

Making Sense of Effective Partnerships among
Senior Leaders in the National Health Service

Abstract

Background: Changing healthcare systems depend on strong organizational leadership that realizes the collaborative potential of both physician and non-physician leaders.

Purpose: This study seeks insight into the everyday healthcare leader experience by examining 24 physician and non-physician leaders working in the UK National Health Service. We explore: (a) how they make sense of and act with respect to specific collaborative tensions in their interactions; and (b) which aspects of their everyday leadership contexts heighten the probability for producing and resolving such tensions.

Methodology: We conducted 24 in-depth interviews with physician and non-physician leaders in job titles including Chief Operating Officer, Managing Director, Medical Director, and Clinical Director. Ideas from the social psychological perspectives of sensemaking, organizational role theory and organizational citizenship behavior helped frame the study.

Results: We identified four areas of ongoing tension between senior leaders. Each of these was linked to a set of underlying drivers, with the strongest support for drivers with interpersonal roots. Effective strategies for resolving tensions involved significant effort by leaders at improving the interpersonal dynamics associated with everyday interaction, and forging relational connections through enhanced trust within the leadership team.

Conclusion: This study outlines the organizational and individual characteristics that lend to effective collaboration among senior healthcare leadership, and the types of collaborative tensions likely to be experienced by senior health care leaders.

Practice implications: Organizations should provide greater role clarity for senior leadership roles; promote 'soft' interpersonal competencies within them; and better assess potential leaders for success in senior roles. Organizational support in the form of facilitation, time, and spaces to learn together can provide a better context for collaborative decision making.

Introduction

Changing healthcare systems depend on the presence of strong organizational leadership to carry through the three-fold challenges of improving quality, lowering costs, and enhancing the overall patient experience. Health care systems in both the United States (US) and United Kingdom (UK) are currently facing key strategic imperatives to meet these challenges. An increase in demand for quality, affordable healthcare is being met in both contexts with resource shortfalls prompting drives for productivity improvements, potentially leaving the quality imperative somewhat unfulfilled. In the U.K., the entry of new players in the field has meant a rapidly expanding role for the private and voluntary sectors, matched by efforts to provide stronger, community-based social care services. In the U.S., shifts towards a “value-based” payment system are accelerating, and care standardization remains a top priority (Centers for Medicare and Medicaid Services, 2016). It is important to harness the potential of collaborative leadership teams that consist of physician and non-physician leaders; different from the traditional US and UK “dual hierarchy” under which such leaders worked in relative isolation from each other.

The concept of shared or distributed leadership helps us to conceptualize the increased need for collaboration and shared imperatives existing between physician and non-physician leaders (e.g. Chreim & MacNaughton, 2016; Döös, 2015; Martin, Beech, MacIntosh & Bushfield, 2015). Such shared leadership can take on various forms, e.g., depending on the nature of hierarchy (equality vs. subordination) and the allocation of specific tasks between leaders (merged vs. divided) (Döös, 2015). Its advantages range from enhanced interaction and learning (ibid.), the combination of “expertise and resources to bring about change” (Chreim, Williams, Janz & Dastmalchian, 2010, p.197), improvements in service outcomes (Boak, Dickens, Newson & Brown, 2015) as well as enhanced organizational capability (Gronn, 2002). However, a number of factors moderate these effects, including contextual features such as the extent of leadership role development and the nature of social relationships among those in distributed leadership roles. Additionally, in working together, leaders must “manage the boundaries between the roles they assume” (Chreim, Langley,

Comeau-Vallée, Huq & Reay, 2013, p.202), which implies additional use of personal and social mechanisms to achieve sustained collaborative working relationships.

Traditionally, physician and non-physician leaders have suffered from major points of tension in their roles resulting from differences in how they view their work and charge; the different constituencies to which they must play; their divergent skill levels and ways of thinking about the healthcare workplace; and the isolated nature of how each often chooses to operate vis-à-vis the other (Fitzgerald, Lilley, Ferlie, Addicott, McGivern, & Buchanan, 2006; Hoff, 1999). In particular, physician leaders' 'medical professionalism' and the more organizationally focused 'managerialism' possessed by non-physician leaders such as nurses may, in effect, condition how they make sense of their contexts.

Previous research examining healthcare leaders has tended to focus mainly on either the physician leader in isolation and related role-adaptation and identity issues, for instance (e.g. Hallier & Forbes, 2005; McGivern, Currie, Ferlie, Fitzgerald & Waring, 2015; Thorne, 2000; Hoff, 1999), or on how the "dual hierarchy" of clinical and non-clinical leadership, enacted separately, functions (e.g. Davies & Harrison, 2003; Davies, Hodges & Rundall, 2003; McKee, Marnoch & Dinnie, 1999; Sinha, Canter & Vince, 2011). Extant research also tends to be more acontextual in the sense of asking questions less focused on how leaders interact with conditions in their surrounding context in forming certain perspectives and behavioral approaches. There has been little work examining how sensemaking and social interaction occurs between physician and non-physician leaders in the course of working together and making shared decisions, i.e. as collaborative leadership teams.

