appropriate to frame their absenteeism as bureaucratic impropriety, however noble their clinical actions performed in its stead might be.

Whereas the interaction of clinicians and managers has been framed in terms of an aspirant managerial hegemony and clinical resistance, this narrow view is incomplete (Numerato et al. 2012, p.426). The normative framework applied and expanded upon in this chapter can add much-needed nuance to this analysis. Clinicians can engage in bureaucratic processes and roles in a manner which is moral (and thus beneficial to patients and staff) or immoral (self-serving or even corrupt, to the detriment of others).

Colleagues and inquisitors: informal norms and professional allegiance

The discretion exercised by clinician-managers at a facility level, both to pursue or overlook misconduct was also described by researchers studying nurse facility managers in South Africa (Daire and Gilson 2014, p.ii91). By framing this exercise of discretion as “difficult conversations” or “relationship issues”, the authors are also describing the collegial focus these managers are expected to take before taking any “formal disciplinary steps”. Parbhoo found that clinician-managers regarded the management of multidisciplinary teams as a particular challenge, which sometimes included setting a boundary with subordinates or indicating that certain commands come from “higher up” (2020).

Similarly, a study on clinician-managers in the Kenyan setting detailed what adopting “informal norms” at local level might mean for managers. This included failures to challenge “poor clinical practice” and “unauthorised absences” (Nzinga, Mcgivern and English 2018). Based on these and other findings, the researchers noted that this might be attributable to “professional allegiance”. The same study also noted how certain procedures, which were meant to investigate adverse events, were used to shift blame.

In a more extreme example, doctors in leadership positions in Sierra Leone were expected to redirect parts of their health budgets towards individuals (colleagues at various levels of the health bureaucracy) or risk being removed from their positions (Johnson et al. 2021, p.1654). In higher income regions, Berghout and colleagues concluded that clinician-managers passed activities such as “performance management” to lay managers so as not to have to encroach other clinicians’ autonomy (2017, p.12). Whereas some of the above researchers chose to theorise

these findings as being context-related or as attributable to a clinical or professional identity, at least one group of authors identified the normative aspect of clinician-managerial work, describing these tensions as resulting from “normative pluralism” (Nzinga, Mcgivern and English 2018).

In all of the above cases, clinician-managers must choose between prioritising their organisations (and its processes), their colleagues (or profession) and patient interests. The collegial and the inquisitorial proprieties are, unsurprisingly, frequently in tension – as clinician-managers are implicitly expected to bend rules in favour of staff, rather than the organisation or patients. Some clinicians do so, some defer such tasks to lay managers and others scrupulously follow procedure and face the wrath of the professional peers.

It is not always clear, however, when this deference represents impropriety, or when inquisitorial actions are taken with ulterior motives (another impropriety). The ethical frameworks introduced in this chapter can firstly be used to elucidate the presence of these conflicting behavioural expectations and to legitimate them. Even the HPCSA’s own guidance describes the how the duties of doctors towards other professionals is to be guided by what is in patients’ best interests (Health Professions Council of South Africa 2019, p.10).

Here, a narrative understanding of these dilemmas is important. Some of the above decisions may constitute, for example, bureaucratic impropriety in the short term, but allow for staff retention and higher morale in the longer term. Focusing on the internal goods of healthcare (contributing to health and wellbeing), can be one standard to which the outcome of a decision is compared.

Conflicting or compatible stories of propriety and virtue?

Clinician-managers have *specific* normative duties emanating from their role in an organisation. Shale's articulation of specific proprieties has several strengths. Firstly, it is readily compatible with both a fragmentary and virtue approach to ethics. Each of the proprieties overlap with several "core ethical values" or the major normative theories in healthcare. Secondly, it is empirically based on clinician-managers and thus its terminology is readily applicable to the dilemmas faced by them. Its application here further lends credence to this, although it may be necessary to add to it, such as a comportment of clinical restraint as part of bureaucratic propriety, or to provide further clarification of its terms. Thirdly, it provides a framework for describing the tensions between different duties, principles or proprieties (however one chooses to define them). There is hope that, given the language to express the dilemmas faced by clinician-managers, the moral weight of their work can be given due consideration.

As Shale writes:

> *[P]roprieties are not necessarily consciously recognised forms of behaviour. Whatever knowledge medical leaders have of the proprieties tends to be tacitly held. This means that the basis for a strongly felt decisional bias may not always be apparent; and that a customary behaviour may take hold of the situation before there is any conscious deliberation about how best to proceed* (Shale 2011).

Understanding the proprieties allows one to understand the explicit and implicit justifications for these "customary behaviours", whether it is neglecting crucial administration in favour of a busy clinic, declining to report an impaired colleague, or marshalling an organisation's resources in pursuit of patients' well-being. Educating clinician-managers on these dynamics may enhance the quality of these decisions.

A finding which merits further research is the paucity of narratives or thematic content which deals with the repair of relationships in this study. This may simply be a result of the overall focus of the study, which was broader than the normative content on which this chapter has focused. However, the restorative propriety is an essential part of the framework which she describes. In order to *repair* moral relations, the moral leaders (as Shale calls them) need to be "astute" to the moral weight of their actions. In the absence of this awareness, how are they to know there are moral relations to repair at all?

One must also remain open to the possibility that clinician-managers are placed at a particular risk for moral injury. Participants' own narratives regarding their exhaustion, burnout and other difficulties relate directly to the challenge of reconciling conflicting proprieties, reflecting their departure from one moral community and, simultaneously, an additional set of constraints placed on their ability to act. This will be returned to in the final chapter.

Reflecting on secular and religious narratives

Many South Africans identify as religious, with 89% of the populace surveyed in one census stating that they had been raised in Christianity and 74% indicating that religion was important to them (Schoeman 2017). Missionary hospitals, in particular, have a long history in South Africa as well, and have played a role in providing healthcare to rural communities, with many now formally incorporated into the national healthcare system (Ingle 2010). However, the South African healthcare system functions within a secular constitutional order, and as others have noted, this does create the potential for healthcare policies (such as the right to terminate a pregnancy) to conflict with health workers' religious values (Vincent 2012).

Given that I did encounter religious content in some interviews, I was surprised that some moral narratives were not more overtly religious in nature. However, this possibly stems from the setting, the manner in which the research project was presented (religion was not mentioned in the research question), the private nature of religious beliefs for some, and possible discomfort for participants to introduce religious reasons for decisions in a secular healthcare system. This is a sensitive subject which future research might be able to elucidate further.

Conclusion

This chapter has demonstrated the normative aspects of the clinical-managerial role in healthcare organisations, as it features in clinician-managers' own narratives. These normative strands are present in both the South African setting and visible, but not necessarily framed as such, in the international literature on clinician-managers. Reconceiving clinicians' advocacy on behalf of patients at organisational level, or the weighing of procedure against respect for colleagues' autonomy, as moral dilemmas, casts new light on these tensions. Describing these conflicts and analysing their meanings has the potential to assist clinician-managers in moral deliberation.

Part 3: Discussion, conclusion, references and coda

Chapter 7: Discussion and conclusion

In this chapter, I discuss the implications and limitations of my thesis. I also suggest future research avenues on clinician-managers and make recommendations with regards to understanding, training and supporting clinician-managers in South Africa. In addition to the above, I will also consider a recent public disagreement with regards to the state of a South African public hospital in light of the findings and theorisation contained within this thesis. The purpose of this example is largely illustrative and to facilitate the discussion.

On 22 May 2022, Tim de Maayer, a paediatrician at Rahima Moosa Mother and Child Hospital in South Africa published an open letter in *The Daily Maverick,* an online newspaper, addressed to his hospital management and the department of health. His “Dear Administrators” letter ran through a list of challenges he and his colleagues faced while caring for patients, including referencing the recent deaths of patients. An excerpt of the letter is reproduced in the text box below.

The hospital CEO, Nozuko Mkabayi, who is also a medical doctor, suspended De Maayer on 9 June 2022, following several days of attention from media, local government and the presidency (Heywood 2022; Metelerkamp 2022). This triggered widespread public outcry, a petition, and ultimately De Maayer’s reinstatement to his former position (Maverick Citizen 2022).

Another open letter was published on 21 June 2022, this time addressed (among others) to the National Minister of Health, Joe Phaahla (another medical doctor). The letter listed signatories typing “I am” followed by their names in a “direct challenge to authorities to discipline them if they dare” (Maverick Citizen 2022). The list included

academics, specialists, heads of department and several other senior figures in the South African healthcare environment. The signatories made several declarations and demands. Among these were references to “profound administrative deficiencies plaguing public health facilities”, which in turn cause “moral injury” to those working in them. Their demands included the cessation of disciplinary steps against De Maayer, as well as:

> *The establishment of a standing Public Health Administration Review Commission to reconfigure the structure and operation of provincial health departments, including:*
>
> *a) The devolution of authority to independent, skilled and capable hospital boards accountable in the first instance to the facility and its staff, patients and communities and reporting to the Provincial Legislature on a regulated basis.*
>
> *b) The appointment of CEOs with operational and financial management skills by these duly constituted boards, in conjunction with the joint staff protocols of relevant academic medical faculties and the provincial administration.*
> (Maverick Citizen 2022)

Excerpts from Dr Tim de Maayer's open letter, published in the Daily Maverick on 22 May 2022:

Dear Administrators

…

I wish you [the administrators] could be there to see the pain and grief that these parents and their families go through.

Children are dying and the horrendous conditions in our public hospitals are contributing to their deaths.

I wish you could come to our unit and see doctors trying to intubate children and administer cardiopulmonary resuscitation by their mobile phone's torch, as the power has failed … again… Or the cold neonate whose incubator went off with the loss of power (from load shedding) and did not keep him warm.

How about excluding a mother-and-child hospital from your load shedding schedule? Our generators are unfortunately inadequately sized to supply the hospital.

I wish you could come and explain to parents that their child needs an urgent computerised tomography scan of the brain but he's going to have to wait, since our scanner has been broken for nearly three months, Chris Hani Baragwanath [a nearby hospital] is overflowing, and Charlotte Maxeke [another hospital] has had crucial parts of its scanner stolen.

He ended up waiting for 48 hours, when the Nelson Mandela Children's Hospital managed to assist.

I wish you would come and look at the toilets when the water has been off because the local water reservoir was running low.

Or, even better, come and see how hospital-acquired infections spread like wildfire through the neonatal ward because the taps are dry, and washing your hands while lifting a five-litre water container after examining each child is just not feasible.

No, scrap that. Please come out of your ivory towers and come and use our lidless toilets. (There is one for fathers on the ground floor; the rest are off limits to men.)

Perhaps you could come and try to manage a critically ill little patient without the benefit of blood test results, as the National Health Laboratory Service's turnaround time is frequently more than 24 hours at our hospital.

