Clinical leadership in Norwegian hospitals: A qualitative study of leadership challenges, skills and development

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Abstract

Title: Clinical leadership in Norwegian hospitals: A qualitative study of leadership challenges, skills and development Project description: The thesis is an exploration of challenges, competences and leadership development experienced by mid-level managers in Norwegian hospitals, based on semi-structured, in-depth interviews.

Background: The importance of clinical leadership is increasing due to restrictions on financial, material and human resources. Simultaneously, medicine and treatment methods are becoming more specialized and Norwegian health care faces increasing costs, demographic changes and higher patient expectations. Previous studies showed that many clinical leaders are persuaded to take on a leadership role, lack preparation for this role and express a lack of guidance along the way.

Aim: Examine participants' experiences with preparation, transitioning and challenges regarding their leadership role to find possible ways in which institutions can strengthen and improve clinical leadership.

Methods: A qualitative research method was chosen. Seven mid-level managers in two Norwegian hospitals in the Oslo area were interviewed.

Conclusion: The majority of the participants received preparation before taking over their position and were generally satisfied with the leadership development program that their hospital offered. They struggled with lack of guidance in the transition phase, a high workload regarding administrative tasks, and organizational problems. In terms of competences, participants mainly identified personal characteristics, self-awareness, skills for the working approach and working with people as important. Participants were recruited internally and often informally. A need for more talent searching, drop-out-procedures and career development for clinical leaders were recognized as important for institutions.

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In any given moment we have to options:
to step forward into growth or back into safety.
Abraham Maslow

This master's thesis has been a project I had feared before I even started my master's degree. Today I can say it was probably the most challenging thing I have done so far, but I gained a lot of knowledge about leadership and the Norwegian health care system. I met very interesting people and I learned so much about myself in this process. This would not have been possible without the following people:

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1. Introduction

The importance of clinical leadership has increased over the last couple of years. A restriction on money, personnel and resources creates a need for more efficiency and new solutions. At the same time, the specialization of various medical disciplines has increased. The specialization and the fragmentation of individual operations requires more team work among different specialists and professions. Coordinating these processes, demands for leaders who know themselves and their teams, who know how to prioritize and how to work with people. Increasing time pressures and shortage of staff may lead to conflicts among staff members, which requires intervention and resolution. (Spehar, 2015) The author has a background in Gerontology and did her internship at the management-level of a nursing home in Germany. The specific problems of mid-level management, such as implementing orders from the top, while meeting resistance from the bottom at the same time, limited the management's power of decision in areas such as personnel, marketing strategy and budget, dealing with staff shortage, and sickness leave. This formulation of unrealistic organizational goals gave the author an incentive to research mid-level management in another health care related field: hospitals. This thesis aims to explore how midlevel-managers in Norwegian hospitals are prepared for their position, which challenges they face in their daily work and which competences clinical leaders need to meet these challenges. To acquire an insight into this topic, the author interviewed seven mid-level managers (seksjonsleder) from two Norwegian hospitals in the Oslo area.

This thesis will first cover background information and the theoretical framework that was used to conduct the study. First of all, this thesis specifies the unique situation in the Norwegian health care system, followed by outlining the differences between leadership and management, as well as the definition of the term of clinical leadership. The author then illustrates the educational background of clinical leaders, describes the problems they are facing according to the literature, drafts necessary competences and skills, and uses the leadership development model „Be, Know, Do" by the U.S. Army and the Clinical Leadership Competency Framework as the theoretical framework. The methodology section explains how this study was conducted and why a qualitative research method with in-depth interviews was chosen as the research method. It also describes how potential interviewees were acquired and how the data was analyzed. The results section presents the findings in terms of changes and future developments, current challenges, preparation, motivation, competences, work-life-balance and recruitment of clinical leaders. Finally, the discussion section will cover the questions of how clinical leaders are trained for their position and how leadership

development programs might help in the transitioning phase. Furthermore the challenges of clinical leadership and the corresponding competences and what competences that are necessary to face these challenges are discussed, followed by a description on how leadership development programs might help in terms of career pathways, dropping out of leadership positions and the recruitment of new, talented leaders for hospitals.

1.1 Why does clinical leadership matter?

The dictionary states that „competence (…) (is the) possession of required skills, knowledge, qualification or capacity“ (Dictionary, 2017). Most people working in health care have received education on a bachelor's or master's level and higher degrees. Because of the highly individual, personal and demanding nature of working with patients, substantial knowledge and training is required to diagnose, treat and encourage prevention of diseases. Besides the technical knowledge, soft skills are also necessary, for instance tailored communication, empathy and the ability to handle difficult situations. Health care professionals take care of patients who might be frightened, stressed or frustrated and may have to deal with worried and emotional relatives as well. They usually work in a stressful environment with many patients, a large amount of administrational work, time pressures and long shifts. Additionally they have a high responsibility to ensure patient safety and quality. Various competences are required to prevent patients to be put at risk, to avoid mistakes and to prevent employees from facing emotional conflicts. Furthermore, the health care sector is experiencing a flood of new studies, new discoveries and new interventions. Workers in this field need competences to navigate through information overload, distinguish between relevant and non-relevant material, and how to put new knowledge into practice. Commitment to lifelong learning is essential. With a growing competition between health care providers, patients seek for the best and latest treatment. It has become an obligation to keep up to date because the current knowledge in a specific field might not be the same in ten years. In addition, team work has become more important than ever. Diseases and treatment options have become increasingly complex, demanding a constant collaboration among different disciplines. As a result of this, teams are increasingly composed of a variety of professions and specialists. They need to understand each other's backgrounds and have to be aware of possible misunderstandings or conflicts in order to find and implement the best individual treatment option for each patient.

While the above competences are necessary for clinical work, clinical leadership demands even more. In the past clinicians could practice without a lot of interaction with higher levels within their

organization. Today there is an increasing amount of administrative work for clinicians, and clinical leaders are much more of a connector between management and the care of the patient. This requires several additional competences. On the one hand, it is necessary to have the technical knowledge to understand management and business administration's work. There needs to be an understanding of what goals the organization has, and how a leader can translate them into the clinical work. On the other hand, the clinical leader needs to be aware of the unique relationship between doctors and their organization. From a historical point of view doctors are relatively autonomous. They are trained to identify and solve problems independently. They are historically used to treating patients, improving their own performance and using time for research and teaching while the administration did their part of the work separately (Fairchild, 2004, pp. 214). Doctors who decided to work in a management position are still seen as people „going over to the dark side." Management and administration are considered as primarily interested in cutting resources and saving money, while clinicians' main interest is the patients wellbeing (Kyratsis, 2016, pp. 240). These different interests and views have resulted in a gap between the two disciplines (Stoller, 2009, pp. 876). Hence, a clinical leader needs to be aware of meeting resistance and conflicts created by misunderstandings and mistrust.

Most Western countries are currently experiencing an increase in costs for health care. Leaders working in this field are required to be competent in identifying challenges, making decisions and implementing new strategies. Understanding processes involved is necessary to create new solutions to issues such as utilizing limited resources (e.g. money, personnel and equipment) effectively. Other challenges include securing access to health care services for all individuals, increasing the quality of treatment and overall health care and hospital environment. This is only possible if clinical leaders manage to convey their vision to their followers, facilitating the identification of factors that could be changed in order to improve quality of treatment. Health care additionally has to deal with an aging society, which means an increase in chronic diseases that require treatment over a long period and multi-morbidity which demands more collaboration between different departments and specialists (Büchler, 2006, pp. 149).

2. Background and theoretical framework

2.1 The Norwegian Health Care System

The Norwegian health care system has gone through a process of decentralization, mainly during the 1980s and 1990s. The municipalities are responsible for primary care, which includes health promotion and prevention, general practitioners, emergency departments, health centers, home care, nursing homes and physiotherapy. The Norwegian government has been responsible for specialized services since 2002 (Braut, 2014), which includes somatic and psychiatric hospitals, polyclinics, treatment centers, rehabilitation centers, private health care, laboratories and x-ray services. The task of specialized services is to diagnose, treat and follow-up patients with urgent, severe and chronic diseases and injuries. Patients can decide where they want to receive treatment. Usually; the larger hospitals provide more specialized services, while smaller hospitals provide health care of a more general nature (Omsorgsdepartment, 2014a). The hospitals are grouped into four regional enterprises: Health South-East (Helse Sør-Øst RHF), Health West (Helse Vest RHF), Health Mid-Norway (Helse Midt-Norge RHF), and Health North (Helse Nord RHF). The enterprises are responsible for providing health care, research, education of health personnel and training of patients and relatives. Patients have the right to receive good and equal health care service independently of their sex, age, place of living, economy and ethnical background. The research involves assessments of treatment methods, medicine and technology used in the system. The enterprises are also responsible for basic, advanced and further training, internships, and education of specialists. They are also required to assist in training patients with chronic and long-term diseases to handle their condition, providing support and information (Omsorgsdepartment, 2014c). These tasks are carried out by regional public hospitals and private hospitals that have contracts with the enterprise (Omsorgsdepartment, 2014b). They are partially financed by block grants and partly by activity-based reimbursements. Since 2006, somatic treatments have been financed by 60% block grants and by 40% activity-based reimbursement (Regjeringen D, 2014).

Norway has around 17,000 hospital beds, 3,000 psychiatric institutions and 27 professions working in the health care sector. There are around 160 admissions to a hospital per 1,000 inhabitants per year, with an the average length of stay of five to six days in somatic institutions and around 40 days in psychiatric units (Braut, 2014). In 2016 the expenditure for health care was 326 billion

(milliarder) Norwegian Kroner, which comes to 62,186 NOK per citizen. This was around 10% of the Gross National Product that year (Statistisk sentralbyrå, 2017).

