Leadership in Norwegian Hospitals: A Qualitative Study on the Leadership Behaviours and Characteristics of Award-Winning Leaders

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Abstract

The overall aim of this study is to explore the leadership behaviours and characteristics of award-winning leaders in healthcare. Increasing expectations to health care, rising costs, and the growing number of older patients with complex diseases have raised public awareness towards effectiveness and quality of care. The importance of good leadership in healthcare is getting recognised, and we have seen an increased interest in recruiting clinicians to management positions.

The Norwegian Medical Association and Akershus University Hospital annually hand out a leadership award to an employee, who, in a jury's point of view, have demonstrated excellent management towards both financial and professional goals. This thesis is based on one-to-one interviews with 4 recipients of one of these awards. Study participants have a clinical background as medical practitioners from various medical fields and were head of their respective department when receiving their award.

Theory on transformational leadership and power was used to analyse and interpret the findings. The thesis seeks to investigate whether the behaviours and characteristics of the award-winners' success in their roles as clinical managers are characterised by transformational leadership. Moreover, if having a professional background affect the strategies used to influence employees.

Findings in this study indicate that transformational leadership might be an effective strategy to employ in a healthcare context. The leaders seem to rely on personal power, rather than using their formal authority as managers. By utilising transformational leadership, and facilitating growth and self-development, the leaders in this study appear to have created a base of followers driven by intrinsic motivation and consequently raised the level of achievement in their respective department.

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Submitting this master thesis signifies the end of five years as a student at the Faculty of Medicine at the University of Oslo. The past few months have been challenging, but also a valuable experience.

Firstly, I would like to thank my supervisor, Ivan Spehar, for the guidance, the support and for being available throughout the process. I am deeply appreciative. Furthermore, I want to thank my fellow student, Tiril Seppola Reed who have checked in with me weekly after the COVID-19 outbreak and given me tips on where to find articles and books when all the libraries closed.

I want to express my gratitude to all the managers who participated in this study and who were willing to put aside time in a busy workday to share their experiences and thoughts with me openly. This project would not have been possible without their contribution.

Lastly, I want to thank my family and friends for all their support throughout this process.

Thank you all,

Tonje Flathus

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1 Introduction

“The challenges that face health care organisations are too great and too many for leadership to be left to chance, to fads and fashions or to piecemeal approaches” (West, Armit, Loewenthal, Eckert, West, &, 2015, p. 23). Increasing expectations to health care, rising costs, and the growing number of older patients with complex diseases have raised public awareness towards effectiveness and quality of care. As a result, a growing number of clinicians are being recruited to management positions (Fulop & Day, 2010; McKimm & Swanwick, 2011; Neogy & Kirkpatrick, 2009).

How to lead and *in what way* is an everlasting discussion in the research literature. Major theories of leadership try to give an understanding of what leadership is, how it should be defined, and what kind of traits a leader should exhibit. The importance of good leadership in healthcare has been recognised by multiple actors, and hospitals (e.g. Akershus University Hospital) and associations (e.g. The Norwegian Medical Association) have begun to reward great management. However, to date, a study dissecting the attributes of award-winning leaders in healthcare and how they are applied to become ‘successful’ has yet to be reported.

I believe a qualitative study focusing on award-winning leaders will contribute to a greater understanding of what it means to be a successful leader in the context of healthcare management. This study explores the leadership behaviours and characteristics of award-winning leaders in healthcare – focusing on, individual leadership styles, the influential strategies they employ, and how they perceive their role as leaders. This is not an attempt to find an ‘ideal leader’, but rather gather information on an ‘award winner' perspective, to highlight concepts to match with management- and emerging leadership trends. I hope this study will provide knowledge that can be useful in relation to developing leadership programs, as well as helping headhunting agencies to identify people suited for management positions in healthcare.

1.1 Conceptual Distinctions

1.1.1 Differentiating Between Leadership and Management

To avoid conceptual confusion, I want to address two terms that are often used interchangeably in the literature, *'leadership'* and '*management'.* To date, there is no universal agreement on how either, leadership or management*,* should be defined, and although the terms are linked, there is a consensus that there are distinctions between the two.