Or see doctors drive around to different hospitals trying to acquire essential supplies that are not available at our hospital.

I could go on, but want to pose some questions to you: Would you admit your child to this hospital? Would you trust the overburdened and burnt-out healthcare staff to look after your little one in their hour of greatest need?

And if you wouldn't, how do you manage to come to work every day, fail at your job of ensuring basic healthcare for the people you serve and still sleep at night? Having worked in the public sector for 21 years, I can tell you frankly: things are falling apart.

If your healthcare workers are the centre of providing care, we cannot hold. Things are going backwards, fast. The care that is being provided in your less than glittering hospitals is getting worse every day.

Are you worried about the greedy lawyers who are waiting in the wings, suing your department for millions because a premature infant went blind because there was no functional meter (which costs less than R1,000) monitoring her oxygen delivery?

You should be, because money is being wasted on paying negligence lawsuit compensations rather than preventing the problem in the first place.

And before you ask, yes, these issues have been raised with management repeatedly, including two reports on the critical state of the neonatal wards and obstetric services in 2016 and 2021, and a more recent letter on 11 April 2022 detailing the disastrous state of the hospital. The "correct procedures" have been followed, with no visible response…

I guess your inaction and disregard for the health of children does not matter, since children cannot vote and so why should you bother to meet their needs?

While Nelson Mandela, Chris Hani, Charlotte Maxeke and Rahima Moosa [the persons after whom the hospitals are named] are turning in their graves, disturbed by the dismal conditions at hospitals bearing their names, I want to reassure them that we, the frontline healthcare workers, will keep fighting to maintain the health and wellbeing of our vulnerable children.

But it would be nice if you did something too. (De Maayer 2022)

Naturally, I viewed the unfolding saga with the findings of this thesis in mind. De Maayer, a clinician, was writing to his hospital administration, a group of people which included both clinical and non-clinical managers. Even though the author of the original open letter was a consultant paediatrician, I was reminded of myself as an intern, puzzling over the management decisions (or indecisions) made by a clinician-manager, wondering why "these things take time". Throughout this chapter, I will explore the Rahima Moosa case, largely by returning to the excerpts above in more detail and viewing them through the findings and analysis of each chapter. By the end of this discussion, it is my aim to have brought some of the underlying conflicts into better focus and, hopefully, to have blurred a straight-forward, Manichean narrative of good clinicians and bad management.

In this thesis, I have explored three main aspects of the clinician-manager's role combination within the South African healthcare setting: how they learn to manage, how they acquire a managerial logic and combine it with their clinical logic, and the normative aspects of their work. The question of *why* clinicians are appointed to management positions in healthcare organisations is more complex than a traits-based perspective would suggest. However, given the reality that clinicians *are* appointed as managers in the South African healthcare setting, I have questioned *how* they combine their training, experience (and sometimes continued work) as a clinician with the responsibilities of a manager. Between 2019 and 2021, I conducted in-depth interviews with 33 participants, 29 of whom were doctors, 4 of whom were nurses. The data were analysed thematically and the results were then theorised using approaches which offered a descriptive and explanatory fit. Following this, the results were considered alongside previous research on clinician-managers.

The three findings chapters of this thesis each address a different aspect of this result. Below, I will summarise my thesis and thereafter I will consider implications of each chapter for the training, appointment and support of clinician-managers. Given that this research has largely focused on medical clinician-managers, the implications of the findings will be explored largely in relation to the training and ongoing education of doctors. I will also consider the limitations of this research as well as outline future research on clinician-managers in South Africa and beyond.

Summary of findings

Learning to manage

Both De Maayer’s open letter and the subsequent declarations and demands by the signatories to the “I am” letter, make claims regarding the shortcomings of the hospital administrators (in this case represented by the CEO, a clinician-manager, but also constituting a cohort of clinical and lay managers and staff). These include scheduled electricity interruptions at the hospital, known as “load shedding”, from which the hospital is not excluded, and for which its generators are apparently inadequate, no running water, a more than three month waiting period for certain imaging and 24-hour turnaround time for investigations.

These challenges form part of combining a clinical and managerial role. In the context of the open letter, one can ask, “how would a clinician, such as a medical doctor stepping into the role of the CEO, acquire the skills to solve such problems?” Chapter 4 of this thesis explored the learning journeys of clinician-managers, as relayed by participants.

Clinician-managers described varying transitions into management positions. Some of the nurse managers contrasted their more gradual introduction into management responsibilities with the more rapid transition they perceived among their medical colleagues. Among the medical clinician-managers, some did describe a progressive transition into a managerial role, whereas others described a sudden, unexpected and sometimes undesired formal or acting appointment into a managerial role.

Participants described a variety of approaches they took as part of fulfilling their roles as managers. Some said that they relied on clinical knowledge of the healthcare system, or even a clinical approach to problem solving. However, this was not without problems. In addition to this, courses, diplomas or degrees aimed at supporting managers in healthcare were used by several participants, and a wide variety of such resources were listed. Attitudes towards these resources ranged from enthusiastic to sceptical. Another approach was to learn "by doing", through trial-and-error, or by emulating other managers. The availability of mentors or networks of other clinician-managers were reported as helpful by some participants, but the exclusion from such informal support also appeared to affect some participants' transition into management.

This chapter introduced the concepts of formal and informal learning, emphasising that the latter takes place outside of a formal curriculum or classroom setting. I also introduced the concept of street-level bureaucracy, which formed part of the analysis in both chapters 4 and 5. However, the overarching analytic approach of this chapter was through three analytic lenses provided by the sociology of the professions, the functional, power, and institutional lenses. Through studying the clinician-managers' own narratives about their learning processes and applying each of these

approaches, this chapter was able to gain a broader understanding of how clinicians learn to become managers within the healthcare system in South Africa. These results also demonstrated how a different approach could be taken to understanding the finding, cited throughout this thesis, that clinicians describe themselves as underprepared for management.

Bearing these findings in mind, the challenges which likely faced the management (both clinical and non-clinical) of Rahima Moosa Hospital are brought into perspective, and a series of questions emerge. Who would be best positioned to solve electricity or water supply challenges? If these were clinician-managers, how could clinicians better be prepared to take on the role of managers and what support could they be offered once in these roles?

Clinical-managerial logic

Several sentences in De Maayer's letter stand out in light of chapter 5:

> *I wish you could be there to see the pain and grief…*
>
> *I wish you could come to our unit and see…*
>
> *I wish you would come and look…*
>
> *I wish you could come and explain to parents that…*
>
> *Please come out of your ivory towers…*
>
> *[M]oney is being wasted on paying negligence lawsuit compensations rather than preventing the problem in the first place…*
>
> *[W]e, the frontline healthcare workers, will keep fighting to maintain the health and wellbeing of our vulnerable children.*
>
> *But it would be nice if you did something too.* (De Maayer 2022)

The first few lines are wishes that the administrators, both hospital and provincial, would "come" out of their "ivory towers" and "see", "look" or "explain" various failures

of care. This implies a geographic separation between the healthcare workers and the administrators who are somewhere else. Secondly, there is the implication, carried on from the previous section, that these administrators are not only failing to deliver electricity, water, or other goods, but are also wasting money on litigation. Not only that, but it is implied that while “frontline” staff are “fighting” (a battlefield metaphor), whatever the administrators are up to, does not amount to “something”.

The highly charged language of this letter is similar to some participant accounts, but also the second-hand accounts that participants relayed about the reactions of clinical peers, once they had transitioned into their management roles. The findings of chapter 5 can help to understand this portion of De Maayer’s letter.

Using an institutional logics framework, I analysed participant interviews to describe the components of clinical logic, which clinician-managers themselves operated within as clinicians, and which influenced their clinical peers. As part of this I described the theories, frames, narratives and vocabularies of practice which formed part of clinical logic, as well as how clinicians depicted managerial logic.

An important aspect of these logics concerned what constituted “real” or clinical work, and by contrast what was described as “admin”. Further exploring this zero-sum divide, I showed examples of the symbolic language and narratives participants employed in this regard. I argued that in pursuit of clinical goals, some clinician-managers assimilated aspects of managerial logic into clinical logic, by learning to “think like a bureaucrat” and thereby “game” the healthcare bureaucracy, or at the very least align it with clinical priorities. Although still based on clinical logic, this clinical-managerial logic possessed distinct theories, frames and narratives. As part of the discussion of this chapter, I explored how these findings related to other

research on institutional logics in healthcare, as well as the concepts of power, distributed leadership and street-level bureaucracy.

In the excerpt above, De Maayer's letter is deploying a particular vocabulary of practice and theory, part of a clinical logic which views management as ineffective, unreal and more concerned with procedure and medicolegal defensiveness than patients. The high concentration of these examples in such a short letter makes this letter a particularly clear illustration of the clinical logic which I have sought to describe in this thesis.

Normative aspects of clinician-managers' work

The editor of the Maverick Citizen, Mark Heywood, wrote a postscript to the first open letter. There he stated that it was a "cry from the heart", arising from:

> *…moral injury occasioned by silence, from a doctor's Hippocratic oath and after years of unsuccessful efforts by healthcare workers at Rahima Moosa Mother and Child Hospital to have the problems it describes attended to* (De Maayer 2022).

The overtly moral framing, using terms such as "moral injury" and "Hippocratic oath" frame the speaking out of the clinicians, not only as an act of moral rectitude, but as a response to severe transgression. This righteous framing implies that the reason for their challenges is due to unethical behaviour by others. This may be so. However, as this chapter explored, the work of clinician-managers beyond the bedside was replete with normative connotation which might not be apparent to full-time or "frontline" clinicians.

In this chapter I sought to illustrate the normative aspects of clinician-managers' work, in terms of what they or others think ought to be done in a situation. In pursuit

of this, I used several participant narratives to depict different practices of responsibility, which I have called proprieties based on the work of Suzanne Shale.

By providing “clinical insight” and orienting the management of the healthcare organisation towards patients’ care (amid the other organisational priorities, such as security or maintenance), participants depicted themselves as emphasizing fiduciary propriety: the patient comes first. In contrast to this, however, clinician-managers were also tasked with ensuring the financial viability of their facilities, and had to exercise budgetary control over their professional colleagues, sometimes through directives and other times persuading by evidence. As bureaucratic level clinicians (a role explored in chapters 4 and 5), their organisations required them to make decisions which prioritised bureaucratic propriety (defensible resource allocation, following procedure) over fiduciary propriety. In these instances, they were called upon to exercise clinical restraint, which some participants described as difficult. This too, could be described as a form of moral injury.

Several participant narratives concerned the challenges of disciplinary action against fellow clinicians who were impaired (through illness, substance use or incompetence). These narratives illustrated the tensions between collegial propriety (treating colleagues as professionals rather than subordinates), inquisitorial propriety (investigating in the wake of harm), bureaucratic and fiduciary propriety. Local factors, such as slow-moving regional administrations appeared to compound these difficulties.