2.2 Leadership

2.2.1 Leadership and Management

Leadership and management are two different concepts, but are often used simultaneously. This could be the case because managers are often also leaders, and leaders can also have management functions. A common definition for a leader is that a person who is in a position to influence people to do what needs to be done to achieve specific goals (Horwitz, pp. 50). One must not necessarily be in a leadership position to be a leader. Therefore, one can distinguish between formal and informal leaders. Formal leaders usually qualify with regard to their knowledge or experience to lead a group while informal leaders generally do not have an organizational position in leadership but are accepted as leaders by other members (Schwarz, 2000 pp. 188). In contrast to management, Bennis (1993) states: „Leaders are people who do the right thing; manager are people who do things right.“ (Schwarz, 2000, pp. 187) Managers are usually associated with planning, controlling and solving problems. While leadership is more about creating and sharing a vision and setting goals, the manager's task is to transfer these goals into strategies, implement them and to evaluate their outcome (Schwarz, 2000; Büchler, 2006).

2.2.2 Clinical leadership

Harper defines clinical leadership as „One who possesses clinical expertise in a speciality practice area and who uses interpersonal skills to enable nurses and other healthcare providers to deliver quality patient care.“ Stanley emphasizes the qualities of leading: „A clinician who is an expert in their field and who, because they are approachable, effective communicators, empowered and able to act as a role model, can motivate others by matching their nursing and care values and beliefs to their practice and who can support and guide the work of others.“ (Stanley, 2006, pp. 20) In a study by Nicol asking participants about their understanding of clinical leadership, one participant suggested that this term has too many meanings and that healthcare leadership needs a more comprehensive definition (Nicol, 2014).

2.2.3 Changes in hospitals

Working in hospitals has changed substantially. The administrative work, the pressure to reduce costs and to increase production has increased; the work force is becoming more and more specialized, and so are the treatment methods and technology. These changes increase the demand for great leadership, but many hospitals have problems with filling positions with competent personnel. For instance, the NHS in the UK, has been confronted with massive management failures in the past. One of the most known cases of this is the Mid Staffs hospital scandal, where 400 - 1,200 patients died between January 2005 and March 2009 due to poor care, shortage of health personnel, uneducated staff members and disastrous unhygienic conditions. These problems were mostly caused by a lack of leadership and wrong decisions from the management (Campbell, 2013). Many hospitals still do not have a permanent chief executive officer (Kyratsis, 2016). In Germany, the health care system is facing the challenges of a demographic change; there is an increase in older patients who often also suffer from dementia and usually have several diseases to be managed. More treatment opportunities and new technological inventions make it more expensive to diagnose and treat conditions, and with increasing privatization the pressure on public hospitals is increasing. There is also a growing patient expectation which needs to be addressed (Bork, 2010).

Bork points out that the organizational structures in hospitals is still too hierarchical. The separation of operational and economic departments make it difficult for physicians to keep economic decisions in mind (Bork, 2010, pp. 696). But a mindset change seems to be occurring: In a study with young doctors, Nicol found out, that many see clinical leadership as a „social movement (…) (and that they) have always lived with targets“. which can be argue to make clinical leadership more acceptable (Nicol, 2014).

2.2.4 Importance of clinical leadership

Why is clinical leadership important? Clinical work is becoming more complex, cooperation amongst different team members is getting more important and therefore the logistics of these collaborations as well. Besides this, physicians are usually trained to work and decide on their own rather than to work in teams (Stoller, 2009). A clinical leader can motivate physicians, decrease turnover and costs, and at the same time increase efficiency and patient satisfaction. They may help to establish a climate of compassion by sharing expertise, helping with problems and finding strategies to implement organizational goals. A clinical leader has responsibilities at all levels, from the bottom to the top, and may also use individual influence to develop a better health care policy (Chaudry, 2008). Schwarz points out that the healthcare industry needs to provide value-added care, e.g. quality by cost. „As the quality increases and cost decreases, value increases. Obviously, from

many perspectives, only physicians, can truly have an impact on this value equation; (…)"(Schwarz, 2000, pp. 187) In addition, Stoller reports that clinical leadership can decrease mortality rates, increase diagnostic accuracy and decrease mistakes in health care (Stoller, 2014).

2.2.5 Challenges with regard to clinical leadership

Clinical leadership is facing various challenges. One of them is a deficit-based focus of physicians. Since they are used to finding solutions for the diseases of their patients, Stoller points out that clinical leaders who have an educational background as a medical doctor focus largely on problems in the organization rather than on the organizational possibilities (Stoller, 2014). Thus, Warren demands for a macroscopic view that all doctors need to develop. Another problem is the training. Doctors are usually not educated with regard to leadership competencies although they possess the character traits for being a good leader (Warren, 2010). Hence, many physicians are chosen by their clinical expertise rather than their leadership skills. Another integral part is the health organization itself. Recruitment professionals have to look for people in their organization who are talented for being a leader (Stoller, 2009) And they need to be trained within the framework of a leadership development program (Stoller, 2014). Doctors are used to find a treatment for a disease (i.e. problem), while problems that are arising in leadership often cannot be solved quickly (Chaudry, 2008). Besides their training it is important to have the opportunity to use these new skills within the organization. Therefore, the administration should involve them in all levels of the decision making process. There must be overall general atmosphere that promotes lifelong learning and the possibility to learn from mistakes (Redman, 2005).

2.3 Clinical leaders

2.3.1 Physicians as leaders

Fairchild points out that medicine and organizational leadership are two different disciplines. Doctors are trained to avoid errors, make their own decisions and their position in the hierarchy is very clear. They are usually very autonomous and separate themselves from managing. The organizational leadership in contrast emphasizes on processes, on communication and collaboration and the attempt to find consensus among team members (Fairchild, 2004; Stoller, 2014). Clinical leaders try to reach a goal with and through their followers, but physicians mostly do not identify themselves as followers. They are trained for individual performance and will therefor focus on improving themselves rather than trying to achieve a shared goal of the organization. Another

reason for that is, that a physician identifies mostly with his or her own profession. While a computer scientist might say „I work at IBM.“ because he is proud to be part of this company, a physician will most likely identify him or her self as a doctor rather than which hospital he or she works for (Taylor, 2008; Bohmer, 2013).

Another role plays the work itself. Stoller describes the difference between product-based and science-based work: „Health professionals learn rigorous scientific discipline as the ‘content’ of their training. The ‘process’ inculcates a value for autonomous decision-making, personal achievement, and the importance of improving their own performance, rather than that of any institution.“ The more they have experienced hierarchical training, evaluation based on their single performance and a „deficit-based thinking“ which means they are usually confronted with a problem (disease) which they try to solve (cure), the higher the resistance to clinical leadership (Stoller, 2009). The awareness of clinical leadership among young doctors is arising, but many feel they have not much experiences with it. In a study 92% of the surgical trainees recorded leadership competencies as somewhat or very important, but only 50% classified themselves as qualified enough in these (Stoller, 2014).

Also becoming a clinical leader is still seen as „going to the dark side“ which usually results in loss of respect and reputation among colleagues. Therefor it’s important in contrast to a general manager in a company to stay active in the clinical work itself, to keep and extend knowledge and respect of colleagues (Kyratsis, 2016).

2.3.2 Nurses as leaders

Since nurses can be clinical leaders in Norway as well, it is important to look at how they are observed as leaders. Tregunno found out that a nursing leader is a person that colleagues go to, that can handle different situations, is well experienced, focuses on patient safety and has an overview about what is happening around him or her. A nursing leader steps in if critical things are happening. The leader also teaches, is non-judgmental and has a respectful contact to the other workers. „In contrast, managers and executives are not seen as being close enough to the patient, nor do they interact frequently enough with the care team, to be a go-to leader. However, managers and executives are seen as important players in promoting patient safety ‘‘at the top’’ of the organization (Tregunno, 2009, pp. 336).

When it comes to clinical leadership they often lack training in leadership skills. Similar to physicians they are usually very experienced in their clinical work but they lack technical skills which can take months or years to obtain (Al-Dossary, 2016; Abraham, 2011). „Some leaders held

the opinion that training should remain focused on bedside care. They were consequently concerned about exacerbating the shortage of bedside nurses if more nurses migrate to leadership positions.“ (Khoury, 2011, pp. 304). There are less nurses than doctors in positions of leaders and the shortage of nurses in many countries make it even more difficult, because they get less encouragement to take a leadership position (Abraham, 2011). In a study about leadership as a career path, only a few nurses reported that they actively applied for a leading position. Most of them took over a position as an interim arrangement or were persuaded by their superiors. Many of them had no plans to be a clinical leader. The ones who decided to follow a clinical leadership path felt they had reached a dead-end in their nursing career and taking over a leading position was considered to be another step in their career path. Nearly all reported that they had gotten little or no preparation before taking over the new leading position (Sherman et al, 2007).

2.3.3 Who can be a clinical leader?

„TEL (theory of expert leadership) suggests that leaders who are experts in the core business of the organizations they are to lead are more likely to appear credible to the core workers, and create the optimal work environment leading to higher levels of job satisfaction.“ (Kyratsis, 2016, pp. 241) Chaudry says that all physicians can be leaders because they already have the characteristics to become a leader, but they might use a deficit-based thinking on problems rather than a process-oriented approach (Chaudry, 2008). They need to learn how to communicate their vision for their department, to bargain and connect with important contacts. „(…)While certain individuals and personality types appear to take to leadership roles more readily, all professionals can develop their ability to lead others and can learn some of the techniques and behaviors that are essential for effective leadership at whatever level they work.“ (Warren, 2010, pp. 28) Schwarz points out, that leaders need to cross so-called barriers of change which can be systematic, behavioral and political. Systematic barriers are linked to the behavior of people, being forced to do something they have not done before. Behavioral barriers can be the perspective the leaders work from. As mentioned before, physicians may have the tendency to face organizational problems with a deficit-based mindset. Political barriers can occur when information is not distributed. In a study with twelve nurses which used in-depth interviews, participants answered the question on what a leader mostly needs to do while „being there“. Staff members need a person to go to, where they can get advice and support. A leader needs to be someone who can listen and who has an overview about what is happening in his or her unit (Burns, 2009).