Countless attempts have been made to define '*leadership'*, and most definitions include the assumption that leadership is a deliberate act to influence other people (Northouse, 2010; Yukl, 2013). Hollander (1978) states that "leadership is a process of influence between a leader and those who are followers" (p. 1). Similarly, Northouse (2010) defines leadership as "a process whereby an individual influences a group of individuals to achieve a common goal" (p. 3). There is the general agreement that the practice of leadership is not solely tied to formal management positions (e.g. Day, 2000), whereas *management is* often used to describe formal positions. In the literature, and in this thesis, *management* is described as achieving specific results by planning, coordinating, organising, and controlling (Kotter, 1990).

1.1.2 Definition of the Terms Manager, Leader, and Leadership

For this thesis, I will use the following definitions when referring to the terms manager, leader, and leadership.

> *Manager - "someone who is vested with formal authority over an organizational unit" (Mintzberg, 1975, p. 54).*
>
> *Leader - "someone who has followers" (Drucker, 2005, p. 110)*
>
> *Leadership - "Leadership is about articulating visions, embodying values, and creating the environment within which things can be accomplished" (Richards & Engle, 1986, p. 206).*

Richards and Engle's definition highlight the main focus of this study; vision, values and environment, and include factors that are central to the theory of transformational leadership, which I will present in the next chapter.

1.1.3 Motivation

To be motivated means to *be moved* to act (Ryan & Deci, 2000). In the literature, *motivation* is often described as either to be *intrinsic* or *extrinsic* based on the different reasons or goals that give rise to an action. Intrinsic motivation refers to initiating an activity because it is enjoyable in itself (e.g. opportunity to explore, learn, and actualise our potential), as opposed to an activity to obtain an external goal (extrinsic motivation). Self-determination theory, presented by Ryan and Deci, claims that humans are inherently directed towards activities that satisfy basic psychological needs, which include the need for social relations (relatedness), competence, and autonomy. Activities that meet these needs will facilitate intrinsic motivation, whereas those activities which undermine them tend to create resistance.

1.3 Aim of the Study

The overall aim of this study is to explore the leadership behaviours and characteristics of award-winning leaders in healthcare. The focusing is on individual leadership styles, how they perceive their role as leaders and the influential strategies they employ towards employees.

2 Theoretical Frameworks

In this section, I will describe two theoretical frameworks that underline my study. The first, transformational leadership, is a popular and well-cited theory about leadership style. The second theory, which focuses on power, is relevant for understanding the influence managers exert over their employees.

2.1 Transformational Leadership

In this thesis, I will mainly focus on the theory of transformational leadership, which can be seen in connection with, or in contrast to, traditional transactional leadership.

2.1.1 Transactional Leadership

Transactional leadership characterises most forms of traditional leadership. Transactional leaders communicate and clarify role and task requirements (Walumbwa, Wu, & Orwa, 2008). They view the relationship between leader and follower as an exchange process and reward followers in exchange for their effort and performance. For example, Burns (1978) notes that politicians, lead by "exchanging one thing for another: jobs for votes, or subsidies for campaign contributions" (p. 4). In academia, the exchange comes in the form of teachers who give grades based on student performance (Jung, 2001). In business, "transactional leadership occurs when the leader rewards or disciplines the follower, depending on the adequacy of the follower's performance" (Bass & Riggio, 2006, p. 8). Rewards may involve recognition from the leader for work accomplished, bonuses, or promotion (Howell & Avolio, 1993). Conversely, employees who do not deliver what the manager expects are punished.

According to Bénabou and Tirole (2003), rewards and punishments are often counterproductive because they undermine internal motivation. Transactional leadership has been criticised, especially concerning motivation (Bass & Riggio, 2006), but as Bass (1985) notes, effective leaders use a combination of both

transformational and transactional leadership. They choose which style of leadership to use depending on the nature of the situation.

2.1.2 Transformational Leadership

In 1978, the publication of James MacGregor Burns's seminal - '*Leadership',* introduced the concept of, transforming leadership. Inspired by Burns and by Robert House's 1976 theory of charismatic leadership, researcher Bernard Bass and his colleagues (1985) developed a model of transformational leadership and the means to measure it. It is a model of leadership that attempts to 'lift' followers beyond their self-interests (Grint, 2010) and it takes place "when a leader and their followers raise each other's motivation and give a sense of higher purpose" (Gill, 2011, p. 81). Northouse (2018) notes that "Transformational leadership is, as its name implies, a process that changes and transforms people. It is concerned with emotions, values, ethics, standards, and long-term goals, and includes assessing follower's motives, satisfying needs, and treating them as full human beings" (p. 161). In other words, unlike traditional leadership theories, which focus on rational processes, transformational leaders are concerned with emotions and values (Yukl, 1989).

