Mobilizing for leadership in health care

A qualitative study of clinicians' motivation to engage in a program for leadership mobilization and for leadership roles

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Abstract

The starting point for this thesis is the national leader mobilization initiative that seeks to identify, inspire, and motivate young clinicians to take on leadership roles in the Norwegian specialist health care in the future. The initiative is taken to be able to deal with the urgent need of successors as many of the current leaders are approaching retirement age.

The purpose of this thesis is to contribute to an increase of the effectiveness of similar future initiatives, and to contribute to a higher knowledge about the clinicians' motivation for management and leadership roles. This is done by providing a better understanding of the participants' motivation to attend this particular program, and their motivation for leadership roles. The study presented is a qualitative study. 11 participants (from two different hospitals out of four partaking in the program) who either have backgrounds as nurses or doctors are interviewed. The interviews conducted were semi-structured in form.

My most noteworthy findings are that certain elements in their motivation for attending this program and for leadership in general, are influenced by the organizations themselves. For participation in this program, the level of encouragement they felt from their closest managers, to a high degree affected their motivation in a positive way. In addition, regarding their motivation for leadership roles, I found that it increased along with their positive experiences and feedbacks after taking on small managerial tasks and projects. I also identified certain challenges that need to be addressed, such as the perceived loss of respect and authority that followed with stepping into management. Participants with a medical background especially emphasized the latter point.

In the future, by focusing on the parts of their motivation that is possible to affect, alongside with slowly dealing with the challenges that are presented, the effectiveness of such initiatives and clinicians' motivation for taking on leadership roles could be increased.

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After some long months, weeks, and days the time has come to finally write the acknowledgments. I am sitting here with mixed feelings, as it is a symbol for the completion of one era and the start of another. Completing the master thesis has been a challenging and a rewarding process. Many people have contributed and deserve my gratitude.

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1 Introduction

1.1 Leadership development and the focus on clinicians

Leadership development as an activity emerged from management training and organizational development programs in the industry, and has since the 1970s gained an immense momentum worldwide across all sectors (McKimm & Svanwick, 2011).

There could be several factors for the increased focus on management training. For instance organizations are becoming more global and competition is becoming more intense. Furthermore, organizations operate in a climate that is characterized by rapid change and increased complexity. This may be due to the technological development the last decade, which facilitates for whole industries changing overnight. Daft (2008) pointed out that our world is enduring a transformation more thorough and deep than any experienced since the industrial revolution, and it is still ongoing. All these factors have led to the immense need for organizations, across different sectors, to become more flexible and responsive to these changing and powerful environments.

On the backdrop of abovementioned factors, the capacity of organizations to identify and develop individuals who can express the passion and vision of the organization, while at the same time leading them trough changes, are more important than ever. Bass and Bass (2008, p. 11) concluded, "When an organization must be changed to reflect changes in technology, the environment, and the completion of programs, its leadership is critical in orchestrating that process".

The focus on good leadership and management is becoming more and more apparent within health care as well. Even though the health care sector has lagged behind other sectors when it comes to realizing this, it has been acknowledged (Firth-Cozens & Mowbray, 2001), as several types of challenges are lining up.

In addition to the challenges mentioned above, leaders in health care also have some sector-specific challenges to deal with.

For instance, they have to respond to crucial needs such as reducing medical errors, increasing investments in information technologies, and addressing inequities and disparities in access to care and medical treatment (McAlearney, 2006). Furthermore, they have to take into account different actors (patients, relatives, clinicians, payers, buyers, politicians etc.) seeking to influence health care based on their varied perspectives about the care delivery and its dynamics (McAlearney, 2006). Moreover, they have to deal with the principle and ideological battles between administrators and clinicians, and also in between different clinical professions (Freidson, 1970, 2001; Abbott, 1988; Berg, 1996)

All these actors, their varied perspectives, mindsets and preferences, create complexity around organizational effectiveness that health care leaders need to interpret and solve.

These challenges have created a need for strong leaders at all levels in health care organizations. Not any type of leaders, but leaders with a clinical background (McKimm & Swanvick, 2011). Having individuals in influential positions that are able to understand both the medical and the organizational perspective, is one strategy pointed out in the literature to deal with the various demand, expectations, and challenges of the health care sector. In other words, individuals who "speak" both languages are demanded, and clinicians might have the best starting point to do exactly that. Primarily because they have the most appropriate background, but nonetheless because they are considered to be among the most trusted members of the society (McKimm & Swanvick, 2011).

McKimm and Svanwick (2011) capture this point in a precise way stating that: "twenty-first century health care professionals will be required to practice in very different ways from their predecessors, responding to increased complexity, demographic change, technological advances, global economic trends, and increased patient involvement and accountability" (p.182). They conclude with the role of all health practitioners changing towards increasingly requiring them to participate in leadership activities.

Furthermore, health care organizations are becoming more and more aware of the fact that they are about to lose a great deal of knowledge as aging health care leaders pursue retirement options. In addition to that, the dwindling number of the younger generation makes the competition more intense for individuals who can replace the people organizations are losing. DeRue and Myers (2014, p.3) points out that even though the "organizations are

increasing their investments in leadership development, there is an emerging consensus that the supply of leadership talent is insufficient to meet the leadership needs of contemporary organizations".

Having these challenges and features of health care and its organizations in mind, it is highly important to identify aspiring and current leader talents within clinicians, and give them proper training and developmental opportunities, as many of them has never been exposed to management before.

Governments and officials around the world are promoting and highlighting the need for medical and health professionals to embrace leadership to improve health service delivery and to deal with the challenges. For the past years, there has been an increased interest in recruiting, developing and encouraging clinicians to take on management positions in health care. Countries such as the UK, Ireland, Australia and New Zealand are all engaging in these types of initiatives (Spehar, Kjekshus & Frich, 2012).

Norway is no exception and on the backdrop of an agenda that stresses the importance of clinical leadership to organizational performance, a wide range of development programs have emerged – among others, the one I am following and assessing.

1.1.1 The leader mobilization program

The four health regions in Norway are working together to strengthen leadership in health enterprises (hospitals) through the National Management Development (Nasjonal Ledelsesutvikling – NLU). NLU is responsible for several initiatives, such as National Executive Management Program (Nasjonalt topplederprogram – NTP) and leadership mobilization. They are now offering a leader mobilization program for so-called "leadership talents" in the health care sector, trying to attract, motivate and develop these talents. This initiative is being carried out as a program involving four pilot hospitals with approximately 70 participants distributed among them.

The backdrop for this program is first of all related to demography and the urgent need for successors as a large proportion of today's leaders are over 55 years, creating a generational problem.

Furthermore, hospitals find it challenging to find good candidates for vacant positions at various levels. There is no systematic work to ensure successors and motivate employees to choose leadership as a career path. In addition to that, many new managers are unprepared for what the role entails, experiences little support, and are finding it challenging to manage a new career path (Spehar et al, 2012).

Another challenge is the reputation of management and leadership in the health care sector. Good leaders are not recognized in the same way as skilled professionals, and many feels that they are being presented in a negative way, both internally and in the media.

A desired future situation is where it is perceived as attractive to be a leader within the health care sector. And where hospitals have a sufficient supply of motivated and competent successors to various management positions. Moreover, a situation where the head and middle managers take an active role in developing the leaders of tomorrow, and where it is functioning venues and processes to identify and follow up potential management candidates. Furthermore, a situation where hospitals are characterized by a holistic management culture and increased diversity in management teams.

The direct goals for this initiative is to develop and try out a systematic process which supports leaders in their efforts to identify, develop and follow up potential leadership candidates in their respective hospitals. While at the same time mobilizing to leadership through creating interest and understanding of what it means to be a leader, and preparing future leaders for future challenges. And the final goals are to strengthen the acquisition of new leaders through systematic recruitment, and give employees an arena to determine whether management is an attractive career path they want to pursue.

The target group for this initiative is employees with interest and potential to go into a leadership role on the lower level, but who currently are not working in a leadership position. Typically, the candidates are relatively young professionals that potentially have many years ahead as a leader. This is an interdisciplinary offer for all groups of professionals, as long as

they have an interest in leadership roles and are considering that as a career path. One of the criteria however, is that they are assessed by their own management as having a potential for leadership.

From an employee and candidate perspective, this initiative is meant to work as a clarification, motivation, and developmental arena for employees with desire and potential for leadership. Meaning that it intends to contribute to a clarification of whether leadership is something for the candidates, and help to assess whether the role as a leader correspond to their wishes for further development. It is meant to provide an insight into what it means to be a leader in the health care sector and what this shift from an employee to a leader will entail.

The leader mobilization program is expected to last 9 months, from April until December 2015, and consists of five different phases. The first phase is to attract employees among the respective hospitals by increasing their interest for management and for this leader mobilization program. The second phase consists of choosing the candidates who match the profile for this program. The third phase aims to create awareness and understanding of what it means to be a leader or manager. The fourth phase involves that the candidates get training in basic management skills. The last and final phase seeks to expose the candidates to some specific managerial tasks and leadership responsibilities, to give a practical understanding of what it means to be a leader.

An important remark is that this program distinguishes itself from regular leadership development programs, as it does not target to develop individuals already working as managers or leaders. Consequently, the focus is not leadership development in that sense. Rather, it seeks to create an interest and motivation for leadership among clinicians, subsequently tempting and inspiring them into taking on leadership roles in the future. This is also reflected in the name as it is called a leader *mobilization* program and not a leadership *development* program.

One of the rationales for this program not being a traditional leadership development program trying to develop knowledge, skills and abilities (KSA), is that literature proposes that individuals are developing the KSAs necessary for effective leadership, but are not choosing

to take on leadership roles. On the ground that they do not see themselves as leaders or they are not motivated to lead given the risks associated with it (Heifetz & Linsky, 2002).

With this in mind, it is rational that the first step should be to increase the interest and motivation to take on leadership and management roles, before initiating any efforts to develop KSAs and using considerable resources on that.

As DeRue and Myers (2014, p.42) states: “leadership development is not simply about developing leadership knowledge and skills, but also about developing peoples motivation to lead, their affect towards the rewards and risks associated with leadership, their identity as leaders, as well as their cognitive schemas about what it means to participate in a leadership process”, which is a good summary of what this mobilization program is aiming to achieve.

2 Theoretical framework

2.1 Conceptual distinctions

Motivation

In the literature about motivation, there is little agreement about how to define and interpret motivation. However, on a general basis it is normal to divide motivation into an intrinsic and extrinsic motivation. People can either be motivated because they value an activity (intrinsic) or because there is a strong external coercion (extrinsic) (Ryan & Deci, 2000). In this thesis I will refer to intrinsic motivation as "inner motivation" and extrinsic motivation as "outer motivation". Furthermore, I will not attempt to give a more profound definition of motivation, as it will not result in any added value for the purpose of this thesis.

Clinical leaders

Reaching a unified definition of clinical leadership and managers has proven to be difficult. Edmontstone (2005) refers to clinical leaders as someone who retains a clinical role alongside engaging in management related activities. However, I will use the same definition as Spehar et al (2012) used, referring to clinical managers as clinicians in formal management positions who may or may not retain a role in clinical work.