2.4 Theoretical Framework

2.4.1 Be, Know, Do - A leadership development model by the U.S. Army

The Be, Know, Do model is a theoretical framework for leadership development within the U.S. Army. It was developed to ensure an unified leadership theory among all members. Its paradigm is that „leaders shape the future by translating concepts into actions.“ The goal of leadership is seen as „influencing people - by providing purpose direction and motivation while - operating to accomplish the mission and improving the organization.“ (Campbell & Dardis, 2004; pp.27). The U.S. Army calls itself a value-based organization, which means it shares common values amongst all members. It assumes that members are receptive to absorb, develop and execute these values by having seniors who live these values by example. There are seven core shared values loyalty, duty, respect, selfless service, honor, integrity, and personal courage. The model consists of three dimensions: What a leader must BE, what a leader must KNOW and what a leader must DO. They are connected with character, competences and actions. The idea behind is, that in order to become a successful leader one has to evolve all three dimensions.

Seven Core Values of the U.S. Army	
Loyalty	To bear true faith and allegiance to the U.S. Constitution, the Army, one’s unit, and other soldiers.
Duty	To fulfill one’s obligations
Respect	To treat people as they should be treated
Selfless Service	To put the welfare of the nation; the Army and subordinates before one’s own
Honor	To live up to all the Army values
Integrity	To do what’s right - legally and morally
Personal Courage	To face fear, danger, or adversity (physical or moral)

Table 1: Seven Core Values of the U.S. Army

2.4.1.1 Be

This part refers to the character, the mental courage to know what is right, and to do what is right. The model assumes that although many attributes can be acquired, a few character traits are constant. One important part is congruence, which means that a leader has to live the values he or she preaches to his or her subordinates. The BE part has specified three attribute groups: mental, physical and emotional. The mental attributes are will, self-discipline, initiative, judgement, self-confidence, intelligence, cultural awareness. Will is defined as the determination to keep fighting

even if the circumstances might force one to give up. A soldier needs self-discipline to perform well in difficult situations. Initiative refers to start acting when a situation is not clear. Judgement is seen as making the best decision under the given circumstances. Self-confidence is the belief in yourself and your actions. Intelligence is knowledge and the application of it. The cultural awareness assigns to different backgrounds in the team and the country`s difference a leader is operating in. Health fitness, physical fitness, professional bearing belong to physical attributes. Health fitness involves health promoting behavior and prohibiting health risking actions while physical fitness is more about being physically fit, to train and to keep and/or improve that fitness level. Professional bearing includes looking like a soldier in terms of clothes and physical requirements, as well as inheriting the competences of a soldier. The emotional attributes are self-control, balance and stability. A leader faces subordinates with emotions such as fear, anger, etc. and needs to react to them in the right manner. This means a leader needs to control his feelings, has to be emotionally balanced and a stable temper.

2.4.1.2 Know

The KNOW element links the character part (knowing what is right) with the action part (doing the right thing) with a competence part (knowing what and how). The integral part is that a leader has competences to operate in the right manner. He or she is also responsible for the competences of his or her subordinates. The model assumes that competences are acquired by hard and realistic training. Gradually, they should receive tasks that are more difficult in order to build their confidence. They are also more likely to increase their will to achieve more. These skills are divided into four categories: interpersonal, conceptual, technical and tactical skills. Leaders need interpersonal skills in how they communicate, teach, motivate and monitor their inferiors. It is also necessary that they learn the right balance of controlling and empowering them. This is mostly important for first-line and middle-line leaders, while top leaders usually do not have direct influence on their subordinates` daily actions. Therefore, they need more competences in psychology and communication. The conceptual skills are critical reasoning, creative thinking, ethical reasoning and reflective thinking. Especially mid-level leaders deal with a high number of information from top and bottom and need to learn how to process and evaluate them. Technical skills refer to knowledge about technological equipment and procedures to reach goals. Tactical skills should be applied in combat.

2.4.1.3 Do

The DO aspect is part of taking action. Having developed the right values, attributes and skills are the basis for leading. Influencing, operating and improving belong to this aspect. Influencing means that a leader has a vision and shares it with his or her subordinates, makes decisions and solves problems to reach this goal. The model emphasizes on the fact that communication must be precise to avoid mistakes under stress situations. It is also desired that the leader prevents conflicts and sees mistakes as a learning opportunity. Another important part is to encourage, motivate and reward team members for actions. Operating refers to the preparation, implementation and evaluation of actions. In this field it is important that leaders know the strengths and weaknesses of themselves and their subordinates, set goals and maintain standards. Improving is the last part, which ensures continuous progress within the organization. The mantra is to leave the army in a better state than before. It shows that the model stresses the focus on long-term goals. They try to prevent leaders from taking action that will only be good in the short term. This is assured by developing subordinates, developing teams and working on yourself.

BE		KNOW	DO
VALUES	ATTRIBUTES	SKILLS	ACTIONS
Loyalty	**Mental** *will, self-discipline, initiative, judgement, self-confidence, intelligence, cultural awareness*	**Interpersonal** *communication, teaching, encouragement, controlling, empowering*	**Influencing** *communicating, decision making, motivating*
Duty	**Physical** *health fitness, physical fitness, professional bearing*	**Conceptual** *critically reasoning, creative thinking, ethical reasoning, reflective thinking*	**Operating** *planning and preparing, executing, assessing*
Respect	**Emotional** *self-control, balance, stability*	**Technical** *knowledge about equipment and procedures*	**Improving** *developing, building and learning*
Selfless Service		**Tactical** *Combing interpersonal, conceptual and technical skills in combat*	
Honor			
Integrity			

Table 2: Be, Know, Do - Leadership development model

2.4.1.4 Leadership development and relevance

New members of the Army Academy (freshmen) are usually going through the BE process first, even though they will have some aspects of KNOW and DO as well. It is important that they learn from experienced members they look up to. After their graduation, the other two parts are getting more important. Important for leadership development is that leaders are open for new input, look for new challenges and have an inner drive to improve. The Army also has a built-in performance feedback system. Members will receive an evaluation by their senior officers and are sent to school periodically, to work on self-reflection and self-awareness (Department of the Army, 1999). Even though this leadership model is not related to clinical leadership, it was chosen as a theoretical framework because of three reasons: First of all, both organization are based on standard procedures. Mistakes can have a great impact on soldiers and in the clinical context, on patients. Knowledge and the right attitudes are therefore of prime importance. Second, the model is simplified, presenting three dimensions that are engaged with each other which might be a good approach to clinical leadership as well. And third, it integrates the emphasize on improving and working with limited resources, whose importance has increased in the last decades in health care.

2.4.2 The Clinical Leadership Competency Framework

The Clinical Leadership Competency Framework is a model developed by the NHS. It was established for all clinical workers, based on the concept of shared leadership. The idea behind is to distribute leadership among all clinicians and not only the ones who hold leader positions. With this approach the NHS tries to disperse responsibility on many shoulders to aspire that mistakes and problems are disclosed more easily and all groups of clinical workers, students, experienced physicians and clinical leaders increase their awareness about clinical leadership. The model is based on five dimensions with respectively four elements. The five dimensions are: demonstrating personal qualities, working with others, managing services, improving services, and setting directions. The elements of the first dimension demonstrating personal qualities are developing self-awareness, managing themselves, continuing personal development and acting with integrity. This refers to knowledge about oneself, understanding ones values, strengths and weaknesses, being organized, knowing how to deal with emotions, identifying opportunities to learn and to grow, acknowledging mistakes, respecting others and having a certain work ethic. The second dimension addresses working with others. Developing networks, building and maintaining relationships, encouraging contributions and working within teams. Leaders need to know how to connect with others, achieve goals, have empathy, listen, understand and acknowledge what others tell them, and

know about their role as a leader. Managing services is the third dimension. Its elements are planning, managing resources, managing people, and managing performance. This dimension is based on the managerial part of clinical leadership, which means analyzing, making plans and decisions, controlling, evaluating them and changing them if necessary. In terms of managing people it is important to give feedback and guidance, helping team members to develop into their roles. It also requires being accountable if something does not work out and taking action actively if required. The fourth dimension is improving services that are represented by ensuring patient safety, critically evaluating, encouraging improvement and innovation and facilitating transformation. This dimension is based on the premise that medicine is in constant development and clinical leaders need to have an inner drive to continuously improve treatment and methods and their own education. This means to assess treatments, procedures and risks for patients on a regular basis, encourage meetings to debate these assessments among various clinical workers, and to motivate and focus on change. Setting direction is the last dimension and includes identifying the contexts for change, applying knowledge and evidence, making decisions, and evaluating impact. This means to understand the context of health care regarding the organizational, political and legal environment, to use this knowledge, to educate and inform people who make decisions, and to measure and evaluate outcomes (NHS Leadership Academy, 2011).

CORE VALUE: Shared responsibility and distributed clinical leadership among all clinical leaders				
Demonstrating Personal Qualities	**Working with Others**	**Managing Services**	**Improving Services**	**Setting Direction**
Developing self-awareness	Developing networks	Planning	Ensuring patient safety	Identifying the contexts for change
Managing yourself	Building and maintaining relationships	Managing resources	Critically evaluation	Applying knowledge and evidence
Continuing personal development	Encouraging contribution	Managing people	Encouraging improvement and innovation	Making decisions
Acting with integrity	Working within teams	Managing performances	Facilitating transformation	Evaluation impact

Table 3: Clinical Leadership Competency Framework

3. Methodology

3.1 Research Design

3.1.1 Research Questions

As explained in the introduction part, clinical leadership is becoming more important. When operational procedures, personnel and other resources in hospitals are obliged to increase their efficiency, clinical leadership may need more attention and improvement too. But improvement is not possible if the underlying problems are not coherent. Therefore, the following research questions were chosen for the purpose of this study:

1. How do clinical leaders get prepared for their position?
2. What are the major challenges a clinical leader faces today?
3. Which competences are necessary to meet these challenges?