According to Bass' theory from 1985, a transformational leader is someone who expresses idealised influence, inspirational motivation, and intellectual stimulation. In 1994, Bass and Avolio added a fourth component - individualised consideration. In the literature, these four components are often referred to as "the four I's". The theory of transformational leadership has been revised multiple times, and in a later revision, Bass and Avolio (1997) divided idealised influence into two components. Descriptions of the four I's is presented in the following sections.

2.1.2.1 Idealised Influence

Leaders who possess idealised influence serve as role models. They act in ways that resonate with people, and this allows them to create a base of followers who trust, admire, and respect them. Followers see these leaders as determined, persistent, and as having extraordinary capabilities (Bass & Riggio, 2006). According to House (1996), idealised influence is a favourable

influence strategy because of its positive impact on a followers' attitude to the work and the organisation. As described, idealised influence is divided into two components. The first component is a leader's behaviour, which is the communication of a sense of values, purpose, and mission importance. The second component encompasses the attributes given to the leader by followers, attributes that induce followers to view the leader with pride and respect (Bass & Avolio, 1997). Idealised influential leaders express high expectations to their followers, but also continually reassure them that they can overcome obstacles. They are driven by more than self-interest and are willing to take risks even at the expense of their own job security and show high moral and ethical conduct (Glasø & Thompson, 2013).

2.1.2.2 Inspirational Motivation

Inspirational motivation is the second factor of transformational leadership and is closely related to idealised influence (Bass, 1985). Charisma is often regarded as an important element of transformational leadership (Martinsen, 2010, p. 109). Combined, idealised influence and inspirational motivation are what constitutes the leader's charisma (Gill, 2011, p. 66). Leaders who express inspirational motivation are passionate about what their organisation stands for and articulate a compelling vision of the future that followers want to be a part of. They show commitment to the central goals and vision of their organisation and encourage a sense of team spirit. Inspirational motivational leaders are optimistic and communicate expectations to followers clearly. They behave in a motivating manner and inspire followers by providing meaning and challenge to their work (Bass & Riggio, 2006).

2.1.2.3 Intellectual Stimulation

Transformational leaders want their followers to look at problems from different angles and include them in processes of addressing and solving problems. They challenge the status quo and encourage followers to come up with and try out new approaches. They stimulate their followers' efforts to be

creative and innovative by approaching old situations in new ways, re-examine critical assumptions, and reframing problems. These leaders do not criticise ideas which differ from their own, and if a follower makes a mistake, they will not receive public criticism (Bass & Riggio, 2006).

2.1.2.4 Individual Consideration

Individual consideration is the fourth and final factor of transformational leadership, and it occurs when leaders relate to followers on a one-to-one basis to elevate goals and develop skills (Barnett, Mccormick, & Conners, 2001). An individually considerate leader recognises, and accept, that people are different and create a safe, supportive environment where followers can utilise their potential. They identify individual needs, abilities, and aspirations, and delegate tasks that help their followers enhance competence, develop, and achieve goals. They spend time coaching and teaching, and they monitor to see if additional support or direction is required and try to do so without followers feeling they are being checked on. These leaders practise "management by walking around", show willingness to engaging in dialogue, they adapt the interaction to fit each follower and are excellent listeners (Bass & Riggio, 2006).

2.1.3 Transformational Leadership and its Effects

Transformational leadership is a style of leadership who has received much attention in the research literature. Research has shown that transformational leadership has positive impact on job satisfaction (e.g. Gilstrap & Collins, 2012), creativity (e.g. Hetland, Skogstad, Hetland, & Mikkelsen, 2011), trust (e.g. Zhu, Newman, Miao, & Hooke, 2013), motivation (e.g. Li, Tan, & Teo, 2012), team effectiveness (e.g. Zhang & Peterson, 2011) and results (e.g. Keller, 2006). However, there is not as much research tied to the application of this leadership style in the healthcare sector.

In 2014 Tawney Hughes conducted a study where she looked at how leadership were expressed in some of the most high-impact and innovative social

sector organisations. The aim was to determine the importance of transformational leadership in this sector. Her research involved case studies and interviews with five recipients of the Henry R. Kravis Prize in Leadership, a prize which "has sought to award outstanding nonprofit organizations all over the globe that are changing the face of the social sector" (p.14). Recipients have been internationally recognised for their leadership and included leaders from Right To Play, mothers2mothers, INJAZ-al-Arab, Fundación Escuela Nueva, and Landesa. Her findings revealed a high prevalence of transformational leadership throughout the principles and behaviours of the organisation's leader, as well as the followers.