This chapter also explored the manner in which some clinician-managers do, at least in their retelling, frame these morally fraught scenarios in terms of ethics, rather than procedure or bureaucracy, being “morally astute” to these issues. Some of these

participant narratives served the additional rhetorical purpose of depicting clinician-managers in a positive light. Further research, in the form of additional interviews with patients and other staff, as well as ethnography, will be important in advancing an understanding of the normative role played by clinician-managers. This is explored further later in this chapter.

Hybridising the clinical and the managerial: implications of this research

Researchers have employed a wide range of metaphors to understand the role of the hybrid clinician-manager. Some have been described them as “two-way windows” (Llewellyn 2001), others as “broken two-way windows” (Croft et al. 2015). Elsewhere, they are described as “poachers” who have become gamekeepers (Hunter 1992). Possibly inspired by the *Star Wars* franchise, Spurgeon and colleagues have made reference to the clinicians going over to the “dark side” (Spurgeon et al. 2017). Keeping with the imperial theme, the notions of colonisation and reverse colonisation have received some mention (Numerato et al. 2012). Yet others have noted the facilitative and collaborative role that these individuals can play, describing them instead as “bridges” (Spehar 2014) or as existing between two “worlds” (Witman et al. 2011). The open letter quoted throughout this chapter described the hospital administration as existing in an “ivory tower” (De Maayer 2022).

All of these metaphors may have some use in providing a map for a terrain which we have yet to fully describe. The metaphorical language includes references to division, observation (from behind the safety of a window), the hostility between thieves and property owners and the deadly conflicts and consequences of colonialism. The more conciliatory language can only describe these individuals as

temporary bridging structures between two separate, distinct worlds. By contrast through this thesis, I have described the clinician-managers I interviewed as a distinct group operating within the healthcare sector. They enter their positions in myriad ways, and acquire new skills and knowledge. Some construct a particular hybrid institutional logic (albeit one which may be predominantly clinical) and are faced with ethical dilemmas which emanate from their positions as both clinicians and managers in the healthcare system. If metaphorical language is called for, clinician-managers occupy a unique territory between the service delivery side of the healthcare system (where their professional colleagues work and their patients are cared for) and the organisational side of healthcare (which funds, regulates and supports these activities). Within this territory, they do not simply build bridges, poach resources or become corrupted by a "dark side". Rather, they have the potential to map this terrain and to facilitate communication, lead cooperation and to enhance the functioning of the system as a whole. This is not a given, however, and it is important to explore the nuances of these findings.

From the basis of a small, select group of participants, and a study which was constrained by a pandemic, I will not make broad generalisations. However, a few implications are evident from my findings.

Learning to manage

Clinical training and experience may hold both advantages and disadvantages for managers. Their familiarity with the healthcare system, legitimacy in the perception of fellow professionals (McGivern et al. 2015), and a "clinical method" for problem-solving may constitute strengths. The mediating role of clinician-managers as

bureaucratic level clinicians is also important to emphasise: they can utilise the authority and resources of management to achieve clinical goals.

The drawbacks of appointing clinician-managers must also be considered, however. Some participants found the "clinical approach" to be of limited use. This compounds with the opportunity cost of removing a highly trained clinician (and sometimes specialist) from the clinical workforce in order to perform tasks which might be done by another category of worker. Once these clinicians have become adept managers, however, expectations for them to "push the queue" in the clinic or "roll up their sleeves" during emergencies also temporarily deprives the facility of their managerial skills or may cause resentment if the manager declines to engage. The self-reported lack of preparation for their role and the perception of limited support available to some clinician-managers, may also result in a heterogenous outcomes across the healthcare system with regards to their success or failure.

Considering the above, the sector-wide role of medical clinicians in management must be analysed. From an institutional perspective, the medical profession in particular has achieved a remarkable degree of occupational closure and restratification with regards to managerial roles within public healthcare organisations. If a role is reserved for a clinician, yet requires a separate set of skills and experiences, clear means of acquiring and demonstrating these competencies must be available. Furthermore, the assumptions underlying the appointments of clinicians to management, possibly regarding insight, competence and ethics, must be articulated and scrutinised.

This need to question the underlying assumptions behind efforts (whether successful or envisioned) at occupational closure for healthcare management also extends to

other parts of the world. In South Africa, there have been efforts to establish a South African Association of Medical Managers alongside a Diploma in Medical Management, which would aim to “determine standards and norms for the training and development of doctors pursuing [the diploma]… or any other medical management qualification… [and] to serve as an examining and certifying body for doctors wishing to pursue a career path in medical management” (Dudley et al. 2013). It is useful to compare these developments to processes underway in the United Kingdom. The UK’s Faculty for Medical Leadership and Management (FMLM) has repeatedly expressed their intention to professionalise medical management, in a healthcare system where non-clinical managers play a significant role in the functioning of the NHS (Lees 2015; Lees and Armit 2020).

Professionalisation, in the context of their claims, includes standard setting, education, consultation, advocacy in the public interest), advancing knowledge through research, representation and “advancing medical management and leadership as a profession” (Lees and Armit 2020, p.135). These authors cite studies from the USA which show an “association” between physician or doctor involvement as CEOs or on hospital boards and subjective hospital “media-generated ranking of quality” (Goodall 2011), or “percent operating margin” (profits) (Tasi et al. 2019) – but I am sceptical that these correlations are appropriate to use to make these claims, nor necessarily translatable to the public, not-for-profit healthcare systems of the UK and South Africa. Another review cited by the FMLM authors, found that clinician involvement in “leadership positions” (largely referring to senior positions on boards or as CEO) was associated with improved financial and non-financial performance of facilities (Sarto and Veronesi 2016). The majority of these studies analysed board-level positions and were from the USA. Given these limitations, I am prone to agree

with two UK-based healthcare management researchers who wrote that a “major issue is that training and development have been *ad hoc* and have not kept pace with ‘frontline’ demands, while developing a body of knowledge has proven challenging” (Kyratsis et al. 2016). In the absence of a clear body of knowledge for clinician-managers, and for skills which make clinician-managers responsive to “frontline” demands, it is perhaps unsurprising that research conclusions about clinicians in healthcare management are not more convincing or generalisable. The clinician-managers in my research found themselves in a policy environment which favoured clinicians for healthcare management, but once in these positions several found themselves underprepared or unequipped – a finding which was not limited to this study (Parbhoo 2020; Pillay 2010), nor South Africa (Ham et al. 2011; Berghout et al. 2017; Imran et al. 2021).

If the healthcare system is to continue to appoint clinicians as managers, then serious attention must be paid to understanding and remedying skills shortages among clinicians entering into management. The above research and policy initiatives are encouraging, but do run the risk of closing of healthcare management from non-clinical, and even non-medical, management expertise. This chapter’s power and institutional analyses open the door to an alternative option: to question whether clinicians should be appointed to roles which require clinical insight, but not necessarily clinical skills. Restructuring management teams to allow senior clinicians to work alongside skilled administrators, but to minimise the loss of clinical skills from service delivery, may be an option. However, this path may disempower clinicians by removing them from decision-making and thus deprive clinical teams of bureaucratic level clinician allies. The open letters and declarations quoted at the outset of this chapter may illustrate this process already underway. It appears that the “frontline” or

street-level clinician who penned the first letter, did not believe that they and their colleagues could rely on bureaucratic-level clinical colleagues to advocate for their cause. This relates to the notion of fiduciary propriety (or impropriety), which will be returned to below.

Another implication of chapter 4 concerns informal learning, particularly exclusion from mentorship and the notion of a hidden curriculum. On the one hand, the informal knowledge which clinician-managers learn through peer networks and mentors may be adapted to their context, and allow for service delivery in spite of financial or other challenges. However, on the other hand, these networks, or specific mentors may exclude certain clinicians or even clinician-managers from this informal learning pathway. This calls for further research and I outline this later in this chapter.

When the signatories to the “I am” open letter published their list of demands in the wake of the Rahima Moosa Hospital saga, they called for “skilled and capable hospital boards” and “the appointment of CEOs with operational and financial management skills” by these boards (Maverick Citizen 2022). Although these demands have implications for the wider healthcare sector, it applies to clinician-managers, who fill the roles of CEOs and may serve on these boards. What this chapter showed, is that the acquisition of such skills may be a substantial challenge, that there may be disagreement as to what constitute the appropriate skills, and that clinician-managers follow various pathways into acquiring these skills, sometimes only after appointment and with little support.

Clinical-managerial logic

When summarising this chapter earlier in this discussion, I listed the language and symbolism De Maayer employed to refer to the administrators he was publicly admonishing. This closely mirrored some of the findings of chapter 5 and it is important to take a step back from the highly charged, emotive imagery and to consider the institutional context that this chapter's analysis brings into focus.

Clinical and managerial work function within different institutional logics. Clinical training (and for the cohort studied, chiefly medical training) instils knowledge and experience, but also clinical logic which influences the way in which they make sense of their environment and their own identity The managerial role, however, comes with a distinct logic and it is the task of the clinician-manager to resist this logic, adopt it entirely or forge a new, hybridised logic.

This conflict was illustrated throughout this chapter in the myriad ways in which non-clinical work (actually a wide range of activities which were collapsed by some into the category of "admin") is perceived and engaged with. Complicating this process for clinician-managers were the expectations of both clinical or managerial colleagues. Sometimes other clinicians did not, according to participant narratives, regard these non-clinical activities as legitimate distractions from clinical work, or did not even regard it as "real" work. Managerial work, on the other hand, might be arranged with limited regard for the demands of clinical work (through the scheduling and locations of meetings, for example). The tensions between these interpretations can be a source of conflict or unhappiness for individuals and organisations.

Clinician-managers who can adopt, even to a limited extent, managerial logic, by learning to "think like a bureaucrat" described this as a way to management to achieve their clinical goals. In chapter 4, this possibility was framed as an inversion of the "street-level bureaucrat": a bureaucratic-level clinician. Lipsky's framework, particularly as applied to the South African healthcare context (Gaede 2016), shows that individual, front-line workers use discretion and "strategic reinterpretation" of policies to deliver services amidst resource scarcity and other challenges (Garrow and Grusky 2013, p.104). I argue that this awareness and discretion can similarly be used by a former or part-time front-line worker placed in a position of bureaucratic authority. Through applying this hybrid clinical-managerial logic, clinician-managers related that they were able to achieve their clinical goals (acquiring new equipment, advocating for specific consumable stock) alongside managerial goals (initiating disciplinary procedures or negotiation for staff posts).