Leadership or management?

To avoid any misunderstanding I also want to address the terms "leadership" and "management". These two terms are linked together, although not being the same thing. Many efforts have been spent trying to define the difference. Some scholars emphasize the differences (Kotter, 1990), while others believe that they are two sides of the same coin (Mintzberg, 1973). Daft (2013, p.9) defines management as "the attainment of organizational goals in an effective and efficient manner through planning, organizing, leading and controlling organizational resources". While House (2004, p.15 defines it as the "ability of an individual to influence, motivate, and enable other to contribute toward the effectiveness and

success of the organizations of which they are members". Many authors have used these terms interchangeably; as both are activities are complementary integrated in formal management positions (Spehar et al, 2012). I will use them in the same way, as any effort to separate these two most likely will cause more problems than it will solve, and will fall out of the scope of this thesis.

2.2 Leadership and management in the Norwegian health sector

In a specialist care that is constantly changing and evolving, with great pressures and expectations from the population, the challenges are many and complex. For this reason the public health sector of Norway, has for the past centuries, gone through a number of reforms trying to increase the efficiency and quality (Gruening, 2001).

To understand these reforms a key concept to note is the New Public Management (NPM), which can be described as the introduction of market-oriented principles in the public sector. A key approach within NPM is a strong and professional management to make the public sector more effective, flexible and consumer oriented (Pollitt, 1990). Managers in organizations that are influenced by NPM receive a new and expanded mandate compared with the mandate they would have had in a more hierarchical and rule-governed organization (Pleym, 2011).

The NPM-mindset, and increasing costs and waiting lists in the 90s, led to the way the public health care sector organizes now with unitary management. Unitary management was first proposed in an official report from 1997 and was followed by a legal requirement to implement it in the specialist health care law (spesialisthelsetjenesteloven) of 2001 (Odelstingsproposisjon nr 10, 1998-1999), meaning that all hospitals had to choose one person to be in charge for one unit (Johansen & Gjerberg, 2009). The unitary manager has a so-called "total" responsibility for the employees in the unit (across professional boundaries), for patient treatment, and for other core activities such as research and development, in addition to the economy.

This was in strong contrast to how things were done before in the dual management model, which developed through the late 70s. In this way of organizing and managing, it was common that there was one head doctor and one head nurse that led the unit jointly, where they for the most part led individuals from their own profession (Nerheim, 2008).

Initially doctors were positive to this reform that was supposed to clarify management conditions, but they strongly objected to the fact that someone from another profession could get the ultimate responsibility and decision authority. This reform meant that doctors, for the first time, could be led by someone belonging to another profession, and this fact was now changing the traditional jurisdictional relationship between the nurses and doctors (Nerheim, 2008).

This stood as a big contrast to how Norwegian hospitals previously had been led. One head doctor led the unit and the management philosophy was simple, the head doctor's power and integrity was based on the professional authority, which had great legitimacy (Berg, 1991).

The unitary management however, emphasized professional neutrality, and since its introduction nurses have been competing directly with doctors for department manager positions.

These dynamics and power struggle are important to know of when we now are going to look at motivational theories for why clinicians seek towards management positions and enter a management and leadership path.

2.3 Theoretical perspectives on motivation for management

The framework for the enquiry of the motivation for management among professionals with clinical background is drawn from among other the sociology of profession (Freidson, 1997, 2001; Abbott, 1988), the theory of path dependency as used by Spehar et al (2012 and the motivation to lead (MTL) theory as suggested by Chan and Drasgow (2001).

Sociological theories of professions suggest that motivation for seeking towards management and leadership positions are driven by the quest for professional dominance and autonomy. Affective-identity MTL and the generic management literature, however, emphasize the inner motivation and interest for the task. While the theory of path dependency suggests that clinical managers often end up in management roles due to decisions taken earlier in their career, or in a more or less random way.

2.3.1 Sociological theories of professions

Throughout the 1970s, there was a wave of change riding through the sociology of occupations and professions. Old ways of thinking and resonating were being criticized with growing confidence. Among the most influential scholars that actively tried to develop new theories and material to abandon the old was Eliot Freidson (1970, 2001). In addition to Freidson, Andrew Abbott (1988) is a leading figure when it comes to the concept of professional autonomy.

Both authors focused their work around the conflicted and dynamic nature of professions. Much of the work up until the 70s was concentrated around identification of factors that separated the profession from other occupations (special knowledge, skill, ethical codes etc.). Freidson (1970), however, is not interested in the specific attributes of a profession. Rather, he is concerned with the concept of power. He points out that the distinguishing feature of a profession is autonomy, which is control over the determination of the substance of its own work (Freidson, 1970).

In the book "System of professions" (1988), Abbott looked at how professions emerge and the competitive nature of their relationship. A fundamental point in his analysis is that professions make up an interacting system in which they battle and challenge each other to maintain and expand their authority and jurisdiction. In this model, professions are seen as mutually dependent meaning that one profession's claim of jurisdiction limits the others.

This concept is called social closure and refers to processes of drawing lines and boundaries in order to monopolize scarce resources for one's own group, thereby excluding others from using them (Murphy, 1988). In Freidson's work from 2001 he implies that without such a

closure, there cannot be a real cultivation and development; “Those boundaries create a mutually reinforcing social shelter within which a formal body of knowledge and skill can develop, be nourished, practiced, refined and expanded” (p.202-203).

Freidson (1970) points out that: “a profession attains and maintains its position by virtue of the protection and patronage of some elite segment of society which has been persuaded that there is some special value in its work. Its position is thus secured by the political and economic influence of the elite, which sponsors it” (p.72).

This is further emphasized by Berg (1996) where he describes the era in Norway until around 1970 as being dominated by doctors who reigned on top of the hospital hierarchy, with the hospital physician practicing “in a secluded and protected world that he could shape as he would”. (p.438). This was possible due to the authorities that owned the hospitals “bowed to the wishes of the doctors and let them organize, and run hospitals as they preferred” (Berg, 1996, p 440).

Some might argue that this way of attaining autonomy was more widespread and common in the early phases of the modern state, as we know it. Nowadays, there are no longer “special treatment” for a single profession (at least not openly) and the terms over which professionals “battle” are slowly becoming more and more equal, even though doctors still have the highest wages and autonomy.

Considering that other professions slowly are closing in on doctors when it comes to status, autonomy, respect etc. it suggests that doctors will actively seek to maintain positions of influence, as their profession is engaged in a struggle for dominance and self-governance. This goes along well with what Abbott (1988) point out as being “continued efforts to secure ownership of medical areas of expertise, as new actors are emerging in the system of professions” (according to Spehar & Kjekshus, p.54). Berg (1996) points out this as well when discussing the role of Norwegian doctors in management: “[…] in order to achieve professional autonomy, doctors must control the conditions under which they practice” (p.432). One effective strategy to control the conditions under which one practice are to be in the manager role.

Taking all this into consideration it advocates for doctors and nurses engaging in management and leadership to secure or defend their professional autonomy. Both Norwegian and international studies in the recent time are backing, and strengthening, this perspective.

Examples backing up this theory

In a study from 2004, Forbes et al examined the processes involved when clinicians assume management roles in the NHS. They found that some managers tended to assume management roles to "protect particular specialties from outside influence or from those they thought would be inappropriate clinician-managers" (p.167). In other words, not because they had great interest in the management position or that they felt a natural attraction to it, but rather the acceptance of the role came as a result of not wanting to be ruled by someone they objected to, or it came as a result of the need to "defend their specialty" (p.171).

Similar results have been found in New Zealand as well (Doolin, 2001). He found that many doctors chose to enter management positions in order to protect medical practice from interventions by general managers and to protect their "clinical freedom".

Common for this group, which Forbes et al (2004) refers to as "reluctants", was that they felt no need to develop a managerial self and they had the perception that managerial duties were simply an "additional burden tagged onto their clinical role" (p.171), thus wanting to minimize their management activities wherever possible.

Studies showing these types of motivation have been supported by Norwegian studies as well, such as Mo (2006). She found that many doctors do not consider other professionals to have the necessary expertise for managing clinical departments. In reasons provided for taking the managerial position it was stated that some had been "strongly urged to apply and were persuaded" (p.405) while others felt a sense of duty – taking it on because it was their "turn". Many of them described it as a step backward and as a decision involving giving up "cherished" activity, i.e. clinical work (Mo, 2006 p.406).

These studies seen in the light of sociological theory of professions give a stronger foothold for claiming that doctors are likely to seek out impact in decision making by entering

management positions that strengthen their formal influence, as claimed by Abbott (1988) and Freidson (2001). Berg (1996) also backs this point stating that while doctors previously have been able to influence decision by virtue of their professional status, they must now increasingly consort to formal means of influence.

Moreover, there is evidence suggesting that not only individuals alone fights this power-battle, but there are also collective actions taken to preserve control and autonomy over professions. An example from Norway can be given from The Specialist Health Services Act from 2001, which required the managers of departments to consult with "medical counselors" in issues concerning medical matters. The Norwegian Association of Senior Hospital Physicians officially advised its members *not* to take on these "medical counselor" positions, as they do not grant formal authority (Spehar & Kjekshus, 2012).

Are nurses included in this theory?

The quest for dominance, self-governance and protecting their profession from outside-influence do not necessarily only applies to doctors, but also to the mindset of other professions as well, such as nurses. In a study from 2009 that looked at how doctors and nurses carried out and reflected over their role as unitary managers, it emerged that some of the nurses experienced that their subordinates expressed disappointment due to the fact that they were no longer their manager, and therefore "could not solely defend their professional interests" (Johansen & Gjerberg, 2009 p.404)

Furthermore, Johansen & Gjerberg (2009) pointed out that nurses had taken on management positions as a mean to increase their professional recognition and status. This again is in accordance with sociological theories about professionalism, in which management positions become instrumental in strengthening one's own profession.

Nurses' need for recognition and status might stem from historically being labeled as a "semi-profession". They are close to the optimal type of professionalism, but have "not established sufficient cognitive authority to dominate either the division of labor in which its jurisdiction is located or public discourse concerning its work" (Freidson, 2001 p. 90).

Etzioni (1969) refers to nursing as a “semi-profession” in the same line as teaching, librarianship, and social work. And describes these groups in a following manner: “Their training is shorter, their status is less legitimated, their right to privileged communication less established, there is less of a specialized body of knowledge and they have less autonomy from supervision or societal control than 'the professions'” (p. v)

Going back to Freidson's work (1970) he states that medicine is the dominant profession and in the light of medicine, others including nurses, is subordinates. He argues that paramedical occupations that are ranged round the physician cannot gain occupational autonomy so long as their work remains medical in character, regardless of their intelligence or aggressiveness. In other words, Freidson might have suggested these occupations to take on management roles as a strategy to cope with the issue of being “subordinate”.

With the latter decades experiences in mind we could conclude that it might not be an ineffective strategy. Nurses seeking for management positions combined with the societal status of nurses and doctors becoming more equal, nurses have to some extent challenged the doctors when it comes to gaining autonomy and status.