The present study brings in this context and aims to understand how senior physician and non-physician leaders working together as relative co-equals in healthcare organizations process and seek to resolve tensions and challenges, thus enhancing their collaborative potential in the face of a changing health system. We define co-equals as executives at the same structural levels within a health care administrative hierarchy; and that are supposed to work in partnership to oversee a service with separate, albeit overlapping, responsibilities. What is noteworthy about such roles is

that because they are new and emerging within the NHS, for example, they often lack detailed guidelines about how they must be enacted. We interviewed senior leaders in the NHS and asked: (a) how do physician and non-physician leaders make sense of and act with respect to specific points of tension in their interactions with their co-equals, for the purpose of seeking greater collaboration; and (b) which aspects of their everyday leadership contexts (e.g. structure, culture) heighten the probability for producing and resolving such tensions?

Conceptual Framework: A Social Psychological Lens on Senior Leader Collaborative Efforts

We draw upon several ideas in framing the study: (a) sensemaking as the overarching lens to conceptualize how leaders process and respond to novel experiences working together, (b) organizational role theory (ORT) to help articulate why tensions between physician and non-physician leaders might arise, and, and (c) organizational citizenship behavior (OCB) to understand the array of reasons why leaders may partner together to negotiate solutions when tensions arise.

Sensemaking (Maitlis & Christianson, 2014; Weick, Sutcliffe, & Obstfeld, 2005) helps us understand how leaders process and respond to novel experiences, in this case working together in a formally integrated fashion. Sensemaking focuses on learning associated with the more immediate lived experience, and in the change-oriented environment of today's healthcare organizations, immediate past experience may dominate the thinking of leaders as they strive to adapt to on-the-ground circumstances for which there are few prior precedents, such as pressures to increase service delivery efficiency in untested ways. Sensemaking is a process in which individuals "engage ongoing circumstances from which they extract cues and make plausible sense retrospectively, while enacting more or less order into those ongoing circumstances" (Weick, Sutcliffe, & Obstfeld, 2005, p.409). Thus, senior leaders, particularly those who have recently assumed these roles and have a more limited pool of past experience, may draw from the repertoire of such recent and ongoing interactions, including those with their peers, intermingled with their own professional norms and beliefs, to interpret and respond to events unfolding in their everyday environments (Maitlis, 2005).

Organizational Role Theory (ORT) aids in understanding why tensions between physician and non-physician leaders might arise in the first place, as a normal condition of their close association with one another. For example, individuals enact the roles assigned to them by their organization in the form of recurring patterns of action (Katz & Kahn, 1966). Because there is often no guidebook in health care for how collaborative or highly integrated leadership roles should be enacted, physician and non-physician leaders may tend to act based on beliefs and values rooted in roles for which they are more familiar and for which they have deeper experiences. There is sensemaking involved in this process, e.g. leaders are processing their lived experience as a doctor, nurse, or administrator and forming strategies for future action based on these role interpretations, chalking out their 'comfort zone' in the process (Cascón-Pereira, Chillas & Hallier, 2016).

This allegiance to prior roles as sources of leader role enactment may be challenged in times of organizational strife, however, when leaders need to abandon parochial role mindsets and instead work together to find integrated solutions. Role conflict may result because the original frames of reference no longer align well, even if only temporarily, with what the current leadership context demands. In addition, working as part of a collaborative leadership team means more fluid role boundaries at the interpersonal level (Chreim et al., 2013). This reality can cast some health care leaders into feelings of greater uncertainty as to how various role mindsets interrelate and should drive action, producing some role ambiguity for the collaborative leader role (ibid., Chreim & MacNaughton, 2016).

Finally, a particular idea from Organizational Citizenship Behavior (OCB) helps to predict the accumulated value for the organization and leadership team that can result from physician and non-physician leaders dealing directly with tensions that arise from working together in a more integrated fashion. This value comes in two forms: (a) a more self-interested benefit to the individual leader (Bolino, 1999); and (b) a larger goodwill or social capital benefit for the leadership team and, ultimately, the organization in which that team is making decisions (Bolino, Turnley, & Bloodgood, 2002). OCB is behavior that goes beyond formal job descriptions, is not necessarily

recognized or rewarded, but that enhances organizational functioning (Bateman and Organ, 1983).

Physician and non-physician leaders may have a more self-interested motivation, i.e. that of wanting to figure out how to perform better in their own roles, and manage others' perceptions of their own effectiveness as leaders, that drives them to be proactive in resolving tensions with other co-equals (Bolino, 1999; also see Chiaburu, Stoverink, Li, & Zhang, 2015).

In addition, leaders may be proactive and employ discretionary, entrepreneurial behavior that is not necessarily part of their formal job descriptions (Organ, 1988) to increase the overall social capital or goodwill available to the leadership team as whole, which then enhances the potential for more collaborative cultures to arise and sustain (Bolino, Turnley, & Bloodgood, 2002). Taken together, these three sets of ideas share an agency-oriented view of leader behavior with respect to making collaborative teams work, and that view helps to drive this study. Collaboration is thus considered at least partially within the control of the leaders themselves, facilitated by a variety of beliefs and behaviors which reflect creative approaches to problem solving.

Method

The present study is qualitative using in-depth, semi-structured interviews, which are a useful tool when less is known about the phenomenon of interest, in this case the experiences and perceptions of senior physician and non-physician leaders in the NHS regarding collaborative decision making. Using an idiographic empirical approach allows insight into the subjective, socially constructed dynamics of physician and non-physician leader interaction. We were particularly interested in the interaction and views of these two defined co-equal¹ leader groups, in part because of their presumably different prior work and role experiences, as well as training backgrounds – implying potentially higher magnitude collaborative tensions as they work together. Typically for the physician leader group their leadership role is part-time and combined with continuing clinical practice, while for the non-physician leader group, it is full-time.