The insights participants shared were often hard-won, with several describing their learning process as difficult or admitting to mental health problems during their times as managers. Some described failures in previous employment as clinician-managers. The fact that colleagues did not share in their painstakingly acquired insight, and continued to disregard management, may have compounded these difficulties.

It is in this context that De Maayer's claims regarding "ivory towers" and plea that administrators "do something too" be viewed. The letter's content is written largely within a clinical logic, where the real work happens at the bedside or "frontline" and where "lawsuits" are where money is "wasted" on "greedy lawyers" and where following "correct procedures" lead to "no visible response". The language employed

by the article and that of subsequent publications also implies that the institutional logic of the administrators diverges from clinical logic, and that this is condemnable.

Educating clinicians about the existence of institutional logics and divergent incentives in organisations may be one way of addressing this challenge. Similarly, providing non-clinical administrators with an understanding of how their decisions affect clinicians and their patients, could also be valuable. Forums created for this purpose have been described as an “enabling condition” which allows professionals to thrive in managerial positions (Giacomelli 2020, p.1636).

Given that the above might prove to be a difficult, longer term objective, it may be realistic to focus on clinician-managers themselves. Explicitly teaching clinicians entering management positions about the clinical logic which they would have acquired through their training, is an important first step. As a template, training on detecting and managing diagnostic and therapeutic bias might be an appropriate starting point (Croskerry et al. 2013a; Croskerry et al. 2013b). Framing the managerial logic as another “language” is another option (Savage 2020; Berghout et al. 2019), although this might not capture the degree to which perceptions might differ.

Making the need for this hybrid logic explicit and listing its development as a goal for clinician-managers, could accelerate and encourage clinicians to engage with management priorities. Ultimately this might facilitate the more rapid inclusion of non-clinical activities as part of “real work”. Teaching materials could discuss narratives such as those from this thesis about the benefits of understanding managerial logic and its objectives. For example, in this chapter these objectives included financial prudence and avoiding litigation. Assisting clinician-managers to

frame clinical objectives in a manner which also meets these objectives, when possible, can be a useful starting point. Alternatively, teaching can use examples which frame managerial objectives as second-order to clinical goals. For example, if patient care is compromised, the risk of litigation increases, or if testing budgets are overspent, then care for future patients is jeopardised.

As more information regarding the management (or indeed, mismanagement) of Rahima Moosa Hospital is entered into the public record, an institutional logics approach would be a valuable asset in understanding how vocabularies, narratives, frames and theories are implicitly held in certain instances, and how these conflict with others.

Normative aspects of clinician-managers' work

The clinician-managers in this study described work with an ethical dimension, which was not simply a scaled-up version of bedside medical ethics. Their work as managers did not amount to amoral deliberations on efficiency, but also had moral implications. The discussion section of chapter 6 explored the application of the moral leadership framework, both to these empiric findings, as well as to several other published works – even when the initial analyses of these studies did not use this language. Much like the clinician-managers quoted in this chapter, there is scope for other clinician-managers to make explicit the implicit moral dimensions within their work. Put differently, they can emphasise that the opposing action to one propriety is not necessarily an impropriety, but might simply be another propriety.

The moral leadership framework relies not only on actions, but also on deliberation and relationships within healthcare. The language supplied by this tool can assist

healthcare workers to approach ethical dilemmas more holistically. Training about this framework might initially be provided through publications. Thereafter, incorporating it into the ethics component of continued professional development may be feasible. A key insight provided by this framework as it applies to the data is to illustrate how clinicians are expected to enact conflicting proprieties depending on their position – with particular focus on the clinicians in management. Clinician-managers are bound not only by professional regulation, but also by a broader set of expectations.

Through describing the informal norms of collegiality, and inquisitorial propriety, healthcare workers may be able to weigh these priorities more clearly against the obvious fiduciary (patient) and bureaucratic (organisational) proprieties. Chapter 6 has also proposed an expanded understanding of the bureaucratic propriety: the comportment of clinical restraint. In this way, for a clinician-manager to refrain from becoming involved directly in a clinical case, they may be choosing the morally justified action. They may also be exercising this restraint on behalf of front-line clinicians.

Furthermore, by understanding healthcare as a collective practice (in the moral sense), one which is engaged in by all actors within a healthcare organisation, managers can be framed as cultivating the internal goods of the practice, alongside front-line clinicians. Within their narratives, the participants in this study were not simply called upon to solve clinical ethical dilemmas (such as bed shortages in intensive care), their work was replete with scenarios which were of moral consequence.

The ethical aspect of clinician-managers' work must be further explored and framed as such, rather than assuming that individual professional ethical frameworks, such as those provided by the HPCSA or clinical training, would suffice. Introducing these concepts earlier in clinical training may be desirable. Integrating further research with the training and support of clinician-managers with regards to ethical challenges, may prove valuable. This is explored later in this chapter.

De Maayer's open letter emphasises fiduciary propriety throughout, by linking each claim or plea to patient well-being. Their own bureaucratic propriety is alluded to through the "correct procedures", but this alone is dismissed as an inadequate excuse for the service delivery failures the open letter describes. Indeed, the repeated "reports" put forth to the hospital administration and the subsequent lack of "visible response", combined with the dire state of the hospital he describes, in effect accuses the hospital management of committing fiduciary and bureaucratic impropriety. The fall-out of the article, with the suspension De Maayer as whistle-blower, also alludes to the absence of appropriate inquisitorial propriety, given the gravity and motivation of the claims made. Furthermore, the whole letter can be taken as an illustration of the breakdown in collegiality between clinicians and clinician-managers, who form part of the "administrators", and this in itself is another form of impropriety.

In the absence of a fuller account, it is not possible to give a complete analysis. However, there are clear expectations of propriety from clinician-managers such as the CEO at Rahima Moosa Hospital and, as claimed by the articles in the public record, these expectations have not been met. A certain level of moral astuteness is certainly required of clinician-managers when faced with these complex normative

expectations. The authors of the open letters have written about the moral injury of clinicians who must practice within difficult clinical environments, but this may also be true of clinician-managers, who cannot always prioritise individual patients. However, acknowledging the presence of moral injury would not necessarily excuse widespread impropriety.

Reflexivity

Throughout this doctoral research, I have remained aware of changes in my own perspectives and identity. I have dedicated more than three years in the conduct of this research, some of which was spent collecting data, and much of which was spent reading, learning new skills, analysing and writing. During this time, I performed limited clinical work and was largely absent from the healthcare setting in which my participants worked – the setting in which I spent many years learning and later practicing medicine. Through studying clinician-managers, I have become a clinician-researcher. With regards to my professional identity, it is an ongoing project to detect and analyse the assumptions and biases which my training and experiences have provided me. In chapter 2, I introduced the notion of the "researcher as instrument", and this is an important and inescapable part of qualitative research.

The realisations wrought by this process of introspection have contributed to each of the empiric chapters – particularly those which analyse and critique a medical perspective. In this thesis, this perspective entails a functional view of the medical profession (chapter 4), the domination of the clinical logic as it relates to (or excludes) non-clinical work (chapter 5) and the tacit primacy of the fiduciary and collegial proprieties over other obligations. Through unpacking the impact of

professional training on myself, I was able to analyse this among participants' narratives.

Other researchers in the South African healthcare setting have found that gender, particularly as it intersects with race and professional hierarchy, significantly affected career trajectories of individual managers and the composition of management in healthcare (Shung-King et al. 2018, p.11). This was not foregrounded, however, in this dataset. This may have been influenced by my own identity (something considered at the outset of the research and described in chapter 2), the settings in which the research was conducted and the cross-sectional nature of the interviews. Had the research been conducted by a diverse team of interviewers, over a longer period to allow for trust to build, it is possible that these matters may have been centred more by some participants. Qualitative research is necessarily perspectival and by remaining aware of this, I aim to position my own contributions to research on clinician-managers next to those of other researchers.

With regards to the findings themselves, it is interesting to return to the earlier reflexivity interview. At that time, I proposed that I might find a spectrum of clinically to managerially oriented participants, and that there might be a prominent role for concepts such as identity. However, the findings of my research resisted these categorisations. Through initially remaining grounded in the data, and allowing for a period of inductive generation, followed by engagement with theory which provided a good fit, the results were more fascinating and challenging than I could have imagined.

Limitations of this research

As discussed in chapter 2, an overarching source of difficulty was the ongoing, myriad impacts of the COVID-19 pandemic. This played a direct role in prohibiting or limiting travel at precisely the time I had planned to conduct the bulk of my fieldwork. The pandemic also rendered ethnography unfeasible. Further, the additional strain placed upon the health system and the individuals whom I hoped to interview, likely influenced response rates to requests for interviews. I am incredibly grateful for the time participants were willing to give as part of this research

This research relies on in-depth analysis of a series of qualitative interviews, as well as some documentary resources. The strengths of this approach have already been discussed and are evident in the depth and richness of narratives and examples provided in the preceding chapters.

These data would have been enhanced by the addition of ethnography. The accounts provided by participants were only one construction of how clinician-managers approached their roles. Through spending time with clinical teams, consisting not only of clinician-managers, but full-time doctors, nurses, rehabilitation professionals and other staff as they interact with patients and relate day-to-day challenges to the clinician-managers would have been invaluable and remains an important further area to study.

Although this research did include some key informants, such as co-workers who worked alongside clinician-managers, the analysis is largely reliant on clinician-managers' own accounts of their work. Furthermore, the research focus did not include lay (that is, non-clinical) managers. This was necessary out of practicality.

However, the inclusion of lay healthcare managers should be a focus of future research. The rationale for focusing on a medical cohort of clinician-managers has already been explained in chapter 2. This remains a limitation with regards to the generalisability of the research.

Future research

The above limitations should be accounted for when contemplating an agenda for further research. The findings of this research project can be further developed in several ways, including further interviews and ethnography. Firstly, the work by other researchers on clinician-managers in South African healthcare setting should be taken into account alongside the findings of this thesis. These would include research into the general experiences of clinician-managers (Parbhoo 2020), the role of identity in shaping practice (Daire and Gilson 2014), the impact of race, gender and profession (Shung-King et al. 2018), the purposes for which managerial skills are acquired (Brooke-Sumner et al. 2019) and the experiences of existing training programmes aimed at clinician-managers (Doherty et al. 2018; Cloete et al. 2020).

A broader cohort of health professionals and lay managers can be included in further interviews with the intention of generating an in-depth understanding of how nurses, rehabilitation professionals, pharmacists and other clinicians combine their clinical and managerial roles. As the above publications also suggest, and as acknowledged in the limitations of this study, this future research into clinician-managers can be enhanced by setting out to understand the role of professional identity, gender and ethnicity in their work. This might require engaging in critical philosophical perspectives in a collaborative manner with participants (Lincoln et al. 2018). Exploratory work of this nature can also set out to probe the role of values in shaping

individuals' understanding of their work as well as their behaviours, something which is touched upon in this thesis, but not explored in depth. Subsequent research can also rely on a more detailed topic guide which can explore the findings among non-medical professions. For example: how do these individual clinicians learn to be managers, with particular reference to their reliance on clinical approaches, informal networks and formal education? How does a clinician-manager's perspective on legitimate work differ from clinicians? How does a clinician-manager balance the prioritisation of patients against the organisation or fellow professionals? How are inquiries into mistakes, misconduct or malpractice conducted? How are relations restored in the wake of harm?