2.3.2 The theory of path dependency

Spehar et al have documented the feeling of persuasion and pressure to enter a management position in a study from 2012. The account given by the managers in this study illustrates how initial decision and actions steered them towards a specific path where they experienced pressure to take on management responsibilities. They found that some of the participants had no ambitions or aspirations of becoming a manager, but persuasion from for example their superior, who was either retiring or stepping down, led to pressure, which eventually led them to apply for the position.

In their study Spehar et al (2012) suggests an alternative route for professionals going in to management positions, namely because of path dependency. This suggestion is derived by the literature of path dependency that emphasize that history matters, as actors are often “tied” to previous decisions. The concepts of path dependency and lock-in originate from the economic history literature (David, 1985), but have been applied to various fields, including

health care (Burau & Vrangbæk, 2008; Kirkpatrick, Jespersen, Dent, & Neogy, 2009; Wilsford, 1994)

Spehar et al (2012) describes one participant that experienced pressure towards accepting a management proposal due to choices made in the past, such as having taken a management or team-building course at a business school. Another case they described was of a surgeon that was left with no choice but taking on a management position after an attempt of trying to prevent someone else from being chosen. They describe this type of experiences as a recurrent theme in their study, where some clinicians felt "trapped or restricted to a specific path" (p.7). These findings are not restricted to the one or another profession, but apply to both doctors and nurses (Spehar et al, 2012).

Other studies are also backing these results, such as one from Hoff (1999) that found that it is: "truly believed that there was a point of no return in the abandonment of clinical work that left little choice but pursuing a full-time management career" (p.337).

2.3.3 Motivation to lead (MTL) theory

On the one hand, there are theories of profession and path dependency suggesting a somewhat hesitant, reluctant and forced way into management. On the other hand however, there are generic management theories that describe managers as the exact opposite. Here individuals seek to management positions out of inner (intrinsic) motivation, which is defined in the literature as an "inherent tendency to seek out novelty and challenges, to extend and exercise one's capacities, to explore, and to learn" (Ryan & Deci, 2000 p.70).

These theories depict a foundational interest for management as their basis. The generic management and leadership are often accredited to the private sector where the focus is on characteristics like innovativeness, creativeness and competency in management. An ideal manager is described as one who has visions, leads via ideas and example, and strives towards a goal (Viitanen, 2009).

On a general basis, it is not much research on why individuals or collectives want to take on leadership roles. But some authors have looked at motivations linked with taking on

leadership roles and responsibilities, and found empirical support for the perception that individuals have different levels of motivation for leadership, and that this motivation influence participation in leadership roles (Chan & Drasgow, 2001).

Chan and Drasgow (2001) present different categories under motivation to lead (MTL) and points to some underlying individual differences (factors) that determine individuals MTL. They define MTL as "a leader's or leader-to-be's decisions to assume leadership training, roles and responsibilities" (p.482).

One category under MTL is what Chan and Drasgow (2001) call an "affective-identity MTL" in which individuals are motivated to lead because they like to lead others. People who score high on this dimension enjoy leading and see themselves as leaders.

Another is what they call for a "social-normative MTL", which entails that individuals take on leadership roles out of a sense of duty or responsibility. Individuals scoring high on this type of MTL are motivated by a sense of social duty and obligation (Chan and Drasgow, 2001). Spehar et al (2012) described a system where nurses "took turn" holding a section management position for a year, which can be interpreted as an example of a social-normative MTL.

Furthermore, Chan and Drasgow (2001) looked at the antecedents of MTL in order to understand the whole concept. They point out personality constructs, general cognitive ability, sociocultural values, leadership experience and self-efficacy as antecedents to MTL. I will not go further into this, as it falls out of the scope of my thesis.

To sum it up, individuals' motivation for management and leadership can be driven by either inner or outer motivation. In terms of the theories I have presented above, the theory of professions; the theory of path dependency; and social-normative MTL (all in which individuals are driven by social pressures, obligations and social responsibilities) can be labeled as outer motivation. While the generic management theories and an affective-identity MTL (both in which individuals do things because they want to and leads out of enjoyment) can be labeled as inner motivation to lead.

The concern of whether people are driven by an inner or outer motivation is a matter of significance as it is shown that people who take actions based on inner motivation have more interest, excitement, and confidence, which in turn leads to increased performance, persistence and creativity, in addition to enhanced vitality, self-esteem and general well being (Ryan and Deci, 2000).

With regards to this, it is reasonable to aspire having individuals driven by an inner motivation to lead in the health care sector.

2.4 Final thoughts

From my literature review we can derive that there is not only one type of motivation that is dominant when it comes to why clinicians seek toward management positions. However, these theories' starting point is usually clinicians that are already in management and leadership positions. There is not much research describing clinicians' motivation for management and leadership when they still are working as "pure" clinicians, in an early stage of their career. Nor is it much literature about their motivation to attend such programs. This is problematic on the grounds that as long as we are not familiar with the motivation of clinicians seeking to these types of programs we do not know whom we are dealing with, thus it will affect the quality, relevance and outcomes of these types of programs and initiatives.

The literature points out that the ability of individuals to learn from experience may be equal, but it might differ considerably on why they would be motivated to develop, and this difference in the source of their motivation may lead to different levels of engagement in a developmental experience, such as this program (DeRue & Myers, 2011).

I want to look closer at the participants' motivation for leadership and to participate in this program, and map out what kind of motivations that are prominent. I hope this thesis will lay the foundation for further research on this topic, of *why* some people are more motivated than others to take on leadership roles and responsibilities, even when they are not designated as formal leaders, a question that in the literature is described as a "fundamentally important question" (DeRue and Myers, 2014).

2.5 Research question

In this master thesis, my overall research question is how to develop good and relevant leader mobilization programs, and how to motivate more clinicians to step into management roles in the future. To answer this, I am going to identify and map out the participants' motives and interest regarding this program and for leadership in general, and see in what degree it correlates to, or differs, from earlier literature on this subject.

This research has three objectives.

1. *Give an overview over earlier literature about clinicians' motivation to enter management positions.*

2. *Explore the participants' motivation to participate in this leader mobilization program.*

3. *Explore their motivation towards management and leadership in general.*

In other words, I want to start at the very bottom and look at the single most important factor when creating programs like this, namely the participants.

Having background information on what drives individuals might help increase the effectiveness and quality of this and future programs. In addition, it will also lay the foundation for future research around this topic.

3 Method and interviews

3.1 Choice of method

My starting point for this thesis was my curiosity towards why professionals with different backgrounds take on managerial and leadership tasks. Specifically, I was curious about the candidates that applied for the program and what their motivation for leadership and management was. I wanted to look closer at this and see if it varied seen in the light of earlier literature on the same subject.

In consultation with my supervisor, I reached the conclusion that qualitative depth interviews of some of the participants in this program would best serve the purpose of this thesis. According to Kvale and Brinkmann (2009, p 43) the "purpose of the qualitative research interview is to understand aspects of the interview objects daily life from his or her perspective".

In the literature (Dalen, 2004) the qualitative interview is described as a way of obtaining in-depth and descriptive information on how people experience different aspects of life, and to acquire insight into their experience, thoughts and feelings. It is often made a distinction between an open form of interviewing where the informant is speaking freely and a structured form of interviewing where the informant is answering pre-defined questions (Dalen, 2004).

I chose a semi-structured way of interviewing where I asked open-ended questions, which is in between the two ways of interviewing mentioned above. The advantage of using semi-structured interviews is that they are flexible if unexpected themes and topics emerge during the interview, and creates an opportunity for follow-up question and elaboration (Kvale, 1996)

3.2 Selection of informants

To participate in the leader mobilization program the participants had to apply for it, whereby they were considered and compared before some of them got an offer to partake. The selection of informants for this thesis took place with cooperation with the representatives of the hospitals in the national project group for the leader mobilization program.

During the preparation of the project description for the thesis it was decided to interview 10 - 14 participants. I interviewed in total 14 participants, but chose only to transcribe results from 11 of them in my thesis. This decision was taken considering conditions related to the time available for completion of my thesis, its scope, and an assessment of the number of participants needed to obtain sufficient information to be able to say something about my research questions.

I recruited my informants from two of the hospitals that will remain unnamed because of anonymity reasons. From the first hospital it was suggested 9 participants that I could contact. From the second hospital I was given the entire list of the participants from that hospital, where I chose to contact 6 participants randomly from that list. I contacted them using phone and explained the reason I called. From the first hospital eight out of nine said yes, and from the second hospital six out of six said yes to be my informants.

Thereafter an approval from the Norwegian Social Science Data Services (NSD) (appendix 1) and an information- and consent letter (appendix 2) was sent out to the participants on e-mail. They were signed on the actual days of the interviews before they started, but the information was sent out beforehand as a part of a strategy to make the whole process more transparent for the participants to feel secure about it.

I conducted all of the interviews at the respective hospitals and the time for the interview was determined as soon as they agreed to be a part of the thesis. When I had sufficient amount of interview agreements I stopped the search for further informants.

In the table under, we see an overview over the informants' profession and gender. Primarily I sought to recruit doctors and nurses, as they are the most interesting seen in the light of the

literature, and given previous conflicts between the two professions in Norway. This variation in the background might also provide different perspectives and thus increased knowledge about their interest in leadership and their motivation to participate in leadership initiatives. Of consideration to the participants' anonymity, I choose not to give any further information about the participants or which hospital they were recruited from.

Table 1. Overview of the participants' profession and gender

Participant 1:	Female	Nurse
Participant 2:	Female	Nurse
Participant 3:	Female	Doctor
Participant 4:	Male	Doctor
Participant 5:	Female	Doctor
Participant 6:	Female	Nurse
Participant 7:	Male	Doctor
Participant 8:	Male	Nurse
Participant 9:	Male	Nurse
Participant 10:	Female	Doctor
Participant 11	Male	Doctor

3.3 Execution of the interviews

I completed the interviews the spring of 2015 as soon as it was decided which individuals are participating, so I carried out the interviews before the program started. I used a PC as well as a recorder to secure that I did not miss anything.

To make the informants feel safe and speak freely about his or hers experiences and feelings Kvale (1996) suggests that the interviewer must establish an atmosphere where the informants feel safe. I started the interviews with an introduction of myself and told them about the purpose of this study, the use of the recorder, confidentiality etc. I also asked them if they had any questions regarding anything before we started. During the interviews, I listened carefully and showed interest in what the informants were saying. At the end they got the opportunity to speak freely and add something if they wanted to.

None of the participants seemed to have any trouble with neither the recorder of the PC. I can state that in terms of how the conversation before, during and after the interview was. I could not notice any difference in their way of speaking and formulating themselves. One reason for this could be that I was clear about the data being anonymized. It was also conveyed that the tape recording would we deleted after completion of the thesis.

Overall, my impression was that all participants were honest in their answers and that me being so transparent before and during the interviews made them feel safe, which again led them to a high degree of openness.

Conducting the interviews was a new experience for me and to start with I had some challenges being "present" at all time as I often thought about my next question or a follow-up question. However, longer into the process I found myself more and more confident, and I managed to use the guide as a checklist, and make the interviews as more of a conversation.

The interviews were approximately 45 minutes long and I chose to transcribe them myself. Malterud (2008) recommend the researcher to transcribe the interview him or herself, as this will give the researcher the opportunity to get to know the material even better and from a new side.