¹ Defined previously

Description of the Sample

The interview sample consisted of 24 senior physician and non-physician leaders (see Table 1) within the NHS that were selected using a mixed purposive, convenience sampling technique. The sampling strategy was purposive in identifying an equal number of both physician and non-physician senior leaders at the regional/directorate (e.g. senior strategic) level within an NHS body and responsible for organization or division-wide strategic decision-making in their organizations, with job titles such as Chief Operating Officer, Managing Director, Clinical Director, and Medical Director. Study participants came from across 11 NHS organizations: 4 mental health trusts, 4 acute trusts, 2 Clinical Commissioning Groups, and 1 regional-level body within NHS England. Getting leaders from a cross-section of NHS organizations, each of which had different patient care responsibilities and missions, was preferred in order to compare and contrast the potentially different interaction experiences existing among them.

<Insert Table 1 about here>

The selection of NHS leaders utilized a convenience approach that involved two of the study co-authors (PB, SD) identifying senior leaders with whom they had some level of familiarity, either through prior work-related activities or word-of-mouth association. One particularly useful mechanism in this regard was to use a co-author's (PB) organization, Oxford Executive Coaching, to identify the first leaders interviewed, as well as the majority of the following group. Participants were approached either by a phone call or e-mail solicitation, following which they were briefed about the goals of the study, and provided with a written consent process. A few of the initial leaders recruited had to be replaced with others given unforeseen scheduling difficulties that arose. Of 36 prospective participants approached for interviews, 24 agreed to be interviewed – 12 physician and 12 non-physician leaders. The study was approved by both the Oxford University (SSH_SBS_C1A_15_051) and Northeastern University (IRB#15-09-21) research ethics boards. Data for the study were collected in two phases to allow for a level of theoretical sampling (Strauss, 1987) to take place.

Data Collection and Analysis

Interviews were conducted between November 2015 and March 2016. The first author (MM) conducted all of the interviews, with 2 done in person and the remainder by phone or Skype. The interview protocol was developed in consultation among all four members of the research team, then tested with the first five senior leader participants. Interview questions focused on the following: (a) describing experiences of working with other physician or non-physician senior leaders; i.e. individuals in the opposite group; (b) identifying the range of specific opportunities for collaborative work with the opposite group; (c) challenges and tensions associated with working collaboratively with the opposite group; and (d) best practices around effective collaboration and shared decision making between physician and non-physician leader groups. Interviews were recorded and transcribed using an external transcription service, and analyzed using Atlas.ti version 7.5 qualitative analysis software. Before any formal coding began, the first and second authors reviewed five interview transcripts, then met to discuss how the questionnaire seemed to be functioning in getting at the phenomena of interest, as well as what might be some preliminary themes emerging.

After this step, the coding proceeded in an iterative fashion using systematic techniques of open coding, which emphasized gaining rich description and identifying general patterns of views, experiences, and behaviors among senior leaders. This was followed by axial coding in which data from the open coding phase were examined in greater depth to identify various types of tensions and contextual drivers underlying them, and then a second-order analytic phase in which the tensions, drivers, and strategies of resolving them were aggregated into larger categories (Miles & Huberman, 1994). To facilitate this interpretive scheme, interviews were analyzed in batches, with the first 7 interviews moving through both open and axial coding phases first, with codes being established or modified and guiding the next batch of interview coding.

This left opportunity for additional open coding and new category emergence to occur. In essence, this approach allowed for some degree of theoretical sampling (Strauss, 1987) to occur on

the data, which enabled the researchers to hone in during later interviews more specifically on phenomena that were emerging as important within the overall data set, in terms of both their frequency of occurrence from a coding perspective and also their analytic depth in terms of what interpretive meanings they were conveying. This also allowed certain aspects of the questionnaire to be delved into more deeply during interviews with participants.

When reporting results, the strength of evidence for various codes was assessed on both the depth and spread of responses. 'Spread' counted the number of participants that discussed a given theme. Depth was calculated as 'number of occurrences of a theme' divided by 'number of interviews in which the theme was reported'. 'Strong' support for a code denoted themes reported by 60% or more of the participants, with 1-2 occurrences on average within each interview; 'Moderate' denoted themes reported by 40-60% of respondents, with 1-2 occurrences on average within each interview. 'Weaker' denoted themes reported by 20-40% of respondents, with 1-2 occurrences on average of the theme within each interview. Ultimately, the coding process uncovered second-order codes in several main areas, i.e. types of tensions that existed among physician and non-physician leaders; contextual drivers of those tensions; tension-resolving strategies leaders employed; and specific tension areas such strategies addressed. These second-order codes were derived from descriptive first-order codes that identified different activities in which leaders engaged, and the contextual features identified across interviewees.

Results

Our analysis yielded four main areas of tension among senior physician and non-physician leaders (see Table 2), with no specific patterns based on sample characteristics such as gender, tenure and others presented in Table 1. Three of these were issue-based and related to service administration, talent management, and clinical issues. The fourth represented tensions arising from behaviors intended to create a functional executive team. All four areas were highlighted by both physician and non-physician leaders and illustrated specific points of disagreement, conflict, or

challenge when moving decisions forward. Table 3 provides representational quotes for each of these areas; the reader is advised to refer to these alongside the analysis that follows.