This research agenda can be accompanied by an ethnographic research project aimed at understanding the day-to-day work of clinician-managers over a period of several weeks or months across different sites. The involvement of multiple researchers from different backgrounds (such other health professions, as well as organisational studies and anthropology) would enrich the data substantially. Both of these projects, especially the latter, can also gather documents for an accompanying documentary analysis which can be done in conjunction with the above research.

I have noted some of the policy frameworks, or indeed gaps (whether in direction or implementation), which have influence on clinician-managers' role in the South African healthcare system, specifically the Department of Health's guidance on the management of public hospital (National Department of Health 2012). My research has, however, made me aware of the complexity and variability of this landscape, according to region or even facility. A recent review and analysis of the South African governmental Human Resources for Health (HRH) strategies yielded insights into

the background, gaps in policies and possible solutions in the governance of health sector staff (Van Ryneveld et al. 2020). A similar approach to studying the history, policies and changing role of clinicians in management, following a similar method and analysis is likely to be useful.

Relating to the variability in the roles played by clinician-managers, even when sharing titles such as clinical manager, one research avenue could analyse job descriptions and organograms for specific clinical-managerial roles across the health sector (looking at job advertisements, contracts, surveys, interviews and ethnography) in order to discern how the roles of clinician managers are envisaged by policymakers and employers, and how this differs from the role played by these actors in their day-to-day work.

It may be desirable to integrate the above or a similar research agenda within some of the formal and informal learning pathways which were identified in chapter 4. Networks of peers (which provide the informal mentorship to one another) could be interviewed as part of focus groups, or a researcher might be imbedded within communication hubs (such as WhatsApp groups, email lists, online forums, journal clubs or meetings) in order to conduct ethnographic observation.

It could also be mutually advantageous to partner with existing leadership and management training courses, diplomas and degree programmes to study the impact of the courses on clinicians, and whether participant experiences are reflected within course content and vice versa. This form of research has already been conducted both within South Africa and as part of several other healthcare leadership development programmes internationally using a variety of methods, including qualitative interviews, ethnography, surveys and mixed methods (Doherty

et al. 2018; Berghout et al. 2019; Hartley 2012; Lyons et al. 2018; Lyons et al. 2021; Savage 2020).

As demonstrated in this thesis, it may prove illuminating to include broader sociological theories (such as critical or institutional theories of the professions) as well as normative theories in these studies and subsequent analyses. This would be in addition to the well-established leadership or management frameworks and theories regarding professional identity. Hence, subsequent research might also elaborate on the ethical labours of clinician-managers, or their roles as institutional agents advancing professional hegemony.

Finally, this chapter's analysis of the recent open letter and subsequent media attention surrounding Rahima Moosa Mother and Child Hospital has sought to demonstrate the ongoing relevance of both the empiric findings and analytic approaches of this thesis. The matter will likely continue to evolve both within and outside of the public record, but the available media discourse has provided ample evidence of the complexities may which underly an otherwise simple narrative. It is my hope that the difficulties are resolved swiftly in the best interests of patients.

Recommendations

Throughout this thesis, I have been careful not to overgeneralise from the narratives available to me within the dataset. I have also made a continual effort to draw the reader's attention to caveats and limitations of the data, as well as to reflect upon my own role within the research. With this preamble in mind, I will make the following recommendations:

Clinician-managers likely require more training and support, both prior to and after being promoted to their role, to reduce the heterogeneity of their learning process and accelerate their becoming effective. The content of such training would require the consolidation of several of the resources listed in chapter 4, in addition to identifying effective informal means of support (such as discussion groups or mentorship networks). Such a program of learning and support would also have to be tailored to suit different settings (such as district hospitals or regional hospitals) and to those of different backgrounds (such as medicine or nursing).

A national healthcare management skills framework, would be one way of supporting these efforts. An evolving collation of the knowledge and skills required of clinician-managers could serve as a benchmark from which to create job descriptions, assess performance and design training curricula. This framework can be created with inputs from existing clinician-managers, governments, patient groups and healthcare management researchers. Competencies could include (among many others) budgeting, conflict management, quality improvement, knowledge translation and stakeholder consultation – skills which are likely already taught in some of the programs in chapter 4. Crucially, this initiative should not serve as a tool by which to "professionalise" (in the sense of appropriating these roles for specific specialties or interest groups) or close off healthcare management from some groups – as this research and a close reading of the evidence have left me sceptical of these efforts.

This policy framework should be accompanied by implementation research with the ultimate goal of assessing the impact of upskilling clinician-managers (and healthcare managers more generally). I would propose using patient outcomes as a primary endpoint and various other aspects of service delivery as secondary

endpoints, such as staff turnover, meeting core standards, financial prudence, and patient complaints. Once an evidence base is established, regulatory frameworks (either through departmental or regulatory body policies or legislation) can begin the task of standardising healthcare management competencies.

Secondly, the effect of differing and changing institutional logics must be further understood and this information should be used to frame organisational decisions and foster mutual understanding between different actors in the healthcare system. Clinicians, clinician-managers and managers should be made aware of different institutional logics, particularly in how they shape understandings of priorities and actions and how these may affect their interactions with those within and outside their institution. Creating opportunities for clinician-managers to learn from one another, through mentorship, shadowing, workshops or courses, could aid health workers in understanding the differing logics which operate in the healthcare system, and to facilitate the adoption of appropriate institutional logics in different settings.

Thirdly, the moral complexity of the clinician-manager role should be further elucidated and guidance should be provided which recognises the proprieties which clinician-managers are expected to balance. Initially, this could take the form of case study research, but as the moral dilemmas facing this cohort are catalogued and understood with the aid of ethical theories such as those presented in chapter 6, specific guidance by bodies such as the HPCSA or academic institutions could follow. A first step towards this could be to collate narratives of moral dilemmas faced by clinician-managers and to collaborate with a multidisciplinary team of managers, clinicians, ethicists, policymakers and patient groups to create a best practice framework for healthcare management ethics.

Conclusion

The primary aim of my thesis has been to understand and theorise how hybrid clinician-managers combine their roles as clinicians and managers in the South African healthcare setting, including understanding the challenges and opportunities resulting from this hybridisation. The empiric chapters of this thesis contain in-depth explorations of clinician-managers' role combination, as well as theorisation of these findings, and as such I regard this aim as met.

The secondary aim was to inform both policy (workforce planning, support and training) and the academic literature (extending an interdisciplinary theorisation) in relation to the role and practice of hybrid clinician-managers South African healthcare setting. This thesis represents the first substantial step towards achieving this aim. I intend to follow this with the publication of these findings in academic journals and to follow through on the research agenda proposed earlier in this chapter.

I commenced this research as a South African clinician interested in how my fellow professionals transitioned away from their core training into new roles within the healthcare system. My investigation showed that this process has in the past been understood using a series of different framings, such as identity, leadership, and management competency. In pursuit of additional ways of understanding this transition as reflected in my dataset, this thesis has explored in depth how a group of largely medical clinician-managers in South Africa combine their clinical and managerial roles.

Arriving at their roles through various routes, clinician-managers rely on clinical approaches, informal learning and formal training in order to learn to manage. I argued that these processes be understood through three contrasting approaches to the professions, each of which highlights a different aspect of the wider context.

As part of their roles as clinician-managers, individuals must blend clinical institutional logic, acquired through training and experience, with managerial logic, which is required by the new role. The language that clinician-managers used created an informal dichotomy between “real” work and “admin”, which further highlighted the gulf which they had to bridge. Some did so by developing clinical-managerial logic, which allowed them to incorporate aspects of managerial practice into clinical logic.

The narratives within interviews also demonstrated the competing proprieties which clinician-managers must engage with, and how this related to the expectations placed upon them by their profession, peers, patients and their organisations. The analysis of these results, which have both surprised and intrigued me throughout the process, have required that I acquire new skills and extensive new knowledge in a variety of fields.

The findings of this research have implications for the training and ongoing support of clinicians in management positions in South Africa. Yet, the research in itself was limited in scope due to the constraints of time, resources and a global pandemic. Therefore, if these results are to have an impact on the organisation of South African healthcare, more work will be required. In light of this, this final chapter has provided an exploration both of the above limitations and the avenues for future research. It is

my hope that I will be able to pursue these routes and collaborate with others in this research journey.

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Coda

Why rewrite the thesis as an allegory?

Having already read through the many pages of this thesis, the reader deserves an explanation as to why I have thought it necessary to add this coda which they are invited to read prior to finally closing this tome. Throughout this thesis, the retelling and reframing of narratives has allowed both the participants and myself as a researcher to interpret different meanings attached to experiences. I was particularly struck by the use of metaphorical language which occurred throughout the dataset. For example, some participants compared the practice of medicine to detective work. At other times, a person's career in management was likened to a long march or to playing a game.

This coda is a piece of fictional, creative writing, which recasts the findings of this thesis as a different, layered process of scholarship altogether. I have chosen to use an allegory, a story which can be interpreted in multiple ways, as this allows me to convey the layered complexity of the research within a single narrative. As should be expected with symbolic representation, the map is not the terrain, but I hope that the reader will find both interesting and enjoyable.

Thesis as allegory[13]

Some years ago, I was indulging one of my passions in life: archaeology. It was a warm summer's day and I was involved in a dig which a colleague had suggested I might take an interest in.[14] There are few better ways of whiling away the long, sunny hours than with a brush in one hand and a notepad in the other. I was sketching a peculiar fossil pattern, when I became aware of a certain angular pressure on my right knee.

Carefully, I shifted my weight and turned my attention to the offending stone or errant excavation tool. To my complete surprise, the prod had emanated from a barely noticeable outcropping in the dirt. There seemed to be the faint suggestion of colour beckoning beneath a thin layer of rust-coloured dust.

Every archaeologist, amateur or otherwise, dreams of stumbling upon the holy grail. Our boisterous flights of fancy are frightened into more cautious steps by the stories of Schliemann[15] and other hapless explorers, who have done our craft great harm.

With the greatest trepidation I proceeded with fine brush strokes and careful bursts of compressed air. Soon, an obsidian tablet peered out from the brown earth. I do not recall how many hours I spent in that position. I ceased to feel pain, hunger or

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[13] Note: This coda is a fictional short story which re-tells the thesis as an allegory. Even though it uses a narrative framing, that of an archaeological find, this is also part of the fiction.