2.2 Power

The term *power* often evokes negative associations in people. It is associated with control, authority, abuse, coercion, and authority (Freeth, 2007). Some definitions of power have a greater focus on negative aspects than others. The well-known sociologist, Max Weber (1864-1920), defined power as “the ability of an individual or group to achieve their own goals or aims when others are trying to prevent them from realising them”, and although this definition has been challenged and criticised, it is still often used in the literature describing power. However, power is not necessarily used in a negative manner. In 2013, Yukl investigated the role of power and how it influences behaviour and leadership effectiveness. In his review, he described power as a flexible concept that can be used in various ways, and that it involves “the capacity of one party (‘the agent’) to influence another party (‘the target’)” (p. 189).

Yukl (ibid.) explains that the agent can be a person, a group, or an organisation who influences a single target person or multiple target persons. My focus in this thesis is on power at the individual level, and I will use the term *power* to describe how one person, ‘the agent’, influence the behaviours or attitudes of their followers, ‘the target’. Moreover, according to Northouse (2010), power is “the ability to affect others’ beliefs, attitudes, and courses of action” (p. 7). As such, this is the definition I will adopt throughout this thesis, as it fits well with the conceptualisation of power described by French and Raven (1959), where they describe how actors may

draw power from particular sources such as knowledge, skills, access, resources, or individual attributes.

2.2.1 Sources of Power

A lot of Yukls research relies upon the power taxonomy proposed by French and Raven (1959). French and Raven classified five sources of power - legitimate, reward, coercive, referent and expert power. Later, Raven (1965) added a sixth power base - informational power. These sources of power, as well as ecological power, is described by Yukl (2013) in his book *Leadership in Organizations*:

2.2.1.1 Legitimate Power

Legitimate power is based on the belief that a person has the right to expect compliance and obedience from others. If someone is hired, elected, or appointed to a specific position that comes with certain responsibilities that are tied to that position they have legitimate power (e.g. a front-line supervisor is responsible for making other's schedule).

2.2.1.2 Reward Power

Reward power is derived from the ability to compensate another for compliance (e.g. through money, free-time, or praise).

2.2.1.3 Coercive Power

Coercive power is the power to punish or potentially punish another for non-compliance. In contrast to reward power, coercive power may use the promise of power without the need to act, e.g. a boss has the power to fire an employee for non-compliance, or a teacher has the power to fail a student who does not submit a paper.

2.2.1.4 Referent Power

Referent power is about likability. People follow because they want to. Someone who influences people because they have charisma, a great relationship with their followers, or people who look up to them, have referent power (e.g. when Oprah Winfrey recommends a book to her audience she is using her referent power to influence viewers).

2.2.1.5 Expert Power

Expert power is the kind of power which comes with expertise. A person with a high-level education (e.g. medical practitioner, lawyer, or engineer) will have skills, experience, and knowledge, in the form of expert power, that others would like to access.

2.2.1.6 Informational Power

Unlike the previous types of power mentioned above, informational power differs because it is based on having control over information. It is about how information is used and shared (e.g. kept for oneself or shared with certain people). Providing rational arguments, using information to persuade others, using facts and manipulating information can create this power base.

2.2.1.7 Ecological Power

The last powerbase described by Yukl is ecological power. Ecological power is about having control over factors in the physical work environment, corporate culture, and personal contacts that influence the behaviour of others.

Yukl distinguishes between personal power and position power. Position power embodies information and ecological power, as well as French and Raven's (1959) original notions of legitimate, reward, and coercive power, and describes the power derived from a formal position or rank in an organisational system. Personal power includes referent and expert power and is the types of power a leader can access regardless of their managerial position.

Yukl (2013) describe that some power bases are more likely than others to produce the compliance and commitment a leader seeks from subordinates and peers. He describes that position and personal determinants of power interact in complex ways, and hence might be difficult to distinguish. What is more, from his research on the use of different types of power by leaders, he argues that that effective leaders rely more on personal power than they do on position power and use power in more subtle ways. He also highlights that the specific *type* of strategies leaders use to make people carry out requests, support proposal and implement

strategies, and the *amount* of power necessary for leader effectiveness, depends on the nature of the organisation, task, and subordinates.