<insert Table 2 about here in landscape orientation>

<insert Table 3 about here in landscape orientation>

Administrative issues were identified as a key source of tension within the leadership group. Included within this broad category were challenges relating to three operational areas: service delivery, service improvements, and contracting. For example, service delivery challenges were described as creating tensions during day-to-day functions, such as hospital ward cleaning (see Table 3). They were also reported for matters relating to audit, compliance, and governance. Tensions relating to service improvements were believed to arise when leaders worked on fiscally-related imperatives such as cost improvement plans, meeting financial targets, and adopting specific measures that entailed using the available infrastructure more efficiently and at the lowest possible cost. Contracting was perceived to generate conflict between physician and non-physician leaders in particular around outsourcing decisions for specific services in the organization.

A second strongly supported area of tension was reported in leaders' attempted to learn to partner together and function as an effective decision-making team. Specifically, partnering was believed to pose challenges when physician and non-physician leaders attempted to collaborate in real-time, given the dual roles many physician leaders still played within their organization, working as both clinicians and managers. Partnering also created tension when leaders worked amidst competing demands to discharge leadership duties effectively, and in leaders' attempts to agree when making joint decisions on operational problems and long-term strategy (see Table 3).

Talent Management was the third area perceived as causing tension among physician and non-physician leaders. The challenges here manifested in joint work relating to the hiring and firing of personnel, staffing and line managing for service delivery, and identifying staff training needs (Table 3). For example, a recruitment decision was described as a point of conflict between a

physician and non-physician senior leader who were both looking to expand their mental health crisis team but did not know whether a doctor or a social worker was suitable for the position. The non-physician leader leaned towards a non-physician taking up the role because she thought it more important to recruit based on a specific skills-set rather than a medical qualification. This did not reconcile with her physician co-equal's view and was thus a longstanding argument between them.

Senior leaders also recounted how clinical issues created tensions in their work with their colleagues. This fourth category was rich with a number of specific stories around challenges posed when leaders jointly sought better bed management, and developed or implemented new care foci, patient follow-up policies, or GP referral pathways (see Table 3). For example, there were two types of bed management issues described – bed oversubscription that led leaders to place patients in private hospitals; as well as undersubscription that led them to face penalties arising from bed vacancies. Both of these scenarios were believed to have financial implications which, under the existing strained overall national context, increased pressure among leaders. This was further exacerbated by non-physician leaders' perception of their physician counterparts as being both ill-equipped to understand 'contracts, penalties and money' because of a lack of knowledge; as well as unwilling to have such 'unpalatable' conversations with their physician colleagues (whom they also managed) based on a fear of being perceived as having gone over to the 'dark side'.

Factors Driving Tensions Among Physician and Non-physician Leaders

Each area of tension or challenge, as described by senior leaders, was linked to a set of underlying drivers (Table 2, column 4). Drivers that specifically sparked tensions between physician and non-physician leaders were identified at three levels: interpersonal (physician-nonphysician differences, interprofessional relationship), operational (time pressures, financial context), and cultural (medical subculture), with the latter two operating at the group and organizational levels.

The strongest support was for drivers identified at the interpersonal level. One set of factors underlying tensions within this category was named "physician-nonphysician differences". Within these were reported differences in leadership priorities between physician and non-physician

leaders. For example, priorities of physician leaders centered around promoting high quality clinical care, keeping sight of the patient at all times, and assessing the clinical risks of operational decisions. Non-physician leaders were focused more on delivering the service on budget and implementing cost improvement strategies, being process oriented, and holding a “bigger picture” view of the service requirements for the patient population as a whole. Such differences in leadership priorities were believed as primarily driving conflict in leaders’ work around service administration and clinical service delivery, but also in leaders’ attempts to partner together to create a functional executive team.

Included within the category of physician-nonphysician differences were also tensions reportedly deriving from leaders’ limited understanding of each other’s roles, which sparked tensions in their collaborative work on service administration and talent management. For example, a physician leader described how his non-physician counterpart did not understand clinical roles within the NHS and therefore insisted on recruiting sessional (paid by the session) GPs who were expensive but logistically easier to recruit; rather than regular, full-time doctor consultants who could make a greater contribution to the clinical life of the organization. Non-physician leaders were also viewed as being unaware of clinical service delivery issues such as hospital ward operational management and medical prescription procedures, which in the minds of physician leaders limited their ability to understand why some cost saving measures were difficult to enact.

A second set of factors underlying tensions at the interpersonal level related to the interprofessional relationship shared between leaders (Table 2). Corresponding tensions were rooted in aspects such as different leadership personalities, communication deficiencies, and role ambiguity. Role ambiguities, for example, were perceived as creating tensions within physician and non-physician leaders’ joint work on talent management, when co-equals were unable to decide who between them was responsible for managing medical staff, or, whose decision it was to determine their training needs. This reportedly created tensions because senior leaders were then not able to implement resource cuts as planned and risked being unable to meet savings targets.

Role ambiguities were also described as leading to the overlapping of responsibilities between physician and non-physician leaders, creating tensions that resulted from the duplication of work.

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Strategies and Tactics for Resolving Tensions Among Physician and Non-physician Leaders

The second part of our analysis explored the strategies and tactics used for resolving specific tensions (Table 4). Effective strategies and tactics were identified at both the interpersonal and organizational levels of analysis. Generally, the three major strategies identified all involved significant doses of individual effort by physician and non-physician leaders at improving the interpersonal dynamics associated with everyday interaction, and forging relational connections through enhanced trust and openness in the leadership team environment.