[14] Regrettably, I am unable to disclose the location of this site, as it would appear that my subsequent discovery, was far from the only one to be made as part of the hoard. It is my hope, however, that the precise location of this veritable wellspring of mystery might be shared with the wider world of academia one day.

[15] Heinrich Schliemann (1822-1890) was a businessman and amateur archaeologist, who wanted to find the lost city of Troy and prove that Homer's Odyssey was based on actual events. He identified the likely site and began to dig with excessive fervour. Dig is a kind word. He dynamited the earth in search of Troy. It is one of history's great ironies that he was right and had selected the correct site, but that his destructive excavation methods destroyed much of what he was looking for. A cautionary tale for all those set off in search of discoveries.

thirst. For a short window in time, I was completely absorbed in the painstaking task of unearthing objects which had not seen daylight for many millennia. I still feel the odd twinge in my neck and knees when I recall the pose I maintained for so many hours, completely absorbed in the task.

When I had completed the task, I was kneeling before three basalt tablets. Each was approximately 60cm long, 40cm wide and about 3cm thick. Such finely crafted artefacts would have justified a lifetime of hopeful excavation for many. The most exquisitely chiselled, sharp corners of these ancient slabs indicated highly advanced craftsmanship, which I am astounded to admit were of a nature and quality that I had not seen before or since. However, these details are banal in comparison to what I discovered next.

After carefully clearing the earth from the surfaces of both tablets, I was electrified to note small, deliberate indentations covering the fronts and backs of each tablet. Writing! It was a script which I had not seen before, and I dare say that in my brief inspection, I noted that each tablet appeared to contain its own script. This was as far as I got before the rapid response team from the local university[16] arrived and relieved me of the burden of the discovery.

Subsequent correspondence has, however, furnished me with scans of the tablets. I am indebted to my colleagues for their assistance in interpreting the ancient texts. Below is my rendition into modern prose, of the enigmatic Voyager Stones.

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[16] I am unable to disclose the name or location of the university in question due to security concerns for the site.

Prologue

It was in the fiftieth year of the reign of the consul Ataraxia, that these events took place in foreign lands. The Federation of Societas, as it was then known, flourished and was at peace with its neighbours. Within its borders, however, its provinces, principalities and territories were constantly at one another's throats.

As time progressed, some of the more powerful provinces broke apart and instead were made to coexist through unsteady alliances. These tablets chronicle the uneasy neighbours of Sanitas and Administrare.

Sanitas, the province of healing, had been growing more powerful over the centuries. As the knowledge of the people of Societas grew, so too did the incredible abilities of its healers in Sanitas. The healers demanded resources and goods from the other provinces of Societas. In return they mended broken bones, cured diseases and drove out the evil spirits which sought to harm the populace. Some in Societas feared the boundless appetites of the healers for resources, but others believed the noble healers to be beyond such material desires and did not believe that Sanitas would be profligate with the gifts of tribute.

All would may have continued so, were it not for the emergence of a new principality. Over the decades before, a new group of citizens had emerged. From the marketplaces in Agora, to the storehouses in Agricola, came promises.

"Render into our hands the decisions about your work," these newcomers would say. "And we shall double your bounty."

The farmers and merchants, fearful of tyrants, reluctantly agreed and were astounded. One after the other, the provinces were convinced of the truth of these

claims. Throughout the republic, harvests increased, profits grew, some grew excited and others uneasy.

The newcomers, who called themselves “managers”[17], demanded and were granted a principality they called Administrare, a region bordering closely on Sanitas. The wise men and women of the other provinces observed these developments and hatched a scheme.

“Grant the managers control over Sanitas. The healers grow fat upon the spoils of our tribute and they will bankrupt our nation. Were the managers to hem in the power of the Medici and the Nutrix, we could have twice the healing for half of the tribute,” said one wise person.

Various plans were drawn up, but the matter proved more difficult than the wise men and women had guessed. At one point, the consul ceded a region of Sanitas to Administrare. This enclave was called Administrare Novo Publica[18]. The healers of Sanitas resisted this incursion fiercely.

“Only a healer should meddle in the affairs of healers!” cried the assemblies of Sanitas. And so it was in some parts. Yet this too, proved difficult. The various sophistries of the managers proved stubbornly useful, even to healers when they were set to guide the affairs of their brethren.

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[17] One of several difficult translations which has had to be approximated for the purposes of legibility. The term “manager” itself derives from the Latin *manus* for hand. From my colleagues’ notes, I have been able to deduce that this class of people were involved in “handling” the affairs of others. I do beg the forgiveness of readers for this anachronistic rendering, but feared that words such as “procurator” or “fiduciary” would have caused unnecessary confusion.

[18] This could be translated to “The domain of new public management”.

One source of difficulty proved to be the unmapped terrain between Sanitas and Administrare. Despite the tensions stoked by the power politics of the nation, there had long been a vibrant trade between the two. One city in Sanitas, Nutrix[19], had built a road for their inhabitants to travel between Sanitas and Administrare. The most senior nurses frequently travelled this route as a matter of course.

The city of Medici, however, did not possess such a road. It seemed that a large chasm separated them from their neighbours. The inhabitants of Medici took it for granted that they would govern their own affairs. However, they were coming under increasing pressure to act like the inhabitants of Administrare in order to do so. For some, this meant an uneasy period of exile, followed by permanent banishment to Administrare, ignominious return to Sanitas, or something in between.[20]

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[19] The terms "nurse" and its Latin origin "Nutrix" are used in their modern senses, rather than as references to the feeding of young children. This is because the terms used in the original text lack precise English equivalents.

[20] This sentence seems to hint at a variety of experiences for those who departed from the relatively narrow, set life pathways available to healers in Medici.

Part I – The Voyager's Path

For Claudia Hippocrita[21], the time had come to decide. She had trained under and practiced among the healers of Medici for many years. She was widely respected by her peers and she was now being asked to choose. She could continue among the healers, or she could take responsibility for a part of the city.

The former was familiar, but the latter held the promise of changing the system in which she worked and which she knew was not perfect. There were those among her peers who looked askance at healers who chose to depart from the sick-chambers and instead spend their time debating in a forum. Some of her teachers would have discouraged her from even contemplating this decision. However, Claudia believed that she could fulfil her obligation to the ill and the infirm on a grander scale if she were to cease upon the opportunity.

It would not be easy. Those who chose this path were expected to undergo a pilgrimage towards the land of Administrare, and to return with the cunning and knowledge of a manager, but use it only for the benefit of Sanitas. It was very seldom inverted and the inhabitants of Administrare, with their strange accents and foreign language ,stood out among the healers in Sanitas. The managers among the Medici were regarded with a certain amount of suspicion. Even the healers who took on the habits and language of the Administrare were regarded with caution.

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[21] The tablets refer to a main character whose name is depicted only as pictograms (perhaps a stylistic feature of the era), whereas the rest of the text uses an alphabet. The result is that no pronunciation of the name can be attempted. Certain clues in the text have hinted that the character's name is an amalgam of titles which carried significance to the domain of Sanitas. Correspondences with certain historians of medicine have suggested that these names might carry similar symbolic weight to modern readers by referencing both Claudius Galen and Hippocrates of Cos.

Undeterred and full of hope, Claudia Hippocrita departed one day from the city walls of Medici into the wilderness beyond, unsure of what to expect. She walked for many days and nights, only to find herself wandering in the desert. She had heard of footpaths in this region, but could not find them. There were many tales told of other Medici healers who had survived the journey, even of those who had thrived while doing so. Others insisted that intrepid travellers could study *The Lives of Noble Emperors, Kings and Generals*[22] to learn from their wisdom. Claudia now found the stories of grand victories and their pithy sayings to be of little help. She had also heard of other healers who had built bridges between Medici and Administrare, but those seemed to be well hidden and she felt instead that she was alone, stumbling in the hot sun and running out of strength.

Claudia had been struggling along the dirt paths for some days when she happened upon an oasis. There she found trees, shade and a lone figure sitting in a shady spot. Silently, she drew water from the spring, ate fruit from the trees and hid herself from the sun, all the while observing the stranger with apprehension.

"I thought I was alone in this desert," she finally said to her host when her throat was no longer so dry.

From the shadows, the figure seemed to study her for some time. Claudia shifted uneasily.

[22] This appears to be a reference to a lost manuscript which collected the biographies of prominent leaders known to their culture. We can infer that the character of Claudia Hippocrita is being portrayed as familiar with what is supposed to have been a classic text. It is unclear how transgressive it may have been to suggest that studying *The Lives of Noble Emperors, Kings and Generals* would have little to teach one about navigation and survival.

“It is not a desert. And you are not alone,” he finally said. He had the accent of a fellow healer of Medici.

Claudia was puzzled by half of what he had said, but relieved at the familiar language. She was full of questions and also eager to contradict him.

“Surely you speak in riddles! What do you call these hills? Before you, I had only snakes and beetles for company,” and as she spoke, she felt the anger rise within her, so she continued. “I have been wandering these dunes for many days. I have used the methods taught to all healers. I have spoken soft words to the wind as one would to a crying child, but it only blew sand into my eyes. I have made the glyphs and balms to abolish a fever, yet the sun seemed to redouble its fury upon my skin. This is a desolate place which is hostile to life.”

The man said nothing for a while. Claudia began to feel that she might have been foolish to vent her spleen to this stranger, whose face she had not even seen.

After a while, he shifted from the shadows and finally she could see him fully. He was some years older than Claudia, but not yet an old man. He wore plain clothing and would otherwise have walked the streets of Sanitas without evoking comment, save for one feature. He wore a bandage over his right eye, obscuring it from view.

“I fear you may feel abandoned by our kin,” he said. “The ways of Sanitas are good for the sick, and they may even help you in these places… a little. But you must learn new ways to survive here. I will teach you.”

The stranger's name was Mentor[23] and he undertook to teach Claudia all that he had learned through his travels, and all that he had learned from his own teachers. He had been correct. They were not alone, for they frequently encountered other travellers. Mentor taught her various paths and shortcuts through the valleys and hills. It was not a desert, but a vast and uncharted land.

"To the east lies Sanitas, where we were raised and inducted into the secrets of the Medici," said Mentor one day as they travelled along a goat path. He pointed over the horizon. "To the west is Administrare, a land we were taught to distrust. It is time you learned more than just what I can teach you as an apprentice. It is time we go west."

So they travelled to a stone structure high in the mountains, on the borderlands of Administrare. It was a place of learning for Administrare. There Mentor left her for some time, to learn the odd language of the managers, and to be taught by them. She found the experience strange, difficult and, most unexpectedly, gratifying. She learned to speak in their tongue – not fluently, but well enough to make herself understood. She studied their sacred texts and saw that, whereas Sanitas places the highest value upon the care of the sick, Administrare valued efficiency above all else. She began to understand the strange ways of the managers, without fully adopting it herself.