3.1.2 Data collection

To explore the pathway of clinical leaders a qualitative research was chosen, facilitating the advantage of gaining deeper insights into motives, experiences and perceptions of the studied material. Flick adds that „qualitative research takes into account that viewpoints and practices in the field are different because of the different subjective perspectives and social backgrounds to them.“ (Flick, 2014, pp. 16) A quantitative research approach was not appropriate due to the kind of research questions this thesis attempts to answer. Although a questionnaire might have given some insights and information regarding competences, it would not have provided sufficient information about underlying attitudes, believes and perspectives of clinical leaders.

Observation as one of the qualitative research methods was not applicable for this thesis since the aim of it was to explore experiences, opinions and feelings of clinical leaders. Therefore, a semi-structured interview was chosen because it can deliver comparable data about the experiences of the interviewees. Pre-chosen subjects that the researcher is interested in were covered in the interviews, while the openness of the question facilitates the collection of sufficient data. The interviewees have enough space to express valuable information that might be interesting for the research project. Focus groups were discussed as an alternative, but were discarded primarily because of organizational circumstances. Due to the difficulties finding adequate interviewees and replacements in case of dropouts and mostly finding a date that was suitable for four to six busy leaders at the same time was seen as too problematical even though it could have given a broader range of information. Topics might have come up, the researcher was not aware of and were

therefore not included in the interviews. On the other hand, participants can be more open in an interview situation with just one researcher. In a group situation participants might not feel safe enough to speak out their individual opinion on critical topics, especially because it could happen that some of the leaders in the group might know each other.

3.1.3 Setting

The interview was centered around three main research questions. The interview guide was inspired by literature, discussion with an expert and the supervisor and own ideas of the author. It contained 23 questions that were categorized into the preparation and transitioning phase, the current challenges they face and their competences. The topics „working with people“ and self-awareness were chosen to be asked separately to receive more information about the work approach and problems they face working with others. Since self-awareness was assumed to be something that was not apparent to the participants when asked about competences, questions revolving around this topic were asked individually. The competence part was leant on The Clinical Leadership Development Framework and the questions asked were developed around the five dimensions described in chapter 2.4. These questions aimed to gain more understanding on how clinical workers become leaders, what challenges they meet in the transitioning phase and in their daily work and which competences are required to be successful leaders. Possible candidates were found through a LinkedIn search. The search involved midlevel managers (seksjonsleder) in hospitals in the Oslo area. The potential interviewees were then contacted via LinkedIn messages and emails. Two participants were referred to from previous participants. The six interviews were conducted at the hospitals the participants are working in and one at the University of Oslo. Each interview lasted between 30 and 55 minutes. Due to this master thesis being conducted in English, the interviews were also performed in English, but participants could use Norwegian words if they did not know them in English. They were recorded and transcribed shortly afterwards. Norwegian words, sentences and phrases have been translated into English. The recorded interviews were only accessible to the researcher on an USB-stick and were deleted after the transcription to meet with data and privacy protection guidelines.

3.1.4 Population

Seven clinical leaders working in midlevel-management at the Oslo University Hospital with locations at Ullevål Hospital, Radiumhospitalet and Rikshospitalet, and Akershus University

Hospital could be acquired for the study. Six of them were in a current leading position and one was a previous clinical leader. The study contained three women and four men. The average age was 52,7 years, while the youngest leader was 33 and the oldest 65. The participants had an educational background in medicine, nursing, psychology or bioengineering.

3.2 Ethical Considerations

The research project was approved by the Norwegian Centre for Research Data (Norsk senter for forskningsdata AS). The participants received a consent form that informed about the research project, gave anonymity, explained that it is voluntary to participate and that they could stop the interview at any time. In that case, recorded material would have been deleted immediately. They were also informed what would happen with the transcriptions, who they could ask for further information and that they could chose not to answer any question, if they did not feel comfortable with it. Participants understood their answers were anonymous, and that after transcription the interviews were anonymized. To reduce participant bias the researcher did not reveal her previous experiences with leaders in health care and ensured the interviewees that their data is fully confidential.

3.3 Data Analysis Strategy

The interviews were transcribed word by word, non-verbal expressions were not documented. The analysis was leant on Flick's thematic coding (Flick, 2014) which contains three steps. The first step was to do a short analysis of each case meaning to develop the main statements to the research questions and main themes. After that an in-depth analysis was conducted. Statements were assigned to categories, links between them were established and if necessary they were disarranged. As a third step a comparison was carried out. The main task herein was to find similarities and differences among the participants. In a last step the themes were put in order with regard to the four main phases of a clinical leader: preparation, transitioning, being a leader and career development.

3.4 Limitations

Although this research project was carefully conducted, there are some limitations to it. The sample size was very small and only two hospitals, located in the Oslo area, were included. Language barriers could also be seen as a limitation. While the majority felt very comfortable to express their views in English, a few struggled finding the right terms. The participants might have given more detailed information if they could have talked in their mother tongue.

4. Results

The following results are grouped into seven categories. These are changes in clinical leadership, current challenges, preparation, motivation, competences, work-life-balance and recruitment.

4.1 Changes and future development in clinical leadership

Over many decades clinical departments have been led by doctors. Usually the most experienced and respected physician was rewarded with a leadership position, receiving prestige and amenities. But this could result in the recruitment of people who were not suitable as leaders. In addition to this, many doctors continued with their clinical work, because of internal motives and in order to keep up their recognition among their colleagues. Therefore, leadership was executed alongside clinical work. The general result of this, as one respondent pointed out, is that the department loses a good doctor and gains a poor leader instead, which is seen as a double loss. The same respondent described the persisting tension between clinical workers and people from the management level:

And leaders are not highly respected. It's the people working directly with the patient they look up to. Being a leader in a hospital is more like making a sacrifice. They are doing the shitty work, it's a profitable work, but also pretty fucked.
Participant 2

And even though that one respondent declared knowing some leaders who got into leading positions as a reward, many other respondents saw a shift in the perspective of clinical leadership resulting in the fact, that more people who might be a good fit for the leadership position are chosen. Due to political and institutional changes, which in turn leads to resources that are more limited and more non-physicians taking over leadership positions, power structures and perceptions change. As one respondent experienced:

First of all, they think they are very special, they think general leadership principles don't apply here. They also think that, if you are not a top professional doctor, you cannot lead this institution. If you don't have a PhD, and so and so many publications, you will have problems. But fortunately this is improving. I have a daughter who's a doctor and she thinks quite different from the colleagues that are my age. So a new generation is coming, that is thinking in different ways.
Participant 1

The respondents' opinions on non-physician leaders were diverse. One respondent who is a doctor stated, that leadership is more neutral to the background of education and that personal talent and abilities would matter more. For this person it was more important that the current leader understands ones`role as well as the distinct processes, challenges and outcomes that have to be improved continuously. Another respondent countered that it could lead to conflicts between the leader and the medical advisor:

I think one problem, major issue with that is; who is making the direction of the discipline? And because every medical subject is involving in some direction and someone else has to have the medical responsibility. And if the leader is non-medical or from another medical discipline he or she needs a medical advisor and in some areas that's a part of incongruence. But the leader is making the decisions. And sometimes it's like, he or she makes the decision and the one with medical responsibility feels like: I don't agree, but I have to support it. Or the leader will not make the decision because it's so difficult, and he or she is pushing it over to the medically responsible doctor and it results into problematic interactions.
Participant 3

An interviewee who had no clinical background denied having problems with the medical advisor, and said that they always try to find a compromise and that they usually have the same opinions on topics. All of the participants agreed on the fact, that an educational background in the discipline the person is leading, would help understanding and ease problems but only three said they found it necessary.
Economy was another topic. In times of fewer money and personnel and a higher workload, the emphasis on economic knowledge and efficiency is increasing. But the answers of the respondents indicate an existing skepticism and mistrust with regard to industrial influences:

This is not a furniture factory. We are handling patients. When you are my patient you would appreciate that I take the time I need, Especially in the hard days. So there are some differences.
Participant 1

In today's world, it's money we talk about. Health, patients, we are on the base, we are doing patient care. But on the top our director asks about how many patients you have „done" even

though he is really concerned about patients, but it's patients and care and what we can give them is up to what we can produce. But I'm very against the use of the word production in the hospital and even though we are talking about production, daily production here, but I don't like it.
Participant 6

4.2 Challenges

Six of the seven respondents mentioned dealing with limited resources and the demand of increasing efficiency as one of their challenges. The challenges themselves varied. One respondent struggled with the fact that he had only 57 beds in his department, but had 70 to 80 patients every day. Another saw the high workload, sickness and maternal leaves as the biggest problems in the department. At one point they had three physicians being pregnant, one physician suffering from cancer and a vacant position of a unit leader at the same time. Time pressure and the balance of quality and treating enough patients were another frequently discussed topic. As one respondent described:

My challenges? That's the famous squeeze of course. In Norway we have to think more about efficiency than we have ever done before. We have been living on this oil bubble and that reflects the culture. Specially I think in psychiatry and addiction there has always been this laid back attitude. And now we have to work faster, spend less money and treat more patients.
Participant 2

Being a middle manager itself was a problem for one respondent. The need to interact with a lot of other units and levels made it difficult to focus on the work in the department. This interviewee felt pressure to deliver satisfying results to the top level management, but at the same time had to defend the department doing the best for them. Another topic that appeared was resistance as one respondent describes:

And that's a culture that's very difficult for the people working here, so getting into that speed. They, it's a lot of complaining, they don't like the new system, the new public management, that's the worst word you can use, there is a feeling that quantity is more important than quality, but at the same time I kinda see it as my responsibility that we have no more money than we have, and the patients will still be coming. So we have to think differently. And it will be people won't be happy in the start, but I think that will change over time because as I tried to say it's the grass isn't greener on the

other side.
Participant 2

The responses made clear that leaders face resistance among their staff members, but they agreed upon the fact that the changes the Norwegian health care system is facing will not disappear, that all departments and medical fields suffer from it and that they will try to do the best out of it.
The current development that the field of medical services gets more and more complex is also seen as a challenge. There is an increasing need for communication and teamwork and reciprocal understanding of the different backgrounds of health care workers.