Strategies at the interpersonal level were reported to be proactively applied by leaders within the context of the specific leadership team in which they found themselves. Enacted on a largely local level, these involved more informal or ad hoc tactics that were linked to the leader's discretion or personal choice. We found support for the application of these interpersonal strategies by both physician and non-physician leaders for addressing tensions and challenges emanating from all three areas of the organization, i.e. business operations, talent management, and clinical service delivery. This is noteworthy, since the interpersonal strategies and the specific tactics associated with them comprise a less prescriptive or compulsory part of such leaders' job descriptions. They are also not typically rewarded or recognized by the organization formally as such, giving them a highly agency-oriented flavor.

The first set of interpersonal strategies fell under the heading of "proactive communication". Reported by both physician and non-physician leaders, proactive communication comprised tactics such as engagement, peer advantage, and problem focus (see Table 4, column 4 for examples of each of these). Each of these involved sharing information, inclusive decision-making, and evidence-based problem solution. The strongest evidence, however, was for the specific tactic of engagement. Leaders reported as having resolved tensions by being open and honest with each other when they

arose, being willing to listen and negotiate solutions with each other, thereby talking their way out of problems. Engagement, and other tactics were described to be most useful in resolving tensions rooted in interprofessional relationship problems, particularly differences of opinions between physician and non-physician leaders. For example:

One of the things we've done is that my counterpart and I go and do ward rounds ... and actually see patients. That is very important because that gives first-hand information and a view of what it is out there ... but also the challenges that the clinicians face at the shop front [Stuart, Physician Leader].

The second set of interpersonal strategies identified were labelled “breaking down silos”. Battling the silo mentality – a parochial mindset that is unwilling to participate or share with others – was perceived as requiring longer periods of continued engagement between physician and non-physician leaders. There were three sets of tactics enacted – finding common ground, tapping into trust, and creating time (see Table 4 column 4 for examples of each of these). Of these, the one described as being most significant in resolving tensions was by finding common ground. Physician and non-physician leaders reportedly achieved this by taking time to identify their shared goal – what was best for the patient using the health service, and using that when at loggerheads with each other over a problem. They encouraged each other to be honest in communicating about areas of disagreement, as well as reminding themselves of their joint responsibility for care, despite their different role foci. Utilizing such tactics was believed to resolve differences of opinion and trust issues between them.

The way I've been trying to address [silos] is to spend more time with the individuals, ... and trying to find projects where we can work together. And then if you've got that trusting relationship starting to build its much more likely people will ... share things that they're anxious about [Jena, Physician Leader].

Physician and non-physician leaders also made use of organizational-level strategies to address collaborative challenges. Labelled “institutionalizing partnership behavior”, this category of

strategies was seldom described independently of the two sets of interpersonal strategies detailed previously. The tactics within this strategy were rooted in using formal organizational policies or procedures for resolving tensions. In this way, they involved the more prescriptive and “approved” aspects of the senior leadership environment. The three specific tactics recounted by leaders aimed at enabling collaboration, engagement, and facilitation at the organizational level (see Table 4 column 4 for examples of each of these). These were reportedly achieved through the creation of work groups for collaborative decision-making, structured away days for leader engagement, and guided coaching to support collaborative leadership.

Usually we make a day out every six months that we can take time to reflect on what we’re doing and try and draw up what our priorities for the year are, in line with the trust priorities, but also [for] developing our locality [Jasmine, Non-physician Leader].

When looked at overall, we found that leaders perceived both sets of strategies – interpersonal and organizational – to be most successful in addressing tensions deriving from their interprofessional relationship and differences in physician-nonphysician leadership priorities (Table 4). The strongest evidence was for the resolution of tensions arising from the former. Within this, the strategies enacted by leaders were described to be most useful in addressing differences of opinion, trust issues, and stylistic variations in leadership role execution. The mitigation of tensions caused by differences in leadership priorities was attributed primarily to proactive communication, and breaking silos by establishing common ground between partners. Leaders were thus able to use such informal and self-interested conflict-resolution mechanisms to make sense of, and resolve, to a considerable extent, tensions deriving from their interpersonal engagement.

Discussion and Conclusion

Our study contributes to the literature on distributed leadership in health care, and the sensemaking in which health care leaders engage when trying to make collaborative relationships work. There are few extant data that speak to these issues at the present time. Utilizing the

sensemaking perspective as the overarching conceptual lens enhanced our ability to see how leaders processed and responded to the tensions emanating from their shared leadership experiences. Our findings indicated that the drivers of tensions between the leaders we examined lay primarily at the interpersonal level. In finding that differences in leadership priorities and personalities, coupled with a limited understanding of each other's roles sparked tensions between leaders, our work illustrates Maitlis' (2005) contention around the divergent frames of reference that underlie, and can explain, the differential roles individuals take on in sensemaking processes in their organizations, and how these differences create potential tensions in attempting collaborative work and decision making.