After many months, and not a small amount of difficulty, she had been inducted into their ways through a ceremony and had a wreath of laurel woven into her hair. On

[23] Readers who find this name implausible might be surprised to learn that the modern use of the term stems from a character in the Homeric Odyssey. Mentor was an adviser to Telemachus. The name itself seems to derive from the Greek "to think".

this day, Mentor also returned. During her months in the mountain temple, Claudia had begun to wonder many things about her native land, and the land of Administrare just across the ridge.

“Why must some of us suffer so to learn their ways, Mentor? Why not simply ask these learned people to aid us in our endeavours?”

Mentor looked at her with a single eye, but did not say anything at first. They walked to the entrance of the refuge and stared across the lands they had travelled together.

“I do not know,” he said at last. “But I believe there is someone who might offer answers.”

So it was that they arrived at the oracle of Academia. They waited for seven days and seven nights at the mouth of a foreboding cave. On the eighth morning, a voice was heard echoing from within the cavernous dark.

Come. Come. Come.

The echoes died away and they travelled inside. They seemed to journey for many leagues before arriving in a giant, domed chamber, deep in the heart of a mountain. It is said that the oracle of Academia needed this distance from Societas in order to have their visions.

At the centre of the room burned a pale fire, unlike anything Claudia had seen before. Next to the flames was a robed figure, seated on a log. The two visitors approached the oracle, with their footfalls echoing through the cavern. They stopped some distance from the white flames, and Mentor whispered to Claudia.

“You must tell a story.”

“What story?” asked Claudia with surprise.

“Your story. My story. The stories of the healers who must travel this in-between land,” answered Mentor.

Claudia did her best, starting with her own journey, but also adding what she knew of the journeys of others. When her story finished, the fire had grown dim and the oracle seemed to be asleep.

There came a long silence, with only the crackles of the strange flames breaking through, and the dancing shadows on the cave walls growing restless. Then the flames turned bright red.

The oracle stood up and threw back her hood to reveal the face of a middle-aged woman with a broad smile and a red glow to her cheeks. Then she began to speak in a soothing, friendly voice.

“You wonder why the healers must travel this journey? Why the supplicant sick and wounded must be left waiting at the gates of your cities while the oldest and most esteemed among you must travel into the desert and live in the lands between Sanitas and Administrare?”

The oracle seemed to laugh from deep within her belly, as if the answer could not have been easier, and as if she were explaining the simplest thing to a very young child.

“I will answer your question with a question. Who better understands the affairs of Sanitas than its own citizens? Who better knows the needs of the sick and the wants

of their families? Are the Medici and the Nutrix not the cleverest, most trustworthy, most selfless of the peoples in all Societas?"

Claudia nodded, almost imperceptibly. She had known these thoughts years ago. These were the unspoken truths which had pervaded her time as an apprentice, as a healer. She too had felt the solid ground of this certainty as she set off from Medici all those years ago. But she had misgivings. Why was the journey so difficulty? Had she not encountered Mentor…

"I see you have doubts," said the oracle, with a grin. It was as if she could see Claudia's mind and that nothing could be more natural than to entertain these misplaced ideas.

"Why did you not rely more upon your incantations and your balms? You are a healer, are you not? They would have stood you in good stead. What is this land other than a patient spread over the horizon? Are the streams not its veins? Are the sands not its flesh? Is the rain not its tears and the quakes not its laughter?"

Claudia's doubt had reached its zenith. These answers would not do. She had experienced too much to be satisfied with only this. She opened her mouth to speak.

A gout of green flame shot from the base of the fire to the scorched ceiling of the cave, obscuring the oracle and blinding Claudia and Mentor for a moment. When the flame subsided, the woman was gone. Instead, there stood, in the same robe, a woman who could only have lived for twenty summers - so clearly was her youth visible upon her face. When she spoke, her voice was like ice and there ran a trickle of disgust and condemnation through every sentence.

“I *know* why you must travel this journey,” she spat out while tilting her head back with an expression of disdain. “It is because you must help your brethren to keep their lands. It is about power. It is about tribute. It has always been thus, and it will always be thus.”

Claudia’s mouth hung open. She felt the resistance rising within her. She looked at Mentor’s face, with his unobstructed eye appearing slightly more moist than usual.

“Do not act so surprised. Long before your healing arts could do more than frighten children or fool the gullible, your forefathers claimed those lands for themselves. Charlatans and well-meaning fools, they chased off the herbalists and midwives and occupied the lands which now form Sanitas. There they sat, extracting tribute but offering little in return. Were it not for the revelations of knowledge which signify this age, that would have remained the case.”

Claudia’s mouth was dry. The indignity of having a child berate her so!

“I will grant you this, however,” said the young oracle, with a somewhat conciliatory tone. “Sanitas can heal the sick. It can mend broken bones and help mothers deliver children into the world.”

The oracle studied their reactions for a moment, and then continued.

“I see you are confused by this admission in light of my judgements. Good.”

“The roots of Sanitas lay in the soil of ignorance, naked ambition and a thirst for power, but its fruits are a mixture. You and your fellow healers may aid the sick, but you always act in your own best interest. The fact that you do any good is more a fluke of history than intention. *You* who have learned what Administrare has to offer,

can you deny that healers are ignorant of these managerial arts and arcane knowledge? Can you deny that your peers waste time and tribute when they could be doing a great deal more good for Societas if only they had a bit of…direction?"

Claudia felt numb. Here she was being invited to make a terrible slander upon her kin. She said nothing and the oracle continued.

"Of course, it is quite beside the point what any one healer's intentions are. On the whole, Administrare is not much better. Both entities would happily swallow the other whole if given the opportunity. The healers would exploit the managers if they could, and the managers would place the yoke upon the healers if given half a chance."

The oracle broke into a mischievous smile.

"You must travel this difficult journey because from Sanitas' perspective, it is more important that a healer is sovereign over healers, than for healers to have an effective sovereign. To concede that Administrare should meddle in any of your affairs, is for the wild horse to offer reins to a rider.[24] *You* only suffer because you wish to do the task well."

The fire went out. The cave was black. Claudia was shaking.

A faint golden glow emerged from the ashes. Now the robed figure was stooped forward and leaning on a crooked, black stick. The oracle appeared to be an ancient woman, the oldest person that Claudia had ever seen. There were hints of the previous two women in her smile and her eyes.

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[24] It would appear that the authors of this tale were familiar with Aesop's fables or an ancestor to the collection.

“You will forgive my sisters, I hope,” she looked at her guests as if to say that this was a joke. “They do not have the advantage of my *experience*.”

The oracle now sat back down onto the log and looked into the glowing centre of the chamber.

“I dare say that they were both describing a shard of the truth, although they do get carried away. It is important to be able to look at something in different ways.”

With these last words she fixed Mentor in her gaze for a few moments.

“I believe you were offered answers when you sought us out, and I hope that you will leave with answers. That is, more than one answer to your question: how should you understand this journey that you are on?”

Claudia considered all of this. She had not actually posed a question, yet this was the one she would have asked.

“Without the *idea* of a place called Sanitas, or the *idea* of a place called Administrare, Societas could not exist as it currently does. Some other notion would have to be plucked from the void and made to serve a similar role. When someone is ill, the language they use, the roads they travel, the buildings they visit, all rely on some notion of health, illness, healers and everything related to that. It is a newcomer, but Administrare has also come to mean something to the people of Societas, when it comes to the control of resources and the use of time. The trouble is that they both hope to encompass these lands. These…”

The oracle looked at her knotted hands by the dim light, and twisted her head as if looking for a word.

“These liminal lands. I do not believe it is settled. For now, it does look as if Sanitas is making more of an incursion into these parts, setting aside Administrare Novo Publica, of course. Only time will tell. However, it is important to listen to my sisters seriously. Each of them made an important point and you would be well advised to heed their words when considering your journey. For now, I would suggest that you contemplate what your brethren take as a given, what you regard as just and who is served by the law codes.”

Goodbye. Goodbye. Goodbye.

When Claudia and Mentor opened their eyes, they were standing at the mouth of the cave again.

Part II – Seeing with both eyes

In the years that followed, Claudia Hippocrita and Mentor returned to Medici to run the affairs of their fellow healers. They both excelled, but found it difficult work. Claudia Hippocrita adjudicated disputes, decided on the allocation of work and negotiated the tribute which came from other parts of Societas.

Occasionally, she would slip from her chambers, evade her retinue and find herself back in the temples where the sick were tended to. There she would while away some afternoons, practicing her art, until urgent matters forced her to return to her meetings and debates.

It was difficult because her fellow healers had somewhat cooled towards her. She was now regarded by some as an interloper in Medici, and senior healers would insinuate in debates that she had ceased to have the best interests of Sanitas at heart. These words wounded her immensely.

She recalled such harsh words when she was telling novitiate healers not to waste ointments, or when she was asked whether a moribund patient should be taken to an inner sanctum for special treatments, and she instructed against it. Some of her former peers had come to resent her absences from their usual place of work, and further resented the constraints that she appeared to place on them.

“She has become one of them,” an apprentice would say to their fellow as they returned from an audience with her. Even though she was widely regarded as reasonable in her decisions, she could not be relied upon to side with healers in every request or conflict – and this was the source of their displeasure. “She has not

spent a full day healing the sick since her return from the other lands," they would mutter as they departed.

Claudia Hippocrita was aware of these sentiments, but felt that she could do little about them. She was preparing to depart on a diplomatic summit with representatives of the consul, Gubernatio and Administrare. The meetings promised to be challenging and much would be at stake. However, as the light began to fade, she felt the urge to disprove her detractors. Once again she made her way to a hall for the ill, where she began to work. She spent some hours in this fashion.

"You are misusing your time," a voice spoke from behind her.

She turned to see Mentor, who was set to accompany her to the summit.

"If I am to do what is expected of me by all, I shall have to be split in two!" she exclaimed in exasperation.

"Perhaps, but for now we must depart and you must bid your patients farewell," said her teacher and friend.

When the representatives of Sanitas arrived at the meeting place, they were greeted by their interlocutors who were already in conversation.

To Claudia it appeared that the discussions continued for several ages. The representatives from Gubernatio and Administrare shared much in common. They spoke revenue, tribute, risk, and such matters, while the delegation of Sanitas sat in silence. Even Claudia, who knew of such matters, struggled to comprehend all.

At the end of the first day, one of the younger healers, called Curatio, confronted Claudia and Mentor.

“They seek to rob us!” exclaimed the man. “They will cede our lands to Administrare and starve Sanitas into submission. You have said little to deter them.”

Claudia would have retorted, but Mentor addressed them both.