One major challenge is that the professional perspective is getting more and more advanced and complex. And that's causing a fragmentation. I am an expert on this one and you are an expert on that one. And I can't do much of yours. It's getting fragmented and if you do not take care of a communication across these different masters, you will have a big problem. And that is the big deficiency we don't discuss, we are not colleagues together.
Participant 1

Respondents belonging to the University of Oslo had some specific problems with the structure of the merged hospitals. Two of them had to lead departments that were spread over two or even three locations, making it difficult to be present as this respondents explains:

And one thing that makes my job more difficult is that we are divided in three parts and to be everywhere is not very easy. I'm trying to be there, but I can't do everything, all meetings with my chief, with other people asking me for meetings, meetings here inside my office with all these institutions we collaborate with, so it's not very easy to share myself, to be everywhere.
Participant 6

4.3 Preparation

Of the seven clinical leaders only three had been prepared for their position. The ones who had not been educated before taking over the position, usually got a formal training afterwards. One respondent had first overtaken an unit and then a department when the actual leader took leave for university education. This interviewee had not had chance yet to obtain a degree in leadership. The

only formal training received were courses from the internal leadership development program of the hospital which were considered to be not sufficient enough to obtain the tools required to succeed in the job. Another one had gotten some administrative tasks before moving into a more formal leadership position, but did not feel well prepared. From the three who had received formal training, two had gone through the leadership development program offered at the corresponding hospital and one had earned a master's degree from the Norwegian Business School. Besides the leadership development programs and education from universities, courses from the Association of Psychology was another source for formal training.

When it comes to leadership development programs, five of the seven respondents reported satisfaction with the program they had completed. A respondent who finished a leadership program at the Akershus School of Leadership explained that after receiving training in computer programs, basics in law and how to deal with certain problems - for instance sick leave - the second part of the education focused on lectures and role-play, going through particular problems the leaders may face in their work. The importance and utility of role-play was mentioned by five respondents. Many felt that this helped them to receive feedback on how they are handling different situations and also to obtain new input by others. One respondent added:

But I think some things are very practical and very good. I have learned the most when we were talking about real concrete practical situations and how you can deal with them. These role plays were very useful. I'm not sure about the theoretical part, but the practical was helpful for me. Participant 4

Another interviewee added that it was well received getting to know all the different support systems (for instance from the Human Resource Department), where assistance and support is offered when required. This person also had the feeling that these support systems were not used as much as they could be because people do not know about them. Learning about oneself was another topic that was mentioned, as this participant illustrated:

It was very good, because I learned so much about myself. I have learned about myself, I have learned about other experiences, not just my own. You think always, what I experience is the worst and I'm the only one suffering here, but you could hear from all the leaders the same. Everything you do you think is the best for other, but they don't see it, but when you know you are not the only

one it's much easier for me.
Participant 6

It also shows that the courses of the leadership development program have an important function as a support system and network amongst the leaders.
There were some criticisms of the leadership development programs amongst the participants. One said the programs usually focus on theories and do not always apply at the work environment. The program from Oslo University Hospital was seen as too short and some courses were perceived as too basic.

Yes, it's a very good program but it's a very short program. So it's not helping much, of course it's helping, it's more than nothing. But it doesn't give me all the tools I would need to feel confident with all the tasks. So it's needed, but it's not sufficient.
Participant 3

Another respondent voted for a longer and more practice-oriented program at that hospital, in order to gain more experience with difficult situations in a safe environment.

When asked about their period of transition into the leadership position, all of the participants expressed a feeling of unpreparedness. It took time to adapt to the new role and the respondents faced quite different challenges in terms of behavior, knowledge and contact with former colleagues. One respondent who was a nurse struggled with feelings of not being accepted by staff members who were all psychologists. This interviewee expressed the feeling that this was due to being a young leader and that the psychologists were to suspicious because of that. This resulted in a a feeling of loneliness when going to the cafeteria with everyone becoming quiet and to be rather hostile towards socializing with the new leader. Two respondents felt uncomfortable with being very experienced in their own field and then dipping into a field of leadership they had no knowledge about. One of them also struggled with staff members who did not appreciate the work. Although struggling with the tasks, this interviewee was motivated by knowing how important the individual work is for running the department. Another respondent worked in the department as a physician before becoming the leader. Willing to show the colleagues that nothing had changed this person was too friendly resulting in some colleagues crossing a line. Furthermore, an expectation

from the former unit was perceived, to give them more advantages, but the respondent wanted to be a leader of all units and treat everyone equally:

Because when I became a leader to just give prove I didn't change I tried to be even more friendly. And people, some of them go over the limits and expect much more than I give. My main aim was to be fair, to be the same for all three units even if I came from here. And it's not easy because people expected much more. The think: Now we have our leader from here! So, it was a big challenge to just give the impression: I'm the leader for all of you.
Participant 6

Another topic that appeared frequently among the responses was learning by doing. Two of the participants mentioned that they had a stiff learning curve in the first two years and did not feel comfortable in what they were doing before they came into their third year. They usually had to learn on their own, little by little. The leaders who had received almost no formal training prior to their job transition reported the need of more support with the on-going job. They missed information about how they could do certain tasks and what they were allowed to do with conflicting staff members.

4.4 Motivation

Well I think that I would like to have some influence and to be a part of a system and decide how things are going to be.
Participant 4

When asked about their motivation to become a clinical leader four of the respondents answered that they wanted to influence the organization. Many of them had worked for several years at the same place and stated that they wanted to change things they did not agree on. One respondent decided to go into clinical leadership after certain negative experiences with the prior leader. Having the feeling that missing out on having a leader who was present and approachable facilitated the wish to change this perception within the organization. The prior leader was always in meetings and busy with administrative work opposing the wish that the leader had been more direct, cheering up his staff and giving feedback on procedures.

Another participant felt having reached an end in the career as a nurse at the age of 28 and wanted some new challenges:

I'm personally always like to reach for the next step, take new education, challenge myself, putting myself in situations I don't like. I like being, I like not feeling good and then developing and then doing good at it and then pushing pushing pushing. So that's was the reason. Yeah and I got being a leader and there will be always a next step. You will never reach the finish line.
Participant 2

New challenges, self-development and „stepping out of the comfort zone“ were also motives that were often mentioned. One respondent explained that having obtained extensive expert knowledge over the years it was time to use it in other ways.
Two respondents had gotten the feedback from their superiors that they had talent for this position and received the opportunity to try it. One of them was interested in communication and psychology and opined, that using these skills in a leadership position rather than at her current level of work made sense.
Another was motivated by helping colleagues by planning meetings, so that they could do their job as explained:

We are not self-manageable. We have to be part of everything and connect and interact and share. So it's not what I really like but I think that if we want people to do their work in a goof manner, we have a lot to discuss, a lot to struggle about and someone has to do this job. That's what keeping me going.
Participant 3

4.5 Competences

What competences does someone need to be a successful leader? The answers of the respondents were categorized into the following elements; personal characteristics, skills, self-awareness and working with people.

4.5.1 Personal characteristics

All respondents advanced the view, that most skills that are required for leading can be acquired through learning, but that there are some certain personal traits of character that are also important. One of them was to be open-minded and show interest in working with people. A leader needs to show all staff members that they are appreciated and that the leader is interested in how they are and what they are doing. Staff members should get the feeling that their leader cares for them and is interested in facilitating a friendly working environment as this respondent pointed out:

Are you a good listener? Can you cry together with some of your employees if it's necessary?
Participant 1

Being motivated to do this job was seen as a crucial characteristic, because leaders face many difficult problems and the solutions will often not please all those involved. With regard to this, stress tolerance is also crucial in order to deal with a vast number of tasks and the potential displeasure of staff members. One participant also saw the importance of how leaders view their own work and appearance:

You have to appreciate that team playing is an important thing. You have to appreciate that there is a continuously need for improvement, that's just the way of working and you need to have the ability to work more as a facilitator than a head for the department.
Participant 5

Another topic mentioned was flexibility. Being too controlling was perceived as problematic because it could decrease motivation and the engagement of staff members. Clinical workers are usually highly educated and are used to a high degree of autonomy which means that leadership needs to take a more gentle approach: Giving space, accepting suggestions and monitor the work in a less autocratic way.

4.5.2 Skills

The participants had many different opinions on which skills a clinical leader should have. They were classified into the following; working approach, pursuing a vision, adapting to change, knowledge and connecting.

One of the most frequently mentioned skills was listening. One of the participants explained, that it is important not just to listen, but also to filter out what is said due to frustration and resistance. A medical department provides care, education of patients and new clinical workers and research opportunities. Therefore, a leader has to have the ability to handle many issues simultaneously. Having structure in the approach to the workload and daily schedule planning was seen as an advantage to handle these problems. The ability to plan and prioritize tasks, while staying flexible in case of unexpected events was also mentioned. Additionally, a leader also requires competences in communication, has to establish a common understanding that every team member is important and that communicating between them is pivotal to promote this understanding and to avoid misunderstandings and mistakes. In this context, a participant mentioned that they had lost a patient due to a lack of communication between two clinical workers, which clearly underlines the importance of this competence to ensure patient safety. Finding solutions, being creative and having good assessment skills were listed as further important skills relating to the work approach. In terms of pursuing a vision, a clinical leader has to share a common goal with his team. Knowing where the department or organization should head towards and how to get there is crucial in order to share a common vision. It is also necessary to have a good overview of what is happening in the particular department and being creative in how goals could be achieved. As one participant said:

I think to have an overview is important. I think it's crucial to know every person. To know them as individuals to be a good leader. And I think it's important think a bit out of the box sometimes to see possibilities and new things.
Participant 3

When asked about which competences they perceived would be more in demand in the future, the ability to change was named by three respondents. Adapting to new circumstances, being able to see things in new perspectives and also pursuing actions that feel uncomfortable or will probably provoke negative reactions came up as well.
Another skill that emerged was knowledge. Since most of the leaders have a background in healthcare, knowledge in the medical discipline was not specifically mentioned, but two respondents said that it is important that leaders know what their staff members work with. In addition, knowledge about data systems and economy was suggested to ease daily problems and to enhance the understanding of economic problems in health care.