Within the overarching framework of sensemaking, ideas from Organizational Role Theory have bolstered our understanding of why tensions between physician and non-physician leaders arise. For example, findings around communication deficiencies and role ambiguities as factors contributing to tensions resonate with what has been reported in the context of shared leadership work characterized by fluid role boundaries (Chreim et al., 2013; Chreim & MacNaughton, 2016). In this regard, Chreim and MacNaughton (2016) report that role ambiguity among leaders with overlapping responsibilities can be avoided if "leaders have agreement on areas of overlap and on which leader assumes ultimate authority in a given area" (p.211). Further, our findings also ring true with Martin et al. (2015), who found that distributed leadership was challenged when leaders experienced disconnect with each other around who had power, where the 'other' was located, and the precise understanding of various value orientations leaders carried with them.

Findings relating to the proactive use of interpersonal-level strategies as the primary means for resolving tensions led us to formulate an agency-oriented view on leader collaboration and problem-solving, pursued by leaders in the course of being good organizational citizens as well as for their own betterment in their roles, and the creation of additional social capital among senior leaders within the organization.

Implications for Research

Our study results suggest several dynamics and realities characterizing senior leadership roles in health care that need to be further explored. These dynamics and realities are served well by applying a more social psychological view that sees health care leaders as proactive agents embedded in constraining circumstances. One area that future research might examine relates to identifying the additional ways in which senior leaders pursue such sensemaking in other aspects of their job, such as engaging in strategic decision-making within the organization, managing external stakeholders, and overseeing line personnel. This speaks generally to how leaders learn to become leaders, and what serves as the best teacher in that regard. A second direction that future research can take is to delve deeper into aspects explored by the current work. For example, what specific circumstances trigger leaders' sensemaking efforts in complex situations where greater collaboration must be achieved? Identifying particular contextual features that push this proactive sensemaking, e.g. periods of crisis versus relatively calm, particular strategic issues versus others would ground the dynamics observed here in the realities of the different types of health care situations that organizations face, creating a more contingency-oriented view of distributed leadership in health care.

A third area on which future research might wish to concentrate relates to the issue of how leaders enact sensemaking that relates to their social interactions with each other, in particular if there are situations where more destructive (for the organization and for enhanced collaboration) rather than constructive sensemaking is occurring. To this end, continuing to apply the OCB lens, and its focus on the self-interested or impression management side of how leaders think and act, would be useful (Bolino, 1999). Using such social psychological frames, that until now have not been applied to analyze senior leader behavior in health care, has value and should be employed further in future studies on topics ranging from health leader behavior to effectiveness.

Implications for Practice

There are two broad implications of our work for leadership practice. The first of these relates to the extent to which healthcare organizations can identify and hone collaborative senior

leadership. Our study suggests that role clarity is a key factor leading to enhanced leadership effectiveness, particularly in working together collaboratively (West, Borrill, Dawson, Brodbeck, Shapiro & Haward, 2003). Such clarity is also required for leaders at the higher echelons of their organizations, and needs to be set by the larger organization, in this case, the NHS. There is value in experimenting with provisional leader selves (Cascón-Pereira et al., 2016) and creating formative spaces such as 'action groups' for reflection and learning together in this regard.

Our results also indicate that healthcare leaders can benefit from gaining a higher degree of emotional intelligence through exposure to training, socialization, and ongoing experiences that allow them to learn valuable 'soft' interpersonal skills and competencies and apply them in appropriate ways (Kerr, Garvin, Heaton & Boyle, 2006). Emotional intelligence is linked not only to more aware and constructive sensemaking, but also to a greater ability for individuals to improvise their roles in fast-moving situations where there is little formal guidance as to how to act (Weick, 1998). At the same time, we found that health care organizations must take greater care in selecting those individuals for senior leadership roles who possess the right mix of skills and attributes lending to emotional intelligence capacity. In short, not everyone moving into these roles can necessarily find success unless they also have a certain set of skills and traits can be drawn upon when devising tactics such as those described in this study. The central question that then begs reflection is: how much is collaborative leadership an organizational development issue and how much a recruitment and selection issue?

Another practice implication relates to the provision of organizational support for the creation of a more facilitative context for collaboration. Although physician and non-physician leaders may have much left to be achieved in terms of collaborative decision-making, their ultimate success is predicated on the provision of organizational support such as adequate time, space, and opportunities for interaction. Coupled with these ingredients are education and training opportunities for sensitization and management of boundaries between shared leadership roles (Chreim et al., 2013). Health care organizations must move beyond individual leadership

development and instead prioritize the collective and relational competencies needed to further tension resolution and build collaborative cultures (Willcocks & Wibberley, 2015). In these ways, the employing organization has additional important roles to play in creating and maintaining a nurturing everyday context for senior healthcare leaders.

Study Limitations

Several limitations of the study should be pointed out. First, the small sample of senior leaders coupled with our specific focus on physician and non-physician leader collaboration (to the exclusion of non-clinical leaders) merits caution in interpreting the findings presented here. However we feel that this is less problematic given the study's exploratory focus, and the fact that to our knowledge few extant data exist around the sensemaking and interactions between senior healthcare leaders, regardless of background and training. Second, since it is a largely convenience-based sample, some potential bias from how participants were selected could be present. For example, did we gain too many "collaborative" senior leaders because of their potential greater willingness to talk about their experiences?