Kvale (1996) describes the process of transcribing as first part of the analysis where the researcher gets familiar with the material. Through the transcribing process, I got some new insight of the information that was given in the interviews. I chose to transcribe as correct as possible, and if the language was vague and informal, I transcribed the essence of that sentence. However, this did not happen a lot and I only did this a couple of times.

In extreme cases, I also took notes of the body language during the interviews, for myself to use when I was interpreting the results.

Transcripts of the interviews were coded and categorized independently by my supervisor and myself, which ultimately resulted in a general agreement on a coding frame.

According to Malterud (2003) a researcher that uses qualitative methods both has a descriptive and interpretive point of view, the researcher can self decide to weigh one

dimension over the other when analyzing and discussing. I chose a descriptive viewpoint, meaning that I strive to be loyal to the voices of the informants and to accept their statements as being true knowledge in accordance to their perception of reality, as I think it is most suitable for my thesis.

The interviews were carried out with the help of an interview guide (appendix 3). This guide was prepared in the light of my research questions and the literature. In addition to this, my supervisor and the national project group, consisting of representatives for all parties that took part in the leader mobilization program, also gave me feedback on this guide.

The main questions were about their motivation for management and leadership positions, in addition to this specific program. By asking about this, they got a chance to explain these things and give their thoughts and reflections about it. Furthermore, in addition to these specific questions, I also asked them follow-up questions during the interviews depending on what they answered.

In the next sub-chapter, I elaborate on how I analyzed and categorized the material.

3.4 Analysis and categorization

When the transcription process was finished, I started the work of coding and systemizing the material into categories. Categorization is one way of presenting qualitative data and involves a systematic conceptualization of various statements (Kvale and Brinkmann, 2009). This meant that I could shorten and group the meaning of longer statements in few and simple categories. For this process I used thematic analysis, which is a method for identifying, analyzing and reporting patterns within data (Braun and Clarke, 2008). It consisted of 6 phases where phase 1 is to familiarize yourself with the data. This step was carried out when I transcribed the data and read it several times after that. Here I tried to notice, and look for patterns of meaning and topics of interest. The next step consisted of generating the initial codes that I found interesting. In Step 3 I collated codes into potential themes gathering all data relevant to each theme. Further, in step 4 I started to look at how themes support the data and tell an accurate "story" about it. In step 5 I clarified what the specifics of each theme are, what aspects of the data is captured and what is interesting about the themes. The final step,

step 6, consisted of me starting the writing process and deciding which themes make meaningful contributions to understand patterns in the data, all related back to my research question and the literature.

The study's main findings are presented using three main categories derived from my research questions, empirical findings and the theoretical framework

The first category - *motivation for the leader mobilization program* - describes the process up until the decision to apply and the underlying motives for that decision. The second category – *motivation for management* - gives a description of the participants' motivation for management and how it evolved. And the final category – *challenges* – describes why it is so hard recruiting clinicians for management and leadership positions, which I felt was important to include in order to draw the full picture regarding the candidates motivation.

The first two categories provide answers to research questions 2 and 3, while the first research question is covered through the literature review.

In my discussion part, I will use the theoretical framework from research question one and compare it to the material I got from my informants. The focus will then be on whether or not my informants reflects what is described in the literature or if I can derive something different from the information and material I have gathered. If I find it necessary, I might also bring in additional theory to discuss the findings in light of that.

4 Presentation of findings

In this chapter I will give an account of the results I found. The presentation of the results is based on categories that are developed on the basis of the research questions. I will first describe the participants' motivation to engage in this leader mobilization program; thereafter I will describe their motivation for wanting to engage in leadership and management. Finally, I will mention some specific challenges related to motivation for management and leadership among clinicians.

4.1 Motivation for the program

In this part, I will render what the participants have communicated to me regarding their motives for engaging in the leader mobilization program. With background in what the participants conveyed to me, and my literature review, I find it appropriate to divide this into two categories, namely inner and outer motivation.

To find an answer to this research question I asked about the participants' motivation and the process behind their decision to apply. As I accounted for in my literature review leadership is not a natural path for clinicians to take, so to understand the motivation and processes behind their interest in this program, is an essential part of improving this and future leader mobilization programs.

4.1.1 Inner motivation

Curiosity

A recurrent theme that I identified regarding the participants motivation to apply was curiosity reasons. They were curious to learn more about leadership and management, and take part in others' experiences to find out more about whether or not this could be a path they wanted to take. Furthermore, they were curious about themselves and their own features and qualities, and wanted to use this program as an arena where they could get to know themselves better.

One male nurse justified his decision to apply and motivation for this program with following quote:

"Coincidentally, I was at the intranet at [mentions hospitals name] and saw the posting there, which was nothing else than pure luck, so I thought a bit about it and came to the conclusion that this is indeed a golden opportunity to try [leadership and management] out a bit, and see if it is something I like"

Another nurse pointed out that it was communicated that they would be able to have conversations with managers at the hospital, and he wanted to use this opportunity to *"get a little taste of what leadership is".*

This curiosity about the leadership and management role was not only expressed among the nurses, but also among many of the doctors. One female doctor pointed out that she had already worked as a head doctor for some years, she was finished with her PhD, and now she wanted to find out if management could be a path for her:

"I have worked several years as a chief physician, I have my job there, I am finished with my PhD, now what? Should I "only" work as a physician or should I think of other things I could do as well? So I guess I am curious… It would be interesting to find out if [management] is a road I could take"

While some wanted to use this program to find out more about leadership and management, others wanted to meet people in the same position as themselves. They were curious about other individuals' experiences and thoughts, and was hoping to benefit from sharing and reflecting together with the other candidates. This went for both the doctors and the nurses and is reflected in this quote from a female nurse working as an assistant manager:

"I have very little experience with management and has worked very little with it. I don't have an education that has something with management to do so my expertise is only experiential, so to meet people in the same position as me to reflect and share experiences, is something I would really benefit from, and which in turn might make me do a better job…"

The other aspects of their curiosity were based around insecurity around themselves and whether or not they possessed the right qualities that was needed in management positions. They wanted to use the leader mobilization program as an arena where they could get to know and explore themselves, nonetheless as a platform for self-development. So their curiosity was not only based around leadership and management roles, but also around themselves. A female doctor working purely as a physician first pointed to the challenges of being in a management role, and then expressed the following:

"If you are going to use nine days on this I hope that it may provide some input in relation to self-development, and that I can discover aspects within myself where I can become aware of things that I need to lead […] I hope I get the opportunity to explore myself."

We can interpret from this quote that some of the candidates felt comfortable with the amount of information they had about what a leadership and management role might contain, and were rather more curious about aspects of themselves and wanted to explore these.

The other candidates reflected this as well. One nurse expressed her curiosity in the following way:

"I hope to find out whether leadership is something for me or not... That I become very clear about whether or not it might be something for me."

While the above mentioned nurse used the word "hope", other candidates were more explicit in terms of expressing themselves:

"I expect to have a clear idea of what leadership is in the hospital, and I expect to have an awareness around my own being – Is this something I can do? Am I suitable for this? Is this something for me?"

Development- and learning desire

Another frequent reason for them applying was the desire for developing and learning. However, an important note is that this was not always related to them in the future wanting to take on leadership and management roles; rather this desire was more anchored in their

current clinical work lives. This went especially for the doctors. They wanted to use this program as a platform where they could develop and learn skills they later could use to become better doctors or advance their professional field. Nurses expressed more mixed motives for development and learning, wanting to be better at dealing with regular tasks and situations. Some also expressed a natural desire to develop and learn new things, with it not being linked back to neither leadership and management, nor their clinical work life.

One doctor told that she might be looked upon as a person that is interested in leadership and management on a higher level, more than she really is. She was not motivated for this program because of a future leader role higher up in the organization, rather she was more interested in developing herself in order to do a better job as a doctor. This doctor's statement of herself captures the mindset of other candidates in a good way as well:

"But it is self-development that is vital for me, and that I want to become a better doctor with this course, not that I want to have a CEO role in the future, it's not really what motivates me..."

In her current position this doctor was leading clinical teams, and she wanted to develop skills in order to become a better team leader in her current job, not because she want to go into leadership and management roles in the future. This candidate expressed a great inner motivation throughout the entire interview session, in terms of becoming a better leader in her current work-life as a clinician.

Other doctors' developmental and learning motives was rooted in learning skills and develop themselves, in order to be in a better position to drive their discipline forward. When describing their motivation to develop and learn more about management and leadership in the health care sector, they tended to circle into what seemed to matter the most for them, namely clinical management. One doctor put this clearly stating:

"The motivation would have been on the academic, i.e. have a function in the clinic that ensured a high professional level around the discipline"

Some nurses pointed this out as well, even though they expressed a more mixed motivation when describing their development and learning desire:

"I'm very interested in everything that is new, everything that can develop the discipline, and everything that can develop myself …I almost feel an ownership to my department, I want to be [in the clinic], but I also want to develop myself"

Furthermore, some of the candidates described a need and desire for development and learning not linked back to anything else than their natural state of mind. They felt a strong personal developmental need for learning something new, not to get a future management role or to improve their current clinical work life. One nurse expressed herself like this:

"… But again, for me it's about not just sitting there and being happy with myself […] I'm not the type not to sit still and not develop myself"

Another nurse made it even clearer that his developmental and learning desire was of a more personal characteristic:

"For me personally management has never really been a goal in itself, I know very little about it and have no need to be the boss and having that career path […] I have however a need to evolve [...] I like to put pressure on myself so I learn something new [...] I feel that I need to put some pressure on myself to be a little better, it was the same under examination at school too ... so it's a personal learning and development need that is the reason I applied. On the other hand, it ***is*** *[emphasized by the participant] exciting to try something new, for curiosity's sake…"*

This candidate expressed a strong personal developmental desire and a need to challenge himself. This goes along well with the overall impression he gave during the interview of enjoying being good at what he does, and a need for *"action and performing life-saving measures"* being the reason he at this point did not yearn for a life in management.

There were also hints of candidates who described their developmental and learning desire with a managerial perspective, but this was not representable for the majority.

One doctor meant that it was obvious that everyone that was going into management needed to be *"schooled"*:

"It's totally obvious ... It's something that you do not ... it's not intuitive to be a leader […] it's not something that is mentioned in our education […] certainly, anyone who wants to engage with management must be trained, me included"

4.1.2 Outer motivation

External encouragement

Another important factor that was continually repeated was that their co-workers or closest leaders encouraged them, asked them, or told them to apply for this. Along with the other factors that I have already mentioned, this was mentioned as an important reason for them to apply in the first place. Some participants stated a moderate expectation pressure and competitive spirit as the deciding factor.