2.2.2 Power in a Healthcare Context

Power is relevant for understanding the influence managers exert over their employees and can provide a clearer picture of how leaders practice leadership. Mintzberg (1979) has portrayed hospitals as “professional bureaucracies” which rely on highly trained professionals, and where goals are to innovate and provide high-quality services. In hospitals, power resides with expertise through knowledge and skills, and a large proportion of power is located at the bottom of the hierarchy, which provides professionals with autonomy. This leaves front-line staff with more independence and allows them to have a greater influence over daily decision making than those in formal positions of authority. On the other hand, strategic decisions and budget processes lay at the top management levels, which is largely founded on top-down models and the logic of economics and administration (Spehar, 2014).

Conflicting values and goals have led to a gap between administrative and clinical understanding (Glouberman & Mintzberg, 2001). Spehar (2014) points out that having budget processes and strategic decisions decoupled from clinical actions and decisions at the front-line level of the organisation, has resulted in a significant distance between actions and expectations concerning strategies, budgets, activities, and quality of care.

Little research has been done on power in a healthcare setting. A study conducted by Spehar, Frich and Kjekshus (2014) on how clinicians in management positions use different influence strategies in hospitals showed that leaders with a medical background were more likely to draw on personal power, than position power. Although their study does not focus specifically on how proficient leaders, such as the award-winning leaders of my study, use different power bases, their finding corresponds with Yukl’s (2013) conclusion that effective leaders rely mostly on personal power.

3 Method

In this chapter, I will explain my choice of method, describe who participated in the study, and how I conducted the interviews. In the last section, I will explain how I analysed the data.

3.1 Choice of Method

The aim of this research is to explore the leadership behaviours and characteristics of award-winning leaders in healthcare. I was curious to see if the award-winners had similar characteristics and leadership style. I wanted to examine which aspects of leadership they particularly focused on and which influence strategies they used. I hoped to uncover information that could provide a better understanding of what great leadership is and what it takes to become an influential leader in the context of healthcare. I was interested to see if the findings could be linked to the theory of transformational leadership and research literature on power. To get in-depth with personal experiences and understand how these leaders work and how they have created a base of followers, I concluded that a qualitative approach would best serve the thesis. I interviewed participants individually using a semi-structured interview format. According to Kvale (1996), an advantage of using a semi-structured format is, that it allows for flexibility if unexpected themes and topics emerge. As such, I was able to ask follow-up questions and still cover what I intended. Although this approach fits well to get in-depth with the study participants, it also limits the number of people to speak to. Qualitative interviews are time-consuming, and hence you only focus on a few individuals. Consequently, the result cannot be quantified to highlight any emerging trends that may apply to everyone.

3.2 Setting and Participants

Participants were chosen using a purposeful sampling strategy. I recruited participants who had received an award for their leadership through the Norwegian Medical Association, or Akershus University Hospital between 2016 and 2019. I

wanted award-winners from recent years, and to include both men and women. I chose two different leadership awards to collect a broader set of perspectives and to get a more significant sample size.

The Norwegian Medical Association is the main medical association and trade union in Norway, and approximately 95 % of medical practitioners in Norway are members of the association (Legeforeningen, 2018). The Norwegian Medical Association has handed out a leadership award to one of its members annually for several years. The recipient would have been nominated by his or her colleagues or employees. The award-winners must, in a jury's point of view, have demonstrated a good willingness and ability to have open dialogues with employees and shown excellent management towards both financial and professional goals. They would also have kept employees motivated, taken responsibility for the operation and development of the business, and contributed to openness and freedom of expression about deficient or critical conditions at the workplace (Baugstø, 2019). Conversations through e-mail with Fagforbundet at Akershus University Hospital confirmed that they considered similar criteria when selecting their award-winners. As part of the preparations, I interviewed a jury member from the Norwegian Medical Association. The jury member described the selection process as comprehensive and reassured me that the leaders were worthy recipients of the award.

Unfortunately, the 2019/2020 COVID-19 global pandemic made it challenging to recruit participants, and some of my planned participants were dropped from the study. Nonetheless, I was able to recruit 4 formal managers from hospital settings, who had experience from various medical fields, and who at the time of receiving their award was head of their respective department (2 males, 2 female).

3.3 Conducting the Interviews

I conducted the interviews between mid-February and the 1st of May. Due to the social and economic restrictions that the COVID-19 pandemic created I had to conduct the last interview by phone.

The early interviews were conducted in person, a couple of them, under strict social distancing guidelines. To comfortably work alongside their professional schedules, we organised a one-hour meeting at the participant's offices. In a few cases, this led to some minor interruptions, however, it also allowed me to gather observational data, especially with the leaders who wanted to show me around their workplace.