We were also aware that the sample inadvertently ended up being disproportionately represented by NHS senior leaders working in particular NHS organizations such as mental health trusts, and that there could be potential findings that were too idiosyncratic and thus not well generalizable across leader-leader relationships in other parts of the healthcare system. We attempted to guard against these issues by making sure that several of the major codes or categories identified were validated and held up across a majority of the interviews, including when data were analysed based on a number of sample characteristics such as gender, type of organization, and professional background. We are, however, mindful that ours was an exploratory study that has made a relevant, yet only preliminary, start in contributing to the existing gaps in literature around co-equal leaders' perceptions and subjective views on their interactions with their peers, and that this work needs to be supplemented by future studies that utilize larger samples and include a representation of the different types of bodies within the NHS.

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Table 1 Sample Characteristics

Total Sample: 24 participants from across 11 organizations				
Gender	Physician Leaders (12)		Non-physician Leaders (12)	
	Male	66.6%	Male	8.3%
	Female	33.3%	Female	91.6%
Mean Age	48 years		52 years	
Organization type	NHS Mental Health Trust	7	NHS Mental Health Trust	9
	Acute Care Trust	3	Acute Care Trust	
	Clinical Commissioning Group	1	Clinical Commissioning Group	2
	NHS England	1		1
Mean Senior leadership tenure	8.6 years		10.3 years	
Professional Background	Physician	12	Nursing	6
			Allied health	5
			Academic	1
Work domain	Mental Health, Clinical and Specialist services, Social Care		NHS Commissioning, Adult Services, Clinical and Specialist services, Drug and Alcohol services, Mental Health	
Titles	Clinical Director (region)	4	Managing Director	6
	Clinical Director (service)	3	Chief Operating Officer	3
	Director (clinical service)	2	Deputy Director of Operations	2
	Medical Director	1	Director of Assurance	1
	Clinical Chair	1		
	Director (R&D)	1		

Table 2 Areas and Drivers of Tension Among Physician and Non-physician Leaders

Areas Of Tension			Corresponding Drivers Of Tension		
Area (second order codes)	Evidence	Examples (first order codes)	Driver (second order codes)	Evidence	Examples (first order codes)
Service Administration	Strong	Meeting service delivery targets, service improvements, specific initiatives, contracting and contract negotiations	1. Physician-nonphysician differences	Moderate	different leadership priorities (e.g. quality versus efficiency); limited understanding of each other's roles
			2. Interprofessional relationship	Moderate	communication deficiencies; stylistic differences in role execution (e.g. micro-managing versus delegating)
Learning to Partner	Strong	Collaborating in real time, discharging leadership duties effectively, gaining consensus in joint decision making	1. Interprofessional relationship	Strong	stylistic differences in role execution; poor interpersonal dynamic; trust issues (e.g. feeling undermined by co-equal)
			2. Time pressures	Moderate	lack of active time together; no time to strategize
			3. Physician-nonphysician differences	Weaker	different leadership priorities (e.g. patient versus process orientation)
Talent Management	Moderate	Hiring and firing personnel, staffing for service delivery, identifying training needs for personnel, line managing personnel	1. Interprofessional relationship	Moderate	role ambiguity between leaders; different opinions on operational decisions (e.g. relocating consultant across teams)
			2. Medical subculture	Weaker	physician leaders as weak managers; physician reluctance for management
			3. Physician-nonphysician differences	Weaker	limited understanding of each other's roles
Clinical Issues	Moderate	Developing/ implementing new care pathways/foci, patient follow-up policies, GP referral pathways, hospital bed management	1. Interprofessional relationship	Moderate	differences in leadership vision, expectations, and expertise
			2. Physician-nonphysician differences	Moderate	different leadership priorities (most notably patient versus process focus)
			3. Financial context	Moderate	efficiency concerns stemming from NHS pressures

Table 3 Representative Quotes Illustrating Each Area of Tension Identified in the Study

Areas of Tension	Illustrative Quote
I. Service Administration	The cleaning of the ward [is] something fundamental...and if the ward is not appropriately clean they have to raise it up to the estates, and [so on] ...and then people start just complaining about it. And our Quality Director [non-physician co-equal], because she's based where the ward is, gets quite drawn into it. I think, you, as a quality director, identify a problem and give advice. But that's sometimes not happening [Erica, Physician Leader].
a. Meeting service delivery targets	
b. Service improvements	I think what doesn't go so well is when we have [a] cost improvement plans [meeting] to make savings...with our managers and ... medical staff.I sent out the papers again beforehand so that everybody had them, went to the meeting knowing that we had to find so many thousands of pounds' worth of savings. [But] how the clinical director [physician co-equal] presented in that meeting with the managers was, he struggled with making savings and understanding why we have to do them [Jasmine, Non-physician Leader].
c. Contracting and contract negotiations	I remember having a difficult interaction when my director of operations told me he had a problem and I felt that it was my role to step up and sort it out...[with] one of our partner organizations... We hadn't communicated very well. I had maybe misunderstood the frustration he was having and I went in and tried to fix a solution by being quite assertive with our partners, and in actual fact that didn't work very well because it wasn't as big an incident as I thought [Tony, Physician Leader].
II. Learning to Partner	[T]ime is always a problem. So the amount of time we get to spend together, that isn't being pulled away by another demand, of a meeting, a task, and actually to spend sufficient time thinking about the right things. So how do we get ourselves into the right headspace so that we sit together and we focus on the right topics? [A] lot of this work requires you to be really thoughtful and when you're multi-tasking all the time being thoughtful is quite difficult to do [John, Physician Leader].
a. Collaborating in real-time	
b. Discharging leadership duties	[T]he demands made upon senior leaders in our organization by the NHS more widely means we're continually being drawn out to inter-trust activity or ... NHS corporate activity, and that takes out attention away from this absolutely critical balance that leaders have to strike between being visible and creating the circumstances for followership, and also being out there in the world and defending the reputation of the organization and finding our place in the bigger picture [Philip, Physician Leader].
c. Gaining consensus in joint decision-making	[I]t takes an extraordinary amount of time, and needing to put yourself in the other person's shoes and encourage them to do the same with you so that you can find the common ground. And time is the one thing that usually goes against that [Emma, Non-physician Leader]
III. Talent Management	[M]y manager was insistent that we get sessional* GP's in to cover clinical workload, and I was saying [they] are actually extremely expensive and there's a much more efficient way to use doctor resource which is a consultant with trainees