One nurse told that it is because of her co-worker that she applied:

"Hadn't it been for my colleagues I wouldn't have applied at all"

This co-worker she told, had printed out the information and while giving it to her, told her that *"this was something for her"* and that "*she **had** [emphasized by the participant] to apply"*

This particular nurse later added this part:

"Of course, external encouragement does count. If I had slightly felt that this wasn't a good idea… for example, if my boss had been a bit hesitant and half-hearted regarding me attending this program I would have dropped it instantly, because being a leader is a fairly new thought for me so… I think I could easily have lost all of the motivation"

Another nurse informed about a similar experience where she had received an e-mail with information from the head nurse, and after running into her several times and being asked if she had applied yet, this candidate finally decided to do it. In addition, this nurse stated that the sense of external support and encouragement was crucial for her to apply:

"It was the head nurse and clinic manager that wrote a recommendation for me and… I feel that they've seen quite a bit of me.. And if ***they*** *[emphasized by the participant] think I'm a candidate for this, I feel comfortable attending this program"*

The importance of this external encouragement was not only crucial for the nurses but also for the doctors as well. One doctor straight out said:

"The reason I applied for this was that I was encouraged to do so, and I don't think I would have applied if it wasn't for this encouragement, nor would I`ve been aware of [this programs] existence"

Another doctor also informed about how his department manager had urged him to apply. He expressed a sense of pressure even though he pointed out that he*" is big enough to say no",* he disclosed at the end that:

"The main motivation [to apply] surely was the encouragement I felt"

While one doctor also brought in the competitive spirit within her as a reason for her to apply alongside with the encouragement:

"I was asked to apply by my new leader, he told me to apply since he felt that I was a good candidate since I already was involved in the management and administration from before […] When it first was mentioned I thought I could just sign up for this, it was when my boss wished me luck and commented things like "Lets see how it goes" that I was extremely motivated – I understood that I wasn't the only one he had encouraged to apply for this, so now it was a competition – a competition I was going to win. Ultimately this motivated me to write a good application"

As we can see from these descriptions their curiosity, developmental desire and external encouragement were important drivers that led them to apply for the program.

My overall impression is that the curiosity is independent of profession and that candidates can be divided into two sections. Those who are curious to learn more about leadership and management - what it is all about, how a typical working day is, and the challenges that come

with it. And those who were more curious about their own abilities and that through this program would want to explore different aspects of themselves and learn more about their own qualities.

Regarding the developmental and learning desire, I found that while for the doctors it was about developing their discipline and becoming better doctors as a motive for applying for this course, for the nurses it was more about a personal developing need. Common for both groups was that it was not necessarily linked back to preparing themselves for a future in management or leadership.

As described, I also found that external encouragement played an important part in the decision making process for these candidates. I want to point out that even though I count the external encouragement as an "outer motivation", in this setting it is not perceived as something negative. Since the participants described this experience as something positive.

4.2 Motivation for management

Most of the candidates expressed a motivation towards leadership and management and in this chapter I wish to clarify how that motivation occurred and what it consists of.

4.2.1 Maturation process

Several of the candidates described their motivation for leadership and management as something that had developed over a long period of time. In this period they got the opportunity to take on different types of responsibilities that varied in size and importance, they found themselves in situations where they received positive feedback, and situations where they felt a sense of achievement. This good feeling contributed to build their self-esteem towards leadership and management, and made them aware of that they were indeed able to take on such roles and responsibilities.
One nurse working as a representative described her motivation for management and leadership as something that:

"Occurred as a result of positive results of my work as a representative […] I have gained acceptance for things and improved things, and felt that I have been heard […] and that is motivating as well […] the fact that [my coworkers] have pointed out that I have done a good job, its good to hear people say that it should have been you who was the department leader"

Towards the end she disclosed that if this was some years back, she would have dismissed the thought of leadership and management immediately, and that being a representative was "nonsense" to start with, but that she thrives now.

These types of statements were common when the candidates described their motivation for leadership.

For instance, another nurse disclosed that she never had any serious ambitions of working "higher up" in the hierarchy, but through different tasks and projects, she feels that she actually matters and does a good job.

"I feel included, that they want me there because they think I'm doing something good, so it`s not that [my leader] has somehow sat down with me and told me in clear words that we think you are good at this and this, it`s not that type of feedback, it`s just that… I feel like I'm wanted"

This maturation process was common for both doctors and nurses. A doctor communicated that him being able to try out small managerial tasks has been crucial for him developing this interest and motivation for management. He reflects that it is about succeeding with something and being trusted by your superiors and co-workers:

"It is all about succeeding with something and showing that you indeed can do it… […] What motivates me is getting comments and more tasks that show that my superiors and my coworkers trust me… Not that there has been any direct contact about [leadership or management roles], but it`s been shown more indirectly through giving tasks that reflects that it is desired that you step into management"

He recalls him thinking about management for the first time as something that was brought about by a question from a colleague of his working at [mentions a hospital] simply asking:

[The candidates name], have you ever thought about stepping into management?"

Another doctor describes a comparable process where she trough leading small projects developed a sense of achievement and a feeling of mastery, as something that has motivated her for management:

"It's where I have worked as a leader in smaller projects and seen that I have got it right, when I have been able to motivate people to do as wanted, and then led them to a finished product and ultimately success […] that is a motivation in itself to take on next project"

From these descriptions we can derive that motivation for leadership and management was not something they brought into their jobs as nurses and doctors, rather, they went through a process where they got a feeling of achievement and build self-esteem for these types of tasks, which again contributed to increase their motivation.

4.2.2 Desire of autonomy and influence

Another aspect of their motivation for leadership and management was that they expressed a desire to influence their surroundings. They wanted to be in positions where they were able to make the calls they felt were right to improve the clinical practice and the professional work. The desire for influence stemmed from a feeling that the focus of the health care sector is headed the "wrong" way. Meaning that they feel the focus is turning away from the patients and the health care workers and more towards economy, budgets, productivity and efficiency. It also stemmed from a need and desire for the surroundings to better understand and appreciate their daily work "on the floor". These factors culminated in a desire of autonomy and influence.

One male nurse based his desire for influencing the health care sector in the abovementioned focus of the health care sector:
"I think the focus in health care has revolved considerably over the past few years which I think is wrong, I think if you are able come into the management some place maybe you get the opportunity to slightly slow these changes one sees […] Health care is politically

controlled nowadays, and it is run as a company financially, and this is a development which I personally think is negative, and a development I want to do something with"

The doctors also reflected this mindset stating that they want to be in positions where they can influence the health care sector in the direction they feel is reasonable:

"If I one day are going in to a leadership position I will surely try to influence processes in the direction I think makes sense that health care should go towards in terms of organization, in terms of where the power lies, who has access to funds and distribution. That's a leadership role I lust after and not one with only responsibilities and no funds […] not only one where I fulfill the commands from above and can`t really change anything"

One doctor relates her motivation for management to counteract the negative outcomes stemming from other professions running the health care sector:

"… You see the danger of… that there are much inconvenient things that happen if you do not have leaders who have [a medical background], if you have pure administrative leaders who only lead after economic principles and do not have the medical background that is needed to run a hospital… To put it like that, we are not running a shop, but a hospital"

Other candidates expressed a desire for the surroundings to understand their perspectives and their work lives. One way to make that happen was to be in such a position where they could influence their surroundings. They felt that doctors could do at least an equally good job as people with other backgrounds. One doctor disclosed this mindset in the following way:

"In a management position I feel that a doctor is at least as good of a hospital director as an economist… It has something to do with understanding deep profound working methods and mindset […] I personally feel that a doctor should lead doctors because of the deep knowledge and understanding he can show for how we work and think, and be more on wave-length with us"

Some candidates also reported a more natural ambition of being in positions where they could influence the surroundings. They were not driven by a quest for changing direction or the focus of the health care, nor wanting more autonomy. They simply just expressed an

instinctive ambition of being among those people who were a part of the decision-making of processes that affected them. One doctor expressed her feelings in the following manner:

"I probably do have something in my stomach – a bit of a leader type in me. I have noticed that I do like to say what I mean and participate in the decision-making"

Another doctor also described an inner motivation or need to:

"…Drive the crowd more than just being a part of the crowd… I'm not… I'm not the one to shut up in a discussion "

It appeared that the need and desire for influence stemmed from an eagerness to be a part of the decision-making that affected them. Either to change the direction of the health sector, or because they yearned for the surroundings to better understand their point of view and daily work life. Some participants also expressed an inherent and natural desire to influence their surroundings, not motivated by anything else than *not* just being another crowd member.

4.2.3 Conflicts between professions

Even though the majority of the participants did not explicitly state that their motivation was related to attaining more power and autonomy, and strengthen their own profession, they acknowledged that there indeed was a power battle going on. Some participants clearly spelled out that this aspect was a part of their motivation to engage in leadership and management. Other doctors pointed to a set of unique skills only doctors possess, that give them a higher chance of succeeding in a leadership role. In order to understand the full picture and the underlying motives for management I am going to present how the participants view their own, and the other professions.

One nurse pointed out that she believed that doctors by nature are a little less focused on the actual patient care than nurses, and that increased status was more appealing to doctors than nurses. At the same time she admitted that her motivation for management was affected by attaining higher status to even out the hierarchy differences, and that her solidarity lied with the nurses. Later she added this:

"The problem with doctors is that many are stunted socially"

Another nurse confirmed this conflict and hierarchy difference between the nurses and doctors by giving an example from another hospital he has worked for in the Oslo area:

"It`s quite a big difference in status between nurses and doctors… On [the hospitals name] there was a huge difference, it was absolutely ridiculous, it was like coming to a military unit"

He then added that if he had still worked in a hospital like that he would have considered to take on a management role just for the sake of getting more respect from the doctors, but underlined that this was not what drove his motivation for management any longer.

A third nurse, even though she highlighted that she disagrees with the power battle going on, described the atmosphere in the union meetings the following way:

"I feel many times that [at the union meetings] the nurses are looking for stuff where they really can "get" the doctors and take them down and sometimes even slander them – It must be a culture from the old days where [the doctors] had a higher position"

These types of harsh descriptions of the other profession were something that was reflected by the doctors as well. One doctor indirectly indicated that no matter what education or position, nurses would never be equivalent to the doctors:

"I believe that there are more and more nurses who take master's degrees […] we doctors will always say… Yes, nurses with master's, excuse me, but doctors are still doctors so full equality is well impossible [...] It will always be so that nurses must have a doctors blessing to give such and such medicine etc. They can have as many master's degrees as they want, but…"

Another doctor first revealed a frustration over current leaders being economists, jurists, and nurses with another focus, before admitting that a part of his motivation was precisely to strengthen and represent his own profession. Later he added that there most certainly is an active power battle going on among the professions:

"[…] It's a pretty active power battle.. you may have heard about it- task shifting etc. The nurses believe they are eligible to take on tasks that historically have been medical tasks"

He pointed out that being a leader in a hospital historically has belonged to the doctors. He than indicated that the nurse's motivation to take on leadership roles might be affected by them wanting to sit in key positions to show that they are important and be appreciated, but also to even out the hierarchical differences. This candidate also indicated that it is okay to have leaders with a nurse-background as long as they are far away from you in the organization:

"It would be difficult at the section level to get a nurse manager, but it's a little different when they are one or two layers up ... when you have less to do with the person"

A third doctor pointed out that the "other" groups in the health care sector don't have the same pride and connection to their discipline as the doctors, so it is easier for them to leave the clinic in favor of management.