In terms of connecting, two dimensions came up. On the one hand, leaders have to network and connect with other units, departments and leaders within the organization, which seemed difficult especially for participants belonging to Oslo University Hospital. Within this cooperation many problems and approaches can appear which leaders have to be aware of and be willing to find compromises for. On the other hand, they also need to network outside of the organization. One respondent emphasized the importance of having social support and getting feedback from others.

4.5.3 Self-awareness

Self-awareness was addressed in different ways. One part was to manage to draw a line between work and private life, coping with stress and tolerating criticism. Another integral part mentioned, was the ability to admit when something went wrong and the courage to change course as this respondent pointed out:

And also a good leader has to have on the radar: Oh, it's not going like we assumed. We agreed, but you are running in the wrong directions, sorry, either you are in or you can go somewhere else. You need the courage to admit and turn around.
Participant 1

It was also mentioned that a leader should try to get feedback from both the top leadership and from the staff members, and take this feedback without getting angry or being disappointed, seeing it rather as an opportunity to learn and grow. One participant said it was required to learn to put perfectionism aside and to acknowledge that not everything can be fixed, but that it is still important to listen to complains.

4.5.4 Working with people

Many of the competences centered around working with staff members and team work itself. One that was mentioned most frequently was being present and approachable as a leader. Being mentally „there“ and reacting to problems was perceived as very important to keep a low level of conflict and a good atmosphere at the working place. A bad leader was seen as:

A leader that hides from the people, like an ostrich that is hiding his head in the sand. I know leaders in this way, they don't see anything, they don't go out, they just don't react and the conflict escalates. It is the worst, if you don't take things immediately when things happen.
Participant 6

Cheering up, supporting and encouraging staff members was also seen as an important part in being a leader. One respondent said, that it is also important, to set rules and more importantly to follow up on arrangements. Experiencing much resistance in decisions being made, the respondent stated that if a leader fails to follow up, nothing would change. But at the same time it is important to find the balance between pursuing goals and to give enough space. A clinical leader should not be too controlling, this was mentioned by four respondents. For one interviewee „being there" also meant, that a leader has to stand in front of the group and take the responsibility if something goes wrong.
Another topic that emerged was teamwork. A clinical leader needs to identify the potential of his staff members and use it, to form a team. One respondent called for establishing an acceptance among the team members that everyone is important and reinforcing the understanding, that everyone has different talents and skills and that the team gets the best result if everyone works together. Another participant compared leading a team with an orchestra:

You are sophisticated part of a very sophisticated team and as a leader you have to orchestrate. A little bit like being the head of a big orchestra. You know, you are not the best violin player, you are not the best trumpet player, but you have to keep an overview and try to make it sound good. This is how I feel too. But I have to try to make these multiple disciplinary teams work together. I have to facilitate for these teams to work together and I have to have a clear view about is the most important, what are we here for. What is that what we do.
Participant 5

Power was discussed as well. A good leader uses power in a way that carries the unit or the department forward rather than getting the most benefits for him or herself.
Another competence that was brought up by two respondents was the ability to adapt the leading style to the specific group he or she is leading. Furthermore adapting the leading style to each individual was seen as important too. Even though leaders should treat their staff members fair and equally, they need to be aware of the different intentions and goals among staff. Some staff members might just want to show up, work and leave. Others want to change or improve things.

Some might like to attend meetings, some may prefer to work alone. The respondents emphasized the importance of finding compromises and being open for creative solutions.

4.6 Work-Life-Balance

Only two respondents reported problems with keeping a work-life-balance as a clinical leader. The main reasons were too many tasks, working long hours, working at home and having work in mind even in their free time. One respondent tries to use only two to three hours at home for work and that this often results in multitasking in terms of preparing food and making calls at the same time or watching television and answering e-mails. Activities with the family of both participants were affected by this, and one also started to experiences physical effects due to stress. Ultimately, this interviewee reduced working hours in order to minimize health issues.

The other five respondents had developed different strategies to keep that balance. One person leaves the job at the same time every day, socializes during free time and tries not to think about the work while at home. Two respondents said it is very important to be mentally present when at home. They arranged with their families that they would tell them if they feel they are not „there". They also developed an understanding for the complexity of their work and emphasized on communication if the respondent began to work too much. One respondent had the opinion that having a family is the best method to set boundaries and leave the job at a given time, because one is forced to to leave due to family obligations. Setting these mental limits were important as this respondent pointed out:

I keep my work-life-balance by being able to not think so much more about work than I have to when I'm at home. I'm quite good at putting limits. When I'm at home I'm concerned over my family and private things.
Participant 3

But six of the seven participants reported that they sometimes had problems with leaving something for work on the next day. Physical exercise as a strategy to cope with stress and to switch-off from work was mentioned by two participants. One used the 30-minutes commute from work to home to exercise by walking or biking and also used a bridge as a mental sign to leave thoughts from work behind and concentrate on private life and vice versa. The other respondent was jogging regularly to relieve stress.

4.7 Recruitment

Two participants talked about the history of clinical leadership in which often the physician who had the most experience, reputation or publications was rewarded by taking over the position as head of the department. But this can cause two problems as one respondent pointed out:

But in principle I don't think there should be a difference before you were like taking: Yeah, you have been a good doctor for 30 years, congratulations, you are a leader. And maybe he's the worst leader ever. Then you both lose a good doctor and get a poor leader. So it's a double loss. So that's not logic at all.
Participant 2

While the majority of the respondents felt that this was an out-dated procedure, one of the respondents said that some of the clinical leaders he knows would not be leaders in a private company although they might have a high expertise in their field, they are not good leaders and only obtained a leading position to be honored for their contributions. One mentioned that clinical workers lose respect from their colleagues when they get into leadership and two others experienced that they were met with refusal or a lack of appreciation for their work after becoming clinical leaders. In the leadership development program one participant learnt that the majority of the other new leaders had no intentions of becoming a leader. They said that they took the position because no one else wanted to take over, or that they were convinced to do it because the hospital could not fill the position.

When asked about weather external or internal recruitment is better for filling a position, the answers were mixed. Two respondents favored external recruitment because a person from the outside might have another perspective on things and new ideas. Internal recruitment was preferred by two other participants who worked in a highly specialized department. They argued that an internal candidate already knows the procedures, what works and what does not. Therefore, the new leader requires less time to get to know all operations and people working in the department. Time consumed by learning by failure would be reduced as well. The other three participants voted for a mix of internal and external recruitment. They felt that when a bigger change is planned for a department, someone from the outside would be more suitable but otherwise it would depend on the situation.

Another topic that emerged was the talent recruitment and career development for clinical leaders. One respondent had the opinion that a talent pool could help with finding talented clinical workers for leadership positions. This pool should also involve some training and tasks they could do, to find out if leading is in their interest before they get the actual position. This interviewee also argued that within the leadership development program there should be additional space for career development for these leaders. This was illustrated by an example of a surgeon, who is going through a lot of formal training and procedures. At the end of this process he or she will be certified to perform certain operations. Clinical leaders do not have that. There is no clear structure to the career path or indicators of where a new leader can be in five or ten years. Furthermore, it was pointed out by this respondent, that there should be an organizational approach on how leaders, who find out that a leadership position does not meet their skills, can leave their position and return to clinical work, or what would happen if the organization has the impression that this position would be better filled by another person. Two other respondents had very different views on returning to clinical work. While one had the feeling that he/she had reached a point where returning to nursing was not feasible, another was very confident that if not enjoying the work anymore, returning to clinical work would be possible.

5. Discussion

The purpose of this study was to explore the experiences of mid-level managers in terms of training, daily challenges and competences for successful leadership. The following chapter will present a summary of the main results and then attempt to answer the following questions:

1. How do clinical leaders prepare for their role and how can institutions help during the transitioning phase?
2. What competences do clinical leaders require in order to solve their daily challenges and how could these competences be developed?
3. How can leadership development programs help in terms of career pathways, the dropping out of leadership positions and the recruitment of new leaders?

5.1 Main Findings

As a result of restrictions on financial, human and material resources compared with challenges regarding demography, development in medicine and technology, clinical leadership becomes more important. This chapter discusses the results of the study, practical applications, possible limitations and suggestions for further research.

The main results summarized were: Leadership positions are filled less and less by doctors with the highest reputation or expertise, but the problem persists that positions are filled by people who are not sufficiently motivated to strive. Clinical leaders struggle with respect and appreciation amongst their staff members. The opinion on the increasing number of clinical leaders with an educational background outside of medicine is mixed, and the economical focus in hospitals is getting stronger and is also more accepted. In their daily work, clinical leaders struggle with a wide variety of challenges: a large number of patients, understaffed units, absence due to sickness or maternity leave, the balancing of quality and increasing treatment numbers, too many meetings and administrative tasks, resistance to change among the staff members and organizational difficulties such as units at different locations. Not all new leaders received training before taking over their new job position. However, all of them have received training through a leadership development program or a master's program at some point later on. The leadership development program at Akershus University Hospital was overall seen as beneficial, while the program at the Oslo University Hospital was seen as too short and less beneficial. Participants valued role-plays, the support offered, and the socialization with other new leaders within these programs. In the

transitioning phase they struggled most with being accepted by colleagues and the feeling of coming from a very experienced field into one they had not much knowledge about. The main motives for transitioning into a leadership position were having influence, seeking out new challenges or having reached the end of the job ladder in their own profession. In terms of competences, four categories emerged: personal characteristics (such as listening, motivation and flexibility), skills (regarding things such as working approach, visualization, adaption to change, knowledge and networking), self-awareness (i.e. reflectiveness, work-life-balance, and learning opportunities), and working with people (being there and approachable, establishing a good work atmosphere and reacting to problems and solving conflicts). The majority of the interviewed leaders did not have problems in terms of work-life-balance. Strategies for „switching off" included leaving work at a specific time, having an agreement with the family that they will communicate if they feel the leader is not present in family life and exercise, such as jogging or biking. The views on internal and external recruitment were mixed. Leaders of highly specialized departments were more likely to vote for internal recruitment, arguing it would be easier to to lead when one already knows the people working there and the daily procedures. External recruitment was considered as a good opportunity to change things and to get new input and a fresh perspective. Talent recruitment and career development were two other topics that emerged; these will be discussed at the end of this chapter.