“The time has come for an important lesson. Tomorrow I will teach you the first part.”

Much excited by this, the delegation retired.

The next day, during the meeting, Mentor proceeded to interrupt and challenge each and every decision the other envoys tried to present.

“This will not do!” he would shout. “This would increase disease among the populace.”

On another occasion, he objected by saying, “If this were to be carried out, the dead would litter the streets like rats during a plague. Heed my warning: do not maintain your ignorance.” As he said this, he brought his fist down hard on the table.

Claudia did not know her teacher to be so rash.

Although the representatives from Sanitas were duly impressed by his spirit, Mentor’s counterparts did not seem to take note. On each matter, Sanitas found itself dismissed, outvoted or simply ignored.

That evening, Curatio sought out Mentor to congratulate him for his vigorous defence of their values. Much to his surprise, Mentor waved a dismissing hand at him.

“You would prefer that I speak the right words in your estimation, rather than do what is necessary and appropriate?”

This confused both Claudia and Curatio, who only stared at Mentor. The older man undid the bandage across his head, revealing a right eye no different from his left. Shocked at the increasingly odd behaviour of Mentor, the delegation retired for the night.

On the third and final day of the summit, on which all decisions would have to be finalized, the healers were in low spirits. Not only were they to leave the negotiations in a severely weakened position, but they had discovered that Mentor had grown senile many years before his time.

Before the proceedings began, Mentor fixed both Claudia and Curatio in his gaze and said, “Now I will show you the second part of the lesson.”

It was as though a river had broken its banks. Mentor spoke the language of Administrare to the managers. He appealed to the self-interest of the Gubernatio delegation. He flattered the consul. He argued the preferred position of Sanitas, alluding to increased tribute, reductions in the need for other expenditures, and the elimination of strife. On each point, the others conceded. There would be more halls built to house the sick, aqueducts would be constructed for clean water, and rabid animals would be destroyed before they could do harm.

Mentor persuaded each of the other groups to take up opposing views, and once they had become fully entrenched in mutual enmity, he interceded as arbiter. By the end of the summit, Sanitas’ position had been substantially strengthened and several unexpected concessions had been made.

The delegation of Sanitas spent the return journey in silence. As they approached the gates of Medici, Mentor bound up his right eye again and explained himself.

“I spent many years in Administrare before. I was fearful of becoming one of them. So I bound my left eye shut and swore an oath to always see the world from that eye as a healer. In time, my right eye came to see the world as a manager does. I saw their reasons for doing things and their reasons for not doing things. Now I keep that eye shut from the world.”

He sighed deeply.

“That was, perhaps, a mistake which I had hoped to spare you. I have to move between two ways of seeing,” as he said this, he pointed to his bandaged eye. “But I have realised that it is possible to see the world from the middle vantage. You must learn to see the world from both points of view simultaneously.”

He held out his hands, with two fingers from each pointing at Claudia and the young healers’ eyes.

“Our neighbours have much to offer us and our fellows in Sanitas require direction and oversight. We as healers can ally these forces for the good of all. You two, who travel the lands between us, can see all sides of the valley at once. It is both and neither. You must use this position wisely.”

Part III – Wisdom

In the ensuing years it came pass that Claudia Hippocrita rose to the role of princeps in Medici. Her duties were now remote from the sick within Sanitas. Rather, she spent her days debating healers, receiving delegations from other cities and provinces, and arranging for the education of novice healers. Many years had passed since she had last felt the pulse on a dying man's wrist, or rescued a newborn that had become obstructed in the womb.

A task which she had not been prepared for, not even by Mentor, was that of judge. Her subordinates, themselves no strangers to the lands between Sanitas and Administrare, would bring to her difficult decisions. Sometimes they wished for her impartial judgement, whereas at other times they wished only to be supported. If the families of the ill and the deceased brought a petition, she would receive them and consider their requests with compassion. Although she was respected, she was regarded as displaying insufficient allegiance to any party – a perspective she secretly come to relish.

On one day, a dispute was brought before her. Curatio, the young healer who had travelled with her to the summit in years past, stood accused of injuring the tranquillity of a scribe.

"He stormed into my cell, grabbed me by my tunic, and dragged me to the halls of the sick," the scribe related the story with great indignation. "I had to cover my nose, for the stench was so unbearable among the dying!"

With this, the scribe folded his arms in satisfaction, certain that his case had been made. Claudia turned her gaze to Curatio and nodded that he should respond.

“This scribe, who is called Noto, is eldest among the scribes,” spoke the healer. There was an air of regret in his voice. “He is learned in the ways of Administrare. I depend on him to send clay tablets as payments to the workers and suppliers in the city. The tribute and gifts to our halls have been slow of late and we cannot pay all of our debts at once.”

Noto, feeling that his position was well put even by Curatio, nodded vigorously.

“I expected him to pay the most pressing debts first, so that we may continue our work. Instead, he burnt most of our granary as an offering to the gods, and then divided the rest among the temple guards. The healers all work without payment, and the ill are fed by charity rather than our cooks. I am ashamed to have failed them so.”

Feeling slighted by this, Noto began to shout, “A debt is a debt! Why should I feed the unwashed masses before the gods? The healers can wait for their bread.”

Claudia held out a hand to silence the scribe.

“In my rage after discovering what he had done, I did indeed drag the scribe from his chambers and took him to an ill mother and child. ‘Look at what you have done’ I told him. ‘These people starve alongside their fevers because you have been so foolish.’”

Curatio was overcome with emotion.

“I should not have been so brash,” he continued. “I should not have allowed matters to get so far out of hand.”

Claudia considered the matter for a day and a night, and gathered the scribe and the healer together for her judgement.

"Curatio, you have left the scribes to their own devices for too long. It is your burden to direct their cleverness towards aiding the sick. They do not feel the urgency that you feel when the halls overflow with the infirm. See that you meet with Noto at every full moon to discuss his work."

Noto was somewhat confused by the judgment and turned to leave. But the judge had words for him as well.

"As for you, Noto, you have been thoughtless. Perhaps you feel that your honour was bruised by your rough treatment at the hands of Curatio. For that, you have his and my apologies. However, your actions have done harm and prevented many from executing their function. See that it does not happen again."

Some months later, a new case was brought before Claudia Hippocrita. A senior apothecary and nurse had nearly come to blows with a young healer. Claudia was intrigued.

The youth entered her chamber full of confidence. He was relieved that a fellow healer would be hearing the case.

"Princeps, I am being prevented from carrying out my role," he began. "This nurse and apothecary wish only to constrain my skills and do harm to my patients."

As he spoke, he gestured to the others with some contempt.

"Last week, a gravely ill man was brought to the steps of our hall," he continued with great conviction. "I went to his side and gave him all the aid that I knew of. Every balm, ointment, ritual and incantation was being performed. Yet, when I asked for

certain items, I was refused! Please, I beseech you to prevent these persons from interfering in my important work.”

The young healer stopped and placed his hands on his hips, awaiting the fury of the judge to be visited upon the others.

Claudia Hippocrita turned to the apothecary and nurse.

“It is true what he says,” began the nurse. “He was creating a loud disturbance at the side of the old man. I assisted him for the first while, but then grew doubtful and called for Curatio.”

The apothecary then added, “I became concerned for our supplies. Some ointments require months or years to make and this healer was requesting them at great volumes. I could not comply without consulting an elder healer.”

Claudia then asked, “And what did the elder healer say?”

“He said that it is a terrible thing for a dying man to be so vexed by a young healer in his final hours. He instructed us to give comfort to the patient, but cease wasting our stores and breath.”

The young healer did not seem deterred by this.

“I have sworn an oath!” he shouted.

“Indeed, you have,” replied Claudia. “But you do not understand your oaths. Be seated. I will tell you a story.”

This is the story she told:

There was a man tasked with guarding his village well. The well came from a spring and it was the only water for a great distance. Yet, the village had prospered in spite of this, carefully guarding the vital source of their life. One day a traveller came from the desert to the village square.

“I have great thirst,” said the traveller, whose skin was burnt by the sun and whose clothing was ragged.

These were hospitable people, and though they did not have much, they swore oaths to aid those in need. The guard drew up a bucket and passed it to the man.

The traveller drained the bucket and then asked for another. He drank that too and asked for another. The traveller continued to drink for many days, and all the while the guard believed that he was fulfilling his oath. On the thirtieth day, the well had run dry and the bucket contained only mud. The traveller thanked the guard and then died of thirst. Thereafter the guard and the rest of his village followed the man in death.

There was silence in the room.

Claudia then spoke to the young healer and said, “We must all draw from the same well. See to it that you do not waste the water.”

The judgements of Claudia Hippocrita drew much comment within Sanitas. In one ruling, she would favour a patient, and in the next, a scribe. Occasionally, she would uphold the self-rule of healers within their halls, and other times she would invoke old customs and laws to constrain them. This baffled and frustrated some in Sanitas.

One night, two strangers were complaining loudly in a tavern.

"She does not seem to follow our teachings with much reliability," said the one who was a healer.

"Nor does she follow only our codes," added the other, who was a scribe and well-versed in the ways of managers.

They continued to complain until a man sat down at their table. His right eye was covered with a bandage.

"You are right, that the princeps does not follow either of your codes. She cannot do so without causing chaos in Medici."

The strangers, who did not think they were being overheard, were silent. The man continued.

"She must direct the labours of our city towards helping the sick - that is what we expect of a healer. Yet she must also safeguard the functioning of our city, lest there be anarchy. In that, she acts as a manager. She does not always rely on laws or judgements to guide the healers, however. Instead, as you have seen, she persuades and influences with great skill. If she were to use her powers as princeps too often, there would be much unhappiness among our brethren. In all this, she must ensure to hear all sides of disputes, make fair judgements and make reparations where there has been hurt or harm."

The two listeners considered this.

"What should we call this way in which she governs, then? It is not the ways of Sanitas, nor Administrare," said the one.

At this, the man stood up, removed the bandage from his right eye and looked at his audience before speaking.

“It is not always possible to do exactly what is required, but when it is done…” he stared at each of them for a while. “I think it should be called wisdom[25].”

[25] It can be argued that “practical wisdom” or “situational judgement” may be equally appropriate translations.

Afterword

It is here that the transcripts conclude. The Voyager Stones appear to relate a journey in more than one sense. Certainly the subject of the stones, Claudia Hippocrita, makes a journey to a region between two provinces in the physical sense. However, the story also references a conceptual journey that healers of her sort must undergo. In some senses, all healers who depart from Sanitas as Claudia Hippocrita did, could be said to remain in those “liminal lands”, facilitating trade between the domains of health and management, and acting as something which is both and neither.

My great gratitude goes out to all those that have assisted in this endeavour, and to those voyagers who sojourn in the great in-between and seek to help others.