The doctors also tended to point out some natural skills and competences that only they possessed by virtue of being doctors. One doctor put it like this:

"I am very unsure about whether or not other healthcare groups can take the same precautions as us as leaders.. One likes to believe that one's own profession is special or bears a special responsibility, and I do believe that about the doctors in the hospital […] Not that I'm afraid of nurses, but I believe that being a doctor in leadership roles brings in an extra dimension […] I do have a natural authority as a doctor"

Based on these quotes and reflections made by the candidates, we can see that there are some candidates that are influenced by a mindset where the motivation for management could lie with getting more respect, autonomy and power to their own profession.

4.3 Challenges

To understand, and get a comprehensive picture of clinicians' motivation for leadership and management it is important to look at why clinicians initially are not interested in going into these roles and take on these responsibilities. During the course of the interviews, I observed a repeating pattern in terms of these reasons. Firstly going into management roles were not seen as a "step up", neither formally (salary etc.) nor informally (prestige) - this go especially for the doctors. Furthermore, the candidates' focus was directed towards the clinic and the patients, even when they talked about management and leadership. Moreover, I found a "fear" of leaving their discipline because that would lead to a loss of respect among their co-workers – again this went especially for the candidates with a medical background.

One doctor believed that most of the doctors are a bit reluctant to go into management because of a fear of "losing" their discipline, he believed that the discipline and hobby overlaps for the doctors making it harder for them to leave it.

A pure leadership role was not something that was tempting for the candidates with a medical background, a doctor voiced this perspective like this:

"For a doctor to become a leader is interpreted as if that particular person is not able to do his work and therefore he ended up in a management position. And I believe that might be correct"

Moreover, the same candidate stated this:

"… Again, if you are to be a manager on a low level and are close to your colleagues on a daily basis you will lose autonomy and authority among them if they feel you are outdated professionally. And at that point you just sit there, write duty plans, manage holiday and your voice doesn't matter when it comes to the major medical decisions – so you need to hold on to your discipline or else you can just forget about it"

Thoughts like these were visible among other candidates with a medical background as well:

"It's a bit like that with me as with other doctors that we want to work with patients, and in everyday life [as a leader] it is very much administrative stuff and the great fear of ours is to go into a position where there is only management […] It's the way of thinking among doctors that the responsibility you have is sacred and patient care is the main interest"

One doctor expressed how leadership and management were looked upon in the following way:

"It is looked upon as worse than cow-shit to be a leader"

However, most candidates were open for combining a leadership role with a role in the clinic:

"I'm not certain about if management is the way I want to go, but if I manage to combine it with my profession I could very well imagine that, but I have no plans on losing my profession because of it"

While the abovementioned candidate want to combine leadership and profession because of personal reason and strong interest, another candidate reckoned that it might be a smart thing to combine a leadership role with clinical work to show people around you that you still have an expertise in what you do:

"I've heard a bit like murmur that … people are commenting that "Yeah, that person haven't been in the clinic for a long time", thus they become a bit like "not one of us anymore" so I think it is better to have one foot in the clinic so that people still know you have a clue about what you are doing, if you do that you don't dissociates yourself from them"

Some of the candidates with a nursing background also expressed similar feelings, but they were not as strong. A nurse who worked as an assistant manager expressed this:

"It would have been difficult to go into management, after all we are here for the patients and that is what is the most important […] in my soul I'm still on the floor with the patient"

As these results indicates it is higher prestige for the doctors to work in the clinic rather than taking on management roles, and it is indeed a great fear of leaving their discipline because

of a strong personal interest, but also because of an anxiety of losing respect and autonomy among their coworkers.

5 Theoretical discussion of findings

The purpose of this thesis has been to explore the candidates' motivation for the leader mobilization program and for management in general. In order to make efficient programs that meet the needs of the participants it is important to know what kind of individuals are interested in these types of programs, and what their motivation consist of.

The main findings of my study is briefly presented below:

My study shows that the candidates' motivation towards this program can be divided in two parts, inner and outer motivation:

- Inner motivation consisted of two parts **– curiosity** and **the desire for development and learning**. Their curiosity was directly related to leadership and management; they wanted to find out more about what it meant to be in a leadership role and what they could expect from it. Furthermore, they were curious about aspects about themselves, whether or not they actually had the qualities needed to be in that type of role. The desire for developing themselves stemmed from a wish to be better clinicians and to help advance their field (especially the doctors highlighted this), but a natural developing desire were also expressed.
- The outer motivation that pushed them to apply for this program was described as **external encouragement** from external actors such as their leaders and coworkers. They emphasized this part as the most crucial one and as something positive as it gave them increased self-confidence.

Their motivation for future management and leadership roles consisted of:

- **Maturation process,** they started out by stating that a management path was not necessarily a path they had envisioned themselves going, but through small tasks and positive feedback they built self-esteem and developed an interest for management and leadership.
- Moreover, they described a strong **desire of autonomy and influence**. They expressed a desire to influence the surroundings around them to "fix" the focus of the

health care sector, or create a better understanding of their own professional work in the environment around them. Some also expressed a more natural desire to be a part of the decision-making process that went on around them.

- A few candidates also mentioned **the power battles between the professions** as a factor that was a part of their motivation. Although the majority of the candidates did not state this as something that affected their motivation, they did however express attitudes and beliefs that are important to understand when trying to grasp what their motivation consists of.

*Finally, I found some **challenges** that need to be understood and dealt with in the future:*

- One of the things that kept showing up as something that demotivates the clinicians (especially the doctors) is that the management path is not seen as a step up in the their career. They have a deep fear of leaving their discipline, either because it means so much for them personally or because they are afraid to lose respect and authority among their colleagues.

Chapter two consisted of a literature review over earlier literature on this subject, chapter four presents my data and findings, and in this chapter I am going to discuss my findings in light of the literature mentioned in chapter two, but also additional literature where it is necessary and relevant. After the chapter about the methodological reflections and the ethical aspects, I am going to discuss how we can interpret and read the results I have found.

Before going any further, I want to clarify that the specific research aims of this thesis have been to look at the candidates' motivation for attending this program and the general motivation for management. However, the overall purpose of this thesis has throughout the entire process been to facilitate for improved future programs and give a better understanding on how to motivate clinicians for management. Therefore, in my discussion part I am going to focus on the findings that are important to answer the overarching purpose of this thesis.

5.1 Methodological reflections and ethical considerations

Generalizability is about transferability; in essence, it means that the findings in one study are relevant in other settings as well (Kuper, Lingard & Levinson, 2008). This is something the reader might decide for himself. Shenton (2004) writes that for a reader to be able to decide whether the prevailing environment is similar to another situation, sufficient detail of the context of the fieldwork should be given to allow transferability.

In other words, to make transferability easier it conditions a close explanation of the whole process of a study, for example when it comes to collection and interpretation of the data. When it comes to my thesis I feel that I fulfill this criteria as I have explained the context the thesis was written in, how I found the participants, which questions I asked them, how the interviews were conducted and the interpretations of the results. Moreover, in my background part I accounted for the historical structures and reforms that are relevant to understand the status quo. By having this information the reader can decide for him or herself whether or not the results of this thesis is transferable to another setting.

Kuper et al (2008) remarks that transferability also is about whether or not the results have a theoretical relevance. As far as I can contemplate my results are indeed relevant seen in the light of the literature review, which is going to be even more obvious throughout the discussion part.

Kvale and Brinkmann (2009) points out that securing the validity throughout the study is a process and not something that is focused upon only in the final stage. One way to do that is by ensuring that the choice of method and design is appropriate to the research questions. I chose semi-structured interviews to provide answers to my research questions. This method and process was chosen with close cooperation with my supervisor as explained in the method part. The research questions and theme of this thesis is obviously a result of my interests, but also what is relevant in terms of challenges the society, and especially the healthcare sector is facing.

The sample in this thesis is on 11 persons, which is relatively few but not uncommon in these types of studies. Malterud (2001) points out that: “the findings from a qualitative study are

not thought of as facts that are applicable to the population at large, but rather as descriptions, notions, or theories applicable within a specified setting" (p.486). Tove Thagaard (2002) talks about a so-called saturation point in terms of the size of the sample. Reaching this means that more participants and interviews for example would not have provided me with a deeper understanding than I already got with this sample. I cannot conclude with me reaching the saturation point, but I feel I have a good understanding regarding my research questions and the data. Towards the last interviews I felt that I got less and less enlightened about the themes, as the participants for the most part stressed the same aspects.

During my transcription work and in retrospective I realize that I asked some additional questions out of pure curiosity, this led to some extra work transcribing the material, but I do not feel like it has affected my thesis in a negative way. In fact, I believe it gave me a wider context to interpret and analyze the answers.

Reflexivity

With background in Malterud (2002), I was also aware of the concept of reflexivity where the "pre-understanding" of a concept is in focus, as this pre-understanding determines what part of the reality is illuminated.

Throughout the whole process I have been aware of this concept, and tried not to have any "pre-understanding" in the sense that it would have reduced the quality of the thesis. After reading the literature I had some thoughts about what might show up in the interviews, but I have worked with myself in terms of not taking that "pre-understanding" into the interview process, or the transcribing- and analyzing process. A close contact with my supervisor was a part of the strategy to counteract any interference by my pre-understanding. Throughout the whole process from the beginning to the end, I strived for the results to be based on real data and not on my own personal thoughts.

Kuper et al (2008) also mention the power relationships between the researcher and the participants as something that might shape the data being collected. There is surely an asymmetry of power as the interviewer defines the situation by introducing the topics and questions that are asked and raised (Kvale, 1996). This asymmetry may lead to a reduced level of trust and openness. To counteract this I focused on decreasing the power asymmetry

by focusing on transparency from beginning to end. From the very first moment of contact over the phone the purpose and form of the study was presented verbally. Nevertheless, I feel that the sense of inferiority may have not been that compelling given that they knew I was a student.

Ethical considerations

The most important ethical consideration was related to the participants I interviewed. They all signed consent to participate in this thesis before the interviews started, and they were all enlightened about the purpose of this thesis and that the participation in this was on a voluntary basis. I also gave them a promise of full confidentiality, that the information they gave would be handled strictly confidential and that they would remain anonymous under my presentation of the data. They were ensured that they would not be cited or presented in a way that would give away their anonymity. This ultimately resulted in me not making it official which hospitals I recruited the participants from, nor the departments or activities they were engaged in. I only mention the 4 hospitals that are a part of the whole leader mobilization program. Mentioning the hospitals that participated was cleared with the respective representatives from the hospitals beforehand. They were also informed about my project being approved by *Norwegian Social Science Data Services* (NSD), which I believe gave me more legitimacy in the participant's eyes.

5.2 How can we strengthen future candidates' motivation for these types of programs and increase the effectiveness of such programs?

The majority of the participants expressed curiosity of one type or another, either related to factors around management and leadership roles or around themselves. Curiosity may be defined as "a desire to know, to see, or to experience that motivates exploratory behavior directed towards the acquisition of new information" (Litman, 2005 p.793).

The curiosity was present among both doctors and nurses and as far as I can assess, it was equal between both groups. It makes sense given that the participants' educational backgrounds do not emphasize the management and leadership discipline in a great manner.