5.2 Preparation

The findings about preparation in this study are similar to the findings of Spehar (Spehar, Frich, & Kjekshus, 2012). They interviewed 30 mid-level and first-line managers in Norwegian hospitals about their career path and other topics. Most of them did not feel prepared for their leadership role and missed having support in their transitioning phase. Another study by Thompson (Thompson & Henwood, 2016) conducted in-depth interviews with six radiology managers in South-East Queensland, Australia and found that all participants faced a lack of preparation. No participant received an introduction or orientation before taking over the job. Many participants did not even get a job description, and were going back and forth with the administration to figure out what their duties were and what was outside of their role.

Participants in this study expressed similar experiences, but the majority of them had previously received education in form of courses on a leadership program or a master's degree in health care management or administration and leadership at the University of Oslo or the Norwegian Business

School. It would appear that hospitals take leadership more seriously and invest in their leadership development programs. While leaders belonging to the Akershus University Hospital expressed a satisfaction with their program, leaders of the University Hospital Oslo were more critical regarding theirs. Due to the small sample there it is difficult to state weather this program is effective or not, but other expressions about the hospital indicate that the merger of several hospitals might have caused problems for clinical leadership in terms of the amount of people to lead, accessibility of support and units at different locations. The positive aspects mentioned by participants, such as role-plays, socializing with other new leaders and getting to know what kinds of support systems the hospital offers and how they could be utilized to strengthen the leadership development programs. Mintzberg (2010) argues that leaders need to reflect on their own experiences within a theoretical framework to develop good leading qualities. Simply completing courses might be interesting, but often clinical leader do not have enough time to implement what they have learnt or to review their actions. This issue could be resolved through an „off-the-job“ learning, which was also suggested by several participants: This could be, for example, a monthly meeting with new and experienced leaders to discuss current problems, giving and receiving support and advice. Thus, the leaders (both new and old) are given an opportunity to reflect on previous steps and attitudes towards particular problems, and a feeling of „not being alone“ in dealing with them. The results also question to what extent someone can prepare for a leadership position, since many of them mentioned the approach of learning by doing. This suggests the possibility of a two-step approach. In the first step, clinical leaders are prepared for things they can be prepared for prior to beginning their role: theoretical, organizational and legal aspects, administrative tasks and procedures, and the handling of computer programs, for example.. There may also be an emphasis on self-awareness, coping with difficult situations and stress, learning to work with people within role-plays and getting to know where they can ask for support and what kind of form that support takes. The second step would be in the weeks and months after taking over the new role. Meeting with a support group, having a mentor for the first weeks or coming together through the leadership development program at weekends might help to develop strategies for current and future challenges, reflecting on one’s behavior and that of others. This also might offer an opportunity for further research to investigate the impact of such regular meetings or coaching for new leaders on the outcome of clinical leadership. Another topic that emerged is the acceptance of clinical leadership. As Bohmer (2013) pointed out, leadership involves shared values and a common goal, but since physicians are trained with an individual mindset and identify more with their own profession than the organization they are working for, this might be difficult. Although there seems

to be a mind-set shift happening regarding leadership among clinical workers, the current leaders in this study struggled with acceptance by colleagues, especially if they had a different educational background than the majority. This indicates two things: A higher degree of clinical leadership and appreciation from a different source are required. The UK, with its Clinical Leadership Competency Framework, is following the right path by emphasizing clinical leadership and shared responsibilities amongst all staff, students, experienced clinical workers and leaders. This might be more prevalent with trainees and clinical workers in Norway as well to get an understanding on what a clinical leader does and why. Appreciation could also come from superiors and other leaders. But since participants reported that they are not much in contact with their superiors, the two-factor theory of motivation by Frederick Herzberg could give some factors that enhance intrinsic motivation. In the author's theory there are two factors of motivation: hygiene and motivational factors. Hygiene factors refer to pay, company policies and administrative policies, fringe benefits, physical working conditions, status, interpersonal relations and job security. They are essential for the existence of motivation and if they are absent, this can lead to dissatisfaction. The motivational factors in contrast lead to satisfaction if they are existent. This can be recognition, sense of achievement, growth and promotional opportunities, responsibility and meaningfulness of work. (Herzberg, Mausner, & Snyderman, 1993) If these factors are given, clinical leaders might need less appreciation by their staff members or subordinates (although it is one of the factors named above), because they have intrinsic motivation.

5.3 Competences and challenges

The leadership development „Be, Know, Do" of the U.S. Army can be applied to clinical leadership. In both cases the security of members of the organization (soldiers, patients) is a high priority. Death is a possible outcome of leadership, and mistakes can have tremendous consequences. Hence, there are many differences in the power structure of the organizations. A soldier learns from the beginning of the career to subordinate and to follow orders. The leader makes the decision for the unit, and prompts subordinates to execute them. Protest are not allowed and this loyal following is extremely important in dangerous decisions to save the soldiers` lives. Physicians in contrast have different surrounding conditions. They have to face critical decisions with a possible dangerous outcome, but usually this will not affect their own life. They have received higher education and are used to working independently, autonomously and without the need to ask the leader for permission. This means the leading style and the extent of orders differ considerably. Still, the study showed

many similarities in the identification of competences this leadership development model suggests. From the „be“ attributes mental will, self-discipline, initiative, judgement, self-confidence and intelligence for mental, professional bearing, physical health and fitness (to a smaller extent) for physical and self-control, emotional balance and stability for emotional attributes were competences that were named during the interviews. In terms of „know“, the tactical skills may be too specific to the U.S. Army, but the other skills were used as well. The participants mentioned interpersonal skills like communication, encouragement and enjoyment of working with others. Conceptual skills referred to working with ideas, thoughts and concepts, which was expressed in having a clear structure, thinking out of the box, having an overview and learning from mistakes. Technical skills such as using computer programs and knowing specific procedures were also named. The „do“ dimension was separated into three elements: influencing, operating and improving. All these aspects were reflected in the answers of the participants.

When asked about their challenges in the study of Spehar, Frich & Kjekshus (2012) many clinical leaders said that they struggle with the high workload, the business and economic terminology, the concept of health, safety and environment, loneliness, a lack of appreciation and support (specifically named aspects were IT and financial support), uncertainty about what could be delegated and not having enough time to use the skills and knowledge they had acquired in their leadership development program. One nurse experienced resistance among the medical staff. Some of the above were mentioned during the qualitative interviews as well, such as the large number of meetings and administrative tasks, time pressures and facing resistance amongst staff members due to a different educational background. However, most challenges the participants described revolved around organizational difficulties: Too many patients, few staff members and equipment, postponed procedures and planning difficulties due to sickness and maternity leaves, keeping up a specific number of treatments per period and leading units at different locations. The differences in expressions about challenges from this study to the study, of Spehar might come from different nature of the questions asked. As they were asked in Spehar’s study, it is more likely they were also asked about their specific challenges when they took over the leading position while this study focused on general challenges of clinical leaders. While the participants of the Spehar study named very specific problems, many of which could be picked up as central themes in a leadership development program, these are not so easy to apply to the more general, organizational problems. Most of issues mentioned in this study will be permanent due to cost reduction, the increase of production and emphasis on effectiveness in the Norwegian health care system. Fighting resistance among staff members might be an argument for a more general clinical leadership as already

mentioned in the previous chapter. But it is possible that resistance will be reduced over time, as the development of clinical leaders with all kinds of educational backgrounds continues and becomes normalized.

5.4 Career pathways and recruitment

How are clinical leaders recruited, and is this the right way? Henry Mintzberg believes that good leaders are not found externally, but should rather recruited from the inside. In his opinion the best way to recruit successful leaders is to observe them at work. Talented people should be challenged with new tasks and slowly transitioned into their leadership positions. He argued that internal recruitment has many advantages over external, since the individual already has some knowledge about the organization, and the procedures, and additionally an element of loyalty (Mintzberg, 2010). The majority of the clinical leaders in this study shared the same opinion. They explained that knowing the environment, the staff and the operations would bear great advantages. To obtain this specific knowledge can be very time consuming. Although some of the participants argued for external recruitment to get new input and a new perspective on particular topics, none of the interviewed leaders were recruited externally.

Apart from a few participants who actively strived for a leadership position, the majority experienced informal recruitment in the study of Spehar, Frich & Kjekshus (2012), while all six radiologists of the Thompson & Henwood (2016) study were recruited informally. The most common procedure was that superiors persuaded them to overtake the position. Although this question was not directly asked, two participants expressed that they had experienced informal recruitment, where they were convinced to take a leadership position. They said that they felt a certain pressure from their superiors to accept. Others had an inner drive to apply for a leading position. Looking for new challenges, having some influence or being a better leader than one's own leader, were named as motives. The statement of one participant that at the leadership development program more than half of the new leaders were persuaded to overtake and actually did not want to be leader and that the interviewees ambition to become a leader because it will be interesting and fun were perceived with curiosity, indicates that informal recruitment is still a common procedure.