a. Hiring and firing personnel	attached, which is a much more difficult thing to set up because you have to get lots of permissions from royal colleges before you can even advertise the job and have it accredited. So that kind of conflict has come up you know a few times in, in the last three years or so [Tony, Physician Leader].
b. Identifying training needs for personnel	The constructive tension is that the [training] requirements of the trust are far too great for the clinical workforce to bear, and ... guided by different parameters to us [clinicians]. That is, absolute safety and security for, for the trust would mean no-one did any clinical work. And so there are areas where I've said I don't believe that that section of the workforce needs to do that two-day training. I guess the area of dispute there is – whose decision is it? [Harriet, Physician Leader]
c. Staffing for service delivery	[The Clinical Director] said that we didn't have a consultant over one of our teams, ...so he was saying, "What I think we need to do is move one consultant from there to there," and I said, "Oh I'm not sure that's a good idea," and gave some reasons for it. And he said, "Well I think that this would work because of the interface with the board," ...and we ... left it at that [Lauren, Non-physician Leader].
d. Line managing personnel	[W]e have ongoing challenges with our medical workforce, with vacancies, with agencies, ...and while we come together to work out what we think that structure should be, the implementation of that, and how to pull that within the resources ... that we have, that's my role. [And] it's my counterpart's role to actually engage his medical workforce [which he is unable to do]. And that's where it all falls down and is very, very challenging [Samantha, Non-physician Leader].
IV. Clinical Issues	[O]ne of the things we spent a lot of time looking at is how many people are referred to hospital for outpatient appointments. ...[A]nd whether we can reduce that down or at least stop it from going up. [T]he managerial culture is to ... reduce the numbers by producing a target and then aiming for that target. Whereas the clinicians will the patient point of view and what are the reasons for referral and not referring, which tends to be quite time consuming and sometimes not that effective a way of doing it, so you end up sort of going round in circles [Jack, Physician Leader].
a. Determining GP referral pathways	
b. Determining patient follow-up policies	[S]ome of our current challenges [are] around our emergency department. ... I believe that in order to get better flow in the hospital, ward rounds need to happen earlier in the day. ...[otherwise] we get really long delays in terms of people being discharged, ...[and] in-day variation in ... capacity which creates a real risk from my perspective. ... [But] I'm not getting any change in the behavior of those medical staff. And my [physician] colleague in particular wouldn't necessarily thoroughly support that. So we're in a bit of an impasse [Lila, Non-physician Leader].
c. Hospital bed management	[C]urrently the medical director and I are trying to deal with a bed crisis, as we have a spike in acute mental health activity ...[a]nd there are more patients than we have capacity for. So we place patients in the private sector [b]ut the cost ... is astronomical; so we're trying to review the whole pathway [to] make it more efficient ... And part of that process is around meeting with the clinical teams on a weekly basis to do checks and tallies around bed management. [But] I just don't think

the [medical director] wants to [manage clinicians] because it's too difficult. And I find that very frustrating [Karina, Non-physician Leader].

*paid by the session rather than as part of a standard employment contract

Table 4 Resolving Tensions Among Physician and Non-physician Leaders

Strategies for Resolving Tensions					Drivers addressed by Strategy	
Level	Strategy (second order codes)	Evidence	Related tactics	Examples of tactics (first order codes)	Driver addressed	Evidence
Interpersonal	Proactive Communication	Strong	Engagement	‘Talking it out’, openness and honesty, listening and negotiating	1. Interprofessional relationship; primarily differences of opinion on operational issues	Moderate
			Peer advantage	Peer mediation, inclusive decision-making, third person perspective	2. Physician-nonphysician differences specifically different leadership priorities	Weaker
			Problem focus	Drawing upon evidence, creative clinical solutions for operational problems	3. Financial context related efficiency concerns, or quality-efficiency trade-off conversations	Weaker
Interpersonal	Breaking down silos	Moderate	Common ground	Identifying shared purpose	1. Interprofessional relationship including difference of opinions and trust issues	Moderate
			Trust	Tapping into; or building trust to find solutions	2. Physician-nonphysician differences in role approach and priorities	Weaker
			Creating time	Finding time to engage and build relationships	3. Financial context related efficiency concerns stemming from NHS pressures	Weaker
Organizational	Institutionalizing partnership behavior	Moderate	Enabling collaboration	Escalation of unresolved issues, accountability framework outlining role clarity, formal collaboration spaces (e.g. clinical action group)	1. Interprofessional relationship including trust issues, and stylistic differences in role execution	Moderate
			Enabling engagement	Leadership away days, diary management support for time creation	2. Time pressures, particularly lack of active time together	Moderate
			Enabling facilitation	External coaching, Internal supervision		