In addition, taking their professional experience into account it is not surprising that they want to learn more about what management and leadership consists of, and whether or not they possess the right qualities to go into a management role. Seen from a professional point of view the candidates were quite young, and so far, they had not received the opportunity to take on any kind of formal management or leadership roles, so this program might work as an arena where they can explore these aspects in a safe environment.

Furthermore, there were expressed a developmental desire where the candidates wanted to learn more about management and leadership. At first glance it looked like they had this inner motivation to develop *because* they are planning on taking on management and leadership positions in the future. However, the more I dived into this motivation it emerged that as for the status right now, they were motivated to develop and learn more about management and leadership in order to become better at performing their *current roles.* This went for the nurses and doctors, but especially for the latter group that through this program primarily wanted to improve their performances as clinicians. For example when it came to leading clinical or research teams. So it stemmed from a wish to be better clinicians and help advancing their professional field or discipline. Meaning that their focus was rather towards the clinic, which is according to the literature presented (I will come back to this point and discuss it more in detail in my third discussion point about ***challenges)***.

However, as my results partly points out, there were some candidates that expressed a more natural desire to develop, but this was more just a part of their personal characteristics and not directly related to a strong motivation towards management and leadership positions. One of the participants pointed out that he had such a strong personal sense of wanting to develop that he recently signed up for a course to become a CPR instructor.

One of my most important findings was that external encouragement or supervisory support was an extensive part of their motivation for wanting to attend this program.

Many of the candidates expressed that had it not been for the encouragement and support they felt from especially their closest managers they would not have applied at all. This was mentioned by so to say every participant between both groups of profession, and was emphasized strongly when they described their motivation.

The big role support and encouragement played in their motivation was one of the findings that I was not expecting in terms of motivation for this program, thus I did cover it in the literature review. However, when it was expressed as strongly as it was, I found it necessary to search for literature about this phenomenon. I found support for this finding in the literature about pre-training environment, which suggest different factors, among other pre-training motivation, as highly influential when it comes to motivation to attend and training outcomes (Switzer, Nagy & Mullins, 2005).

Facteau, Dobbins, Russell, Ladd and Kudisch (1995) highlights supervisory support as one of the main factors that leads to increased pre-training motivation and thereby a greater motivation to attend and learn from programs: "[…] managers who perceived a greater degree of support from their immediate superiors for training reported greater motivation to attend and learn from training" (p. 20)

As the abovementioned quote indicate, not only is the degree of supportiveness candidates feel from their superiors important in terms of wanting to ***attend*** the program, but it has also shown to be important in terms of what they get out of it. Individuals who reported higher levels of pre-training motivation were more likely to indicate that they had benefitted from it (Switzer et al, 2005).

Richard Ritchie (1976) writes that the role of a supervisor is to "mobilize human and material resources in the accomplishment of a task" (according to Cohen, 1990, p.392). Supervisory support can be defined as "going beyond the fundamental components of overseeing and directing to show concern for the subordinate as an individual and foster encouragement, bolster individuals self-image, and help sustain that self-image over time" (Cohen, 1990 p.392).

In the context of this program, the way participants described the encouragement I believe that the candidates' closest leaders surely did go beyond "the fundamental components" and

helped “bolster individuals self-image”. Rather than just enlightening the candidates about the program and doing nothing more, they encouraged them and motivated them in different ways. One of the candidates reflects this expressing that:

“My boss had written a recommendation letter that was very pleasant reading and was really good for my motivation”

I cannot say for sure whether or not to show supervisory support was a conscious act (from those responsible for the leader mobilization program) to increase the candidates’ motivation to attend, and to increase the effectiveness of the program. However, I can conclude with the participants indeed feeling a high degree of supportiveness from their managers, which was an important part of their motivation and contributed to increase it.

To clarify any misunderstanding, in the pre-training environment literature they do not give any definitions of what kind of programs are defined as training programs or not. Given the examples given in these studies and formulations like this: “organizations will need to enhance their recruitment efforts to attract qualified entry-level employees…”(Facteau et al, 2005 p.2) I would define this program as qualified to be interpreted as a “training program”.

5.2.1 Implications

As shown through the pre-training environment literature, organizations can to a certain degree influence the participants’ motivation to attend these types of programs and thereby also increase the effectiveness and outcomes of the programs. So I would recommend that those in charge for these programs put efforts in understanding what other factors, on beforehand, besides supervisory support, contributes to increasing the effectiveness and outcomes. Switzer et al (2005) points to self-efficacy among the candidates as one factor, but they especially highlight the reputation of a program to be *the* most important factor that influences what the candidates get out of the program. What trainees know or what they believe they know about the training program may have a major impact on the outcome and effectiveness (Switzer et al 2005). Thus, for future programs it is wise to consider the general impressions of the program, and focus on how to launch and promote it. One way of

increasing the reputation of a program could be by strengthening the credibility of the instructors, mentors, and the general message communicated in the program.

5.3 What is their motivation for management and how can we initiate the process towards developing that motivation?

As expressed in the result part one of the main aspects of their motivation for management was that they wanted to be a part of the decision-making process around them, and be able to influence the surroundings. Both groups expressed more or less the same desire for wanting to have the power to change or affect someone or something. Even though they expressed the same desire for influencing, it was derived by different reasons, all of them, which has coverage in my literature review.

Some of the candidates were frustrated over the direction or focus of the health care and wanted to influence that in the right direction again. Other candidates were more concerned with current managers and leaders' lack of medical knowledge that was handicapping them in terms of taking the right choices and understanding the clinicians' point of view. This frustration and motivation to lead can be understood in the light of the sociological theories of professions, where professionals are engaged in a struggle for dominance, self-governance, and seeks to control the conditions under which they practice (Freidson, 1970, 2001; Abbott, 1988; Berg, 1996; Mo, 2008; Spehar et al, 2012)

However, the same candidates that expressed the abovementioned motivation, to a certain degree also expressed a more natural desire towards influencing and wanting to lead. This can be interpreted as an inner motivation or an affective-identity MTL as described by Chan & Drasgow (2001), where individuals lead because they like to, not because they have to. I did not find any results indicating that they were path dependent as suggested by Spehar et al (2012). This might be because of their relatively young "professional" career or age, and that they have not taken any big decisions, yet.

It is hard to determine which type of motivation is the more dominant. The former one where the motivation is driven by the quest for professional dominance and autonomy – out of a strategic standpoint (outer motivation), or the latter one, wanting to be in a position where they can influence processes because they like to and want to (inner motivation). It is not easy to give a conclusion looking at these descriptions isolated. However, if we look at these in the light of my other results, we might get a pinpoint on what drives this motivation to influence.

What supports that they might be more motivated for management positions out of strategic standpoint are the results from chapter 4.2.3, where the conflicts in between professions are presented. Some of the candidates clearly stated that *a part* of their motivation was driven by a quest for professional dominance and a wish to promote their profession. However, the majority of the participants did neglect that this was a part of their motivation; all the same, they did admit that these kinds of mindset and professional battles was indeed alive.

Tipping the balance towards them being driven by an inner motivation to lead and influence is the information they gave about their active participation in other arenas of life as well, such as in the personal life (among family and friends). Many of them also reported about an active participation in taking on roles in either a study or sport context. Moreover, the majority of them were also active participants in their current work life, where they currently or previously had responsibility for small projects and were working as union representatives etc. Based on this information it is quite rational that they expressed a natural desire to wanting to have a say and being able to influence the surroundings.

Many of the same candidates expressed their motivation both in terms of an inner motivation and in terms of the motivation stemming from a strategic standpoint (outer motivation). So it is hard to conclude which one is the most dominant, out of my result it might be a mixture of both.

Irrespective of whether or not it was an inner drive or a more strategic drive, my most important finding regarding their motivation for management was that this motivation did not come suddenly, nor was it already there when they started working. As I was trying to find out more about their motivation it appeared that this motivation had developed over time – they had been through what I have defined as a maturation process towards leadership and

management. A maturation process consisting of them taking on small and big responsibilities, and thereby finding themselves in situations where they got positive feedback and responses from either their leaders or coworkers. Which led to a sense of achievement and increased self-esteem around leadership and management tasks, which in turn led to higher motivation towards stepping into a management role.

What they are describing is what in the literature is described as self-efficacy, trusting oneself to having what it takes to cope with a given situation (Bandura, 1997). It is frequently defined as our ability to succeed in reaching a specific goal.

According to Bandura (1997) there are four factors that influence our self-efficacy. Among my informants two of them were particularly noticeable, namely *mastery experiences*, which is successful experiences through repeated effort that leads to a sense of achievement and belief. This is reflected in my result part where several of the candidates describe different kinds of positive experiences that led to an increased motivation for management.

The other is *verbal persuasion*, where other people around us convince us that we have what it takes to master certain activities. This was also something that was especially visible among my candidates. Many of them described situations where they had received positive feedback from their coworkers and leaders as remarkably important for their motivation for taking on leader roles. The last two Bandura (1997) mentions are *vicarious experiences* (observing and doing) and *physiological and emotional states* (lowering stress and tension and managing our emotional states).

This finding of developing a motivation for leadership and leadership development is supported in other literature as well. Avolio (2005) makes a strong case that leadership development is a process and not an event.

Day and colleagues (2011, 2009) have hypothesized about the possibility of leader identity-development spirals. When people find themselves in leadership situations, the experience strengthens the salience and centrality of a leader identity. Positive experiences further strengthen the leader identity by increasing the individual's self-efficacy and motivating her or him to search for additional developmental opportunities. This makes sense seen in the

light of the candidates' described curiosity and motivation for the leader mobilization program.

Together with my finding about the external encouragement, I would describe this as my most important finding, as these are the actual factors organizations, and those in charge, can affect themselves. As Chan and Drasgow (2001) conclude, the finding that leadership self-efficacy and experience are related to motivation to lead, means that this motivation is not only affected by stable traits like personality, but also that motivation to lead is a dynamic construct that is partially changeable trough social-learning processes and experience. Which is particularly useful information for every organization or institution involved in leadership selection, mobilization and development.

5.3.1 Implications

Taken together, these results suggest that much focus should be placed on building future and current candidates' self-efficacy trough providing them with the opportunities to try on management tasks and providing them with sincere positive feedback about their attempts to solve those tasks and projects. I also recommend striving to foster a climate in which both superiors and coworkers support the employees' efforts, as this is a big part in building the self-efficacy. Moreover, I suggest to follow up candidates after these small engagements and provide them with an arena to analyze their own efforts by using systematic reflection, feedback and debriefings with others. So they can use this information to redefine one's self and to seek out to new identities, and thereby maybe grow closer to a hybrid model as managers *and* doctors/nurses. My last proposal is to provide the candidates with role models (trough mentoring etc.) similar to them that have succeeded and thrives in order to inspire and motivate them.

5.4 What main challenges are to be coped with?

As explained in chapter 4.3 I found that many of the candidates and especially those with a medical background were not willing to go into a pure management and leadership role with no clinical work. Either because of a strong personal interest and commitment to their discipline, or because of a fear of losing respect and authority among their coworkers. Seen in

the light of the rest of my results that makes sense. It is clear that they understand management and leadership out of a clinical perspective. This is in accordance with Berg (2006) who believes that doctors prefer to lead out of their medical and clinical work.