In their study, Spehar, Frich & Kjekshus (2012) also found that there is a concept of „no return". Clinical leaders feel they are at a point where they cannot go back to clinical work. However, it is not clear, if this is due to technical or self-motivated reasons. Due to fast developments in the field

of medicine, it might be not that easy to move back to clinical work without some additional training. Another possible reason for the point of no return is that someone who has been a leader, has experienced that people approach the leader for advice or feels they are looked up to, and thus has too much pride to go back to a same level. The leader might also fear to lose one`s face and the respect from the staff members. They may also have gotten used to their new financial benefits they might not want to give up. All of these may be reasons why clinical leaders might not step back, even if they perceive their current work as not satisfying enough. In this study, two participants talked about the point of no return. One had the feeling that going back to clinical work will not be an option, while the other said, returning to be a psychologist would not be a problem, if clinical leadership did not meet the personal skills and the organizations` goals. Other statements by participants might indicate that this point of no return is dependent on the educational background and the period of being a clinical leader. One participant mentioned, that after three years, he/she would not be able to perform the procedures that where necessary in his/her department. Another participant had given up performing surgery, which he was doing one day per week, because of the feeling of not being able to maintain adequate operational skills and to keep up with the developments in the specific discipline. Therefore, it is even more important that hospitals reduce the amount of clinical leaders who actually do not want to do this job or who are not suitable for such a position within the organization. Because a leader who is is not appropriate or motivated correctly may harm the organization, the staff members of the particular unit or department and also him- or herself. There are three possible solutions for this problem. One solution would be a „hybrid leadership“ where leaders perform leadership and clinical work in equal measure. The advantages would be that they are able to maintain their knowledge and skills in their original field, and it would be easier for them to return to only clinical work if they wish to. But this has several disadvantages. Firstly, this means that the leading position would not be independent with regards to the educational background, the leader would need the particular education that staff members have. Secondly, role ambiguity could occur. Research shows, that being in this compound position hybrid clinical leaders may not achieve the goal of their function due to lack of competences and knowledge in leadership, time pressures and personal factors. They tend to have internal conflicts, when organizational goals conflict with values and attitudes as a doctor. They are also more likely to spend their time on clinical work rather than their management work, because they feel primarily as a doctor, not as a manager. This can result in delays in decision-making regarding organizational topics which affects other members of the organization. A hybrid clinical manager has on one hand, the role as a colleague among the other doctors, and on the other hand, the function as a superior

with some degree of power. Since interests of doctors and management can be conflicting, a hybrid clinical manager might find him- or herself in a difficult situation he or she cannot win. (Kippist & Fitzgerald, 2009) Misunderstandings and conflicts may arise because it is unclear what the individual is requesting as a leader, and what is an inquiry of a clinical worker. The question is also whether the increasing leadership demand of coordination of teams and schedules, and planned action steps in procedures, is so high that clinical work is just not possible anymore. The study of Thompson & Henwood (2016) also showed that the radiologists saw themselves first as clinicians and only second as managers. Hence, organizational goals that contradict physician's views might be less enforceable. Another solution could be a specific „drop-out-of-leadership" program for clinical leaders who are not eligible for the position or who do want to return to clinical work. This program could offer a training and educational plan, so that these people are slowly integrated back to their original workplace. But this requires a certain permeability in the leadership system, a work atmosphere that does not judge people who return to clinical work, and a greater deal of individuality, financial resources and structures in order to offer these people additional training. The third solution would be a system to identify talented clinical workers and guide them into a leadership position. This could be incorporated into existing leadership development programs. Current leaders could point out or nominate potential candidates for leading positions and these candidates could be gathered in a talent pool. They could take some courses of the leadership development program, take over some tasks from their current leader and receive some mentoring in their transitioning phase from an experienced clinical leader. This would give the individual an opportunity to decide if leading is something they want to do, and the organization has a chance to see if this person is suitable for a leadership position. As with the second solution, this would require a great deal of financial and human resources, but it may be the most successful at helping to find the right leaders for the hospital.

5.5 Generalization and reflection

Although the sample size is small and limited to a specific area, research in other countries such as Australia (Thompson & Henwood, 2016) and New Zealand (McKenna & Richardson, 2003) points to similar results and therefore allows for external validity. „A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions" (Malterud, 2001, p. 483-484). The author attempted to reduce this

by keeping a reflective journal, writing down after each interview how her own behavior could have influenced the statements of the participant.

6. Conclusion

The purpose of this thesis was to explore experiences of mid-level managers in Norwegian hospitals regarding the transition into a new leadership position and the corresponding preparation, challenges, competences and recruitment process. The study conducted semi-structured in-depth interviews with seven clinical leaders in two hospitals in the Oslo area. The majority of the participants completed a formal training prior to taking over their new leadership position. They were mainly satisfied with the leadership development programs, although they saw potential in terms of length and contents. Participants longed for more coaching, mostly during the transition phase. Overall, the awareness for the importance of clinical leadership has increased and the preparation through courses within a leadership development program is considered to be more important compared to the past. In their daily work, clinical leaders face a high workload of administrative work, meetings and unpredictable events. According to that, clinical leaders require distinct competences, such as flexibility, self-awareness, communication skills, knowledge of administrative tasks and soft skills in working with people. The latter include connecting teams, adapting the leadership style to individuals and being present. Clinical leaders also deal with a large amount of organizational circumstances they have no influence on: an insufficient number of beds versus an increasing number of patients, personnel changes, technical equipment and other crucial resources. Thus, they have to think out of the box at many instances, find new solutions, and maintain an inner drive to improve the work situation and internal processes. The preferred way to recruit new clinical leaders is internal and often informal. The study demonstrates a need for profound talent acquisition from within the organization, a coaching of new leaders and a suitable solution for clinical leaders who are not suitable for a leadership position or desire to return to their clinical work. This requires certain institutional structures, a shared openness and a non-judgmental approach within the organization. Furthermore, career pathways for clinical leaders should be elaborated through future research by conducting focus groups interviews with upcoming, recent and experienced leaders, who will share their valuable insights into talent recruitment, career management, dropout rates and possible strategies in order to find feasible and suitable solutions facilitating a smoother transition for future clinical leaders in Norway.

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Appendix

I. Approval from the Norwegian Centre for Research Data

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0318 OSLO

Vår dato: 20.02.2017 Vår ref: 52234 / 3 / IJJ Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 17.01.2017. Meldingen gjelder prosjektet:

52234	*Ledelsesutvikling i helsevesenet*
Behandlingsansvarlig	*Universitetet i Oslo, ved institusjonens øverste leder*
Daglig ansvarlig	*Ivan Spehar*

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, 31.12.2020, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Kjersti Haugstvedt

II. Consent Form

U N I V E R S I T E T E T
I O S L O

AVDELING FOR HELSELEDELSE OG HELSEØKONOMI

Postboks 1089, Blindern
NO-0317 Oslo

Samtykke om å delta i forskningsprosjektet "ledelsesutvikling i helsevesenet".

Som mastergradsstudent ved Avdeling for helseledelse og helseøkonomi, UiO, skal jeg gjennomføre et prosjekt med mål om å undersøke ledelseskompetanse i helsevesenet. Prosjektet blir veiledet av postdoktor Ivan Spehar og er meldt til Personvernombudet for forskning, Norsk senter for forskningsdata.

Hva innebærer deltakelse i studien?
Deltakelse i studien innebærer at du blir intervjuet i om lag en times tid. Målet er å utforske synspunkter knyttet til ledelseskompetanse og ledelsesutvikling i helsevesenet. Samtalen vil bli tatt opp digitalt og deretter skrevet ned i en tekstfil. Hvis du samtykker til å delta i studien, så vil informasjonen du gir kunne brukes i forbindelse med utvikling av et spørreskjema om ledelsesutvikling.

Hva skjer med informasjonen om deg?
Alle personopplysninger vil bli behandlet konfidensielt. Resultatene fra studien vil bli søkt publisert i et fagfellevurdert tidsskrift. Deltakerne vil ikke kunne gjenkjennes i publikasjonen. Denne masteroppgaven er en del av et større prosjekt om ledelseskompetanse og ledelsesutvikling i helsevesenet. Prosjektet skal etter planen avsluttes ved utgangen av 2020. Lydfilene vil da slettes, og deltakerlisten vil anonymiseres.

Det er frivillig å delta i studien og du kan på et hvilket som helst tidspunkt trekke deg uten å måtte begrunne dette nærmere. Dersom du trekker deg, vil vi så godt det lar seg gjøre slette dine utsagn.

Har du spørsmål i forbindelse med denne henvendelsen, eller ønsker å bli informert om resultatene fra undersøkelsen når de foreligger, kan du gjerne ta kontakt med undertegnede:

Julie Popp
Masterstudent
Avdeling for helseledelse og helseøkonomi,
Universitetet i Oslo
Tlf. -----
E-post: ----

III. Interview guide

Warm-Up

- What is your age, job title, your educational background and how long have you been with this organization?
- What are the major challenges a clinical leader faces today?

Transitioning into clinical leadership

- Why did you choose to become a clinical leader?
- When you made the transition into management, what did you feel confident about in terms of your skills and abilities and what did you feel was missing?
- How did you prepare for this position?
  - Did you get formal training?
- What is your opinion on leadership development programs?
  - Should there be more focus on leadership development programs?
  - What should leadership development programs pay more attention to?
- What do you enjoy most about your leadership role?

Working with people

- In terms of working with staff members, what skills do you, as a leader, need the most?
- Can you tell me about a difficult situation with a staff member and how you solved the problem?

Self-Management & Knowledge

- What have you learned from being a clinical leader?
- How do you stay up-to-date with new developments in your discipline?
- How do you keep a work-life balance?
- In which way does leadership in health care differ from leadership in other industries?
- How do you set goals and implement them?

Competences

- Which competences are necessary to be a good leader?
- If you hired a replacement for your job what skills would this person need?
- Should clinical leaders be recruited internally or externally?
- Are there character traits of a leader that are innate or do you think everything can be learned?
- What distinguishes good leaders from bad leaders?
- Are there any competencies which you believe will be more in demand than others in the future?
- If someone told you he/she wanted to become a clinical leader one day, what advice would you give this person?
- In Norway, physicians, nurses and people with other educational backgrounds can be leaders. How does that affect clinical leadership? (Are there different skills/problems/leadership styles…)

- [ ] Is there anything more you would like to tell me?