Other authors and researchers have found similar results as me when it comes to the strong interest and commitment to clinical work. Johansen & Gjerberg (2009) looked at how managers with different professional backgrounds carry out and reflect upon their roles; and found that the doctors were highly committed to clinical tasks, and to a great extent stressed that clinical tasks should be integrated in management at the departmental level. Doolin (2001) also found similar results when he studied to which degree clinicians adopted the role of a clinical manager that was defined for them in the new clinical leadership strategy. He found that if most of them had to choose they would have chosen the clinic, and that clinical work is what really inspires doctors.

In addition, my informants' fear of losing respect and legitimacy among their coworkers if they step into a pure management role is also supported by earlier studies. Johansen and Gjerberg refer to Ouchi's (1979, 1980) concept of "clan control" in an attempt to interpret similar results; in this concept behavior within the group is regulated through mutual monitoring by group members. Other studies have shown similar results where clinicians fear that the loss of skill would affect their relationship with their colleagues and a loss of professional belonging (Doolin, 2001; Llewellyn, 2001; Ferlie et al, 1996; Johansen & Gjerberg, 2009).

This mindset and attitude could also be understood in light of Michèle Lamont's theory about symbolic boundaries (2001), which according to her helps highlight whom we wish to be identified with. Ultimately, it is about how individuals through behavior and attitudes draw boundaries between themselves and others (Lamont, 2001). In her earlier work she has pointed out that, activities we do in our daily lives are about achieving a good sense of self-identity within the cultural codes and boundaries to the group we are a part of (Lamont, 1992). In light of this, the candidates' fear of too much managerial work is rational, as that would drive them away from those they want to be identified with, namely other doctors. Doolin (2001) found similar results and states this about doctors:" […] managerial identifications were unable to interest them [doctors] in the same way their professional identification with medicine did" (p.247).

However, even though most of my candidates did not want to go into a pure managerial role, they were open and keen on combining management with clinical work. This is covered in the literature as well, and is referred to as a hybrid model (Jespersen, 2005). Hybrid managers have values and attitudes from their own profession, for example, the wish of professional autonomy, but at the same time, they have values that are more characteristic of general management (Jespersen, 2005). My findings support this and it was especially visible when I asked them about what good management is for them. Johansen and Gjerberg (2009) found that the nurses also preferred hybrid managers.

The mindset that leadership should be integrated in the clinic was reflected in their expressed need for development and learning as well, where they wanted to go back to the clinic with the knowledge they acquired on this program. However, I do not think this should be a big worrying point. After all, the whole purpose with this program is to inspire and motivate them, so them not showing a great interest to go into a management role at this point should not be a cause for concern. Seen in the light of their expressed curiosity towards management and leadership; they cannot be expected to show a developmental need and desire towards something they are not quite sure about yet. The positive thing is that they are curious about management and leadership roles, and are open for stepping into these roles in the future – if so as hybrid health managers.

5.4.1 Implications

As we see from my results and earlier studies doctors (mainly) are concerned with holding on to their clinical work for different reasons. At the same time, they are indeed open for going into management roles if they are able to combine those roles to a certain degree. My recommendation is a re-evaluation of the whole manager and leader role in the hospitals, and organize it in the way that make it possible to combine those fields (hybrid model) in a smoother way. However, it is important to keep in mind that a change in behavior and mindset does not automatically follow from changes in organizational structures, especially not in complex institutions such as hospital. Moreover, further steps should be taken cautiously and one should be aware of not to dilute or undermine the professional values and norms when trying to renegotiate the boundaries between management and other professional disciplines. One strategy to cope with this could be a closer cooperation with the doctors

union to openly acknowledge and endorse a hybrid model. This may also be effective in challenges related to doctors' feeling of losing recognition and legitimacy among their peers.

6 Conclusion and recommendations for future research

One of the purposes of this thesis has been to inquire about, and describe the participants' motivation towards this leader mobilization program and for management and leadership in general - in order to provide a better understanding of why they are attracted by these types of programs. Furthermore, the main purpose of this thesis has been to contribute to building future programs that are able to meet its intended goals in a more efficient way, along with giving insights on how to motivate clinicians for management and leadership roles.

As I found, the participants' motivation for this leader mobilization program and for management in general consists of elements that the organizations, to a certain degree, can affect themselves. Meaning that these types of programs are not the only way to inspire and motivate individuals for taking on management and leadership roles in the future. Much can be done in the local work environment as well. To succeed with this, it presupposes that those in charge for leadership and organizational development locally, are given the right information *and* the scope of action to use the information in a way that increases the probabilities to succeed with these types of programs. And nonetheless, that strengthens the foundation to efficiently face future challenges. Furthermore, in addition to actions on a local level, it is wise to combine efforts on a national level to deal with the challenges described.

Moreover, my research has shown that there is indeed a great need of programs like this in the future that seeks to enlighten professionals about leadership and management, and provides them with an arena to explore this field, and themselves, in a deeper manner. As far as I know this program is designed to meet several of the expressed motives by the candidates, but whether or not they will meet them in a sufficient enough manner, remains to be seen.

Limitations and future research

There were several of the findings that I did not anticipate and accounted for in my literature review, such as the important part external encouragement plays in their motivation to engage in the leader mobilization program, and how in different ways it is possible to increase their

motivation for management (maturation process). I recommend that future research look closer into the concept of pre-training environment, to assess how much of a difference different factor can do in terms of the outcome and efficiency of such programs. Furthermore, it is also desirable that future research looks at what type of management tasks and projects that could be "outsourced" to employees to most efficiently build their self-efficacy and motivating them for management.

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Appendix

Appendix 1: Approval from the Norwegian Social Science Data Services (NSD) (In Norwegian)

Appendix 2: Information- and consent letter (In Norwegian)

Appendix 3: Interview guide

Appendix 1:

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Harald Hårfagres gate 29
N-5007 Bergen
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Ivan Spehar
Institutt for helse og samfunn Universitetet i Oslo
Postboks 1130 Blindern
0318 OSLO

Vår dato: 25.08.2014 Vår ref: 39481 / 3 / SSA Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 18.08.2014. Meldingen gjelder prosjektet:

39481	*Hva er motivasjonen, behovene og forventningene til kandidatene på ledermobiliseringsprogrammet og hvordan utvikler de seg?*
Behandlingsansvarlig	*Universitetet i Oslo, ved institusjonens øverste leder*
Daglig ansvarlig	*Ivan Spehar*
Student	*Umair Aslam*

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meldepliktig i henhold til personopplysningsloven § 31. Behandlingen tilfredsstiller kravene i personopplysningsloven.

Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 15.06.2015, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Katrine Utaaker Segadal

Sondre S. Arnesen

Kontaktperson: Sondre S. Arnesen tlf: 55 58 33 48
Vedlegg: Prosjektvurdering

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Avdelingskontorer / *District Offices*:
OSLO: NSD. Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. nsd@uio.no
TRONDHEIM: NSD. Norges teknisk-naturvitenskapelige universitet, 7491 Trondheim. Tel: +47-73 59 19 07. kyrre.svarva@svt.ntnu.no
TROMSØ: NSD. SVF, Universitetet i Tromsø, 9037 Tromsø. Tel: +47-77 64 43 36. nsdmaa@sv.uit.no

Appendix 2:

Forespørsel om deltakelse i masteroppgave

"Hvilken motivasjon har kandidatene for ledelse generelt og for ledermobiliseringsprogrammet?"

Bakgrunn og formål

Stavanger Universitetssjukehus/Finnmarkssykehuset/Sykehuset innlandet/St.Olavs hospital og Nasjonal ledelsesutvikling gjennomfører i 2015 et ledermobiliseringsprogram. Målet er å få flere av foretakets medarbeidere til å velge ledelse som karrierevei.

I forbindelse med et masterstudium i European Master in Health Economics and Management ved Universitetet i Oslo skal jeg nå skrive en masteroppgave om ledermobiliseringsprogrammet.

Formålet med denne oppgaven er å kartlegge lederkandidatenes motivasjonen for ledelse og ledermobiliseringsprogrammet.

Dette vil kunne bidra i evaluering og forbedring av ledermobiliseringsprogrammet. For å gjennomføre dette, ønsker jeg å gjennomføre kvalitative intervjuer med lederkandidater. Jeg håper du har anledning til å bidra som en av disse informantene.

Hva innebærer deltakelse i studien?

Intervjuet vil foregå i uke xx-xx og ta omtrentlig 45 minutter. Samtalene vil bli tatt opp på bånd. Etter at intervjuene er avsluttet vil de bli transkribert (overført fra muntlig til skriftlig form) og deretter analysert. Resultatene vil til slutt bli presentert i min masteroppgave.

Spørsmålene vil i all hovedsak omhandle din motivasjon som lederkandidat.

Hva skjer med informasjonen om deg?

Alle personopplysninger vil bli behandlet konfidensielt, og det vil være full konfidensialitet mellom meg og mine informanter. Alle data vil bli anonymisert på en slik måte at det ikke vil være mulig å gjenkjenne noen av informantene i den ferdige oppgaven.

Ved prosjektslutt vil alle lydbåndopptak bli slettet når oppgaven er ferdigstilt i juni 2015. Andre eventuelle koblinger vil også bli slettet eller anonymisert.

Frivillig deltakelse

Det er frivillig å delta i studien, og du kan når som helst trekke ditt samtykke uten å oppgi noen grunn.

Dersom du ønsker å delta eller har spørsmål til studien, ta kontakt med Umair Aslam på telefonnummer: (+47) 476 27 727. Mailadresse: Ch.umaasl@gmail.com. Du vil bli kontaktet for avtale om tidspunkt for intervju snarest.

Det vil bli innhentet skriftlig informert samtykke fra alle deltakere. Studien er meldt til, og godkjent av, Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS. Studien er også godkjent av leder Nasjonal ledelsesutvikling Agnete Rieber-Mohn og av veileder Ivan Spehar ved universitetet i Oslo.

Samtykke til deltakelse i studien

Jeg har lest og forstått informasjonen om prosjektet og har fått anledning til å stille spørsmål. Jeg er villig til å delta i et intervju. Jeg er klar over at jeg når som helst kan trekke meg fra undersøkelsen uten å oppgi grunn.

(Signert av prosjektdeltaker, dato)

Appendix 3:

Interview guide

Background questions

- Age
- Marital status
- Education
- Current position
- Earlier work
- Extracurricular activity

Regarding the motivation for the leader mobilization program

- Can you tell me a bit about your motivation for this program?
- What motivated you to apply to this program to begin with?
- Have you ever doubted your decision of attending the program?
- Have you taken any decision earlier that made you feel like you ”had” to apply?

Regarding management and leadership in general

- Can you tell me about how you define good leadership?
- What made you interested in leadership?
- Why do you want to work with leadership and management in this sector?
- Is it something about leadership that does not motivate you?
- Are there sometimes you are feeling more motivated to work as a manager or leader than others?
- Do you see your background as beneficial or as a disadvantage for working with management in the health care sector?
- Do you want to add something?