3.3.1 Interview Format

Introductory Stage

Initially, I re-introduced myself and gave a more detailed explanation of the study's aim than when I first contacted the leaders.

Questions from the Participant to Interviewer

Before the interviews, each participant was given formal information concerning confidentiality and the use of the audio recorder in the form of a consent form (appendix II). They were also given a second copy in person, and time was taken to answer all questions they had before we began.

Guided Interview Stage

The interviews were semi-structured to allow a natural flow (appendix I). I listened carefully and showed interest in what the participants were saying. I attempted to adapt my questions to fit the different participants instead of following the interview guide question by question. I felt this gave the interviews a more natural feeling and allowed the participants to relax. I also believe this made me able to get more personal and understand what each of the participants particularly valued. Malterud (2017) suggests that an interview guide is similar to a checklist, therefore, I used the one presented here (see appendix I) to make sure I covered all the questions. At the end of the interview, each participant got the opportunity to speak freely and add anything if they wanted to.

3.4 Analysis

I started transcribing the interviews soon after the meetings when the experience was fresh in mind. This was a time-consuming process, and even though everything made sense when conducting the interviews, a few things were not as clear listening to the recording, I still felt I got the essence of what was said. I read through the transcribed interviews several times to familiarise myself with the data before I started the work of coding and systemising the material into categories. I used a thematic network analysis. According to Attride-Stirling (2001), “thematic analyses seek to unearth the themes salient in a text at different levels, and thematic networks aim to facilitate the structuring and depiction of these themes” (p. 387). I followed the six-steps process described by Attride-Stirling, where the first step is to reduce data. I did this by labelling interesting features with different codes across the entire data set and divided the data into purposeful and manageable text segments that could contribute to my research aim.

The next step was to identify themes. I re-read the text I had worked with multiple times and gathered related codes into themes. These themes laid the foundation for step 3 - constructing thematic networks. A thematic network summarises the main themes constituting a piece of text and is illustrated in figure 1.

Figure 1. Structure of a Thematic Network (Attride-Stirling, 2001, p. 388).

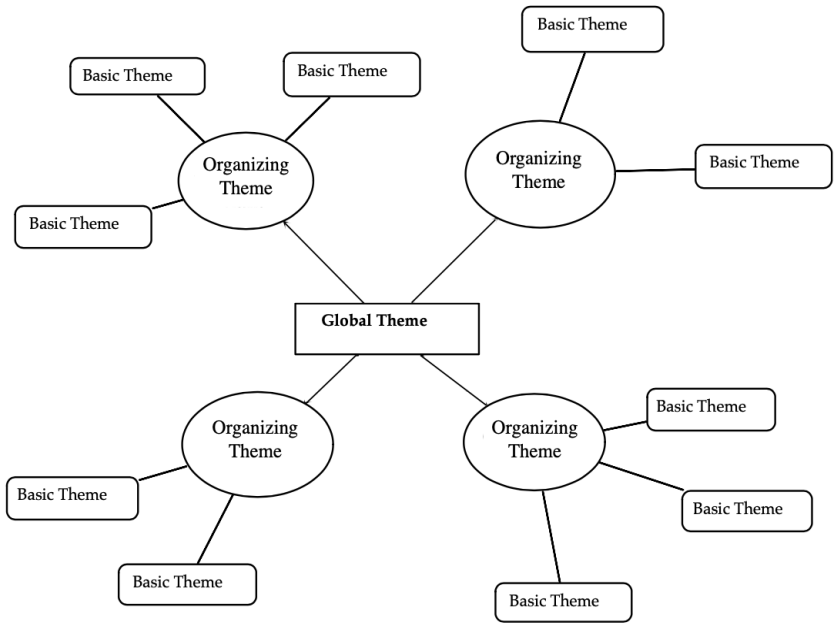

FIGURE 1. *Structure of a thematic network.*

The themes derived from the interview texts were assembled into groups, these groups are what Attride-Stirling calls "basic themes". The themes that centred around the same issue were grouped together and categorised into "organizing themes". I made five “organizing themes” that I felt could give a meaningful contribution to understanding patterns in the data related to the research aim and literature; “personal characteristics”, “availability”, “cooperation”, “communication”, and “motivating others”. I derived my overall theme, the "Global theme", from the content of these, namely: “Leadership behaviours and characteristics”. A thematic network summarising the main themes is illustrated in **figure 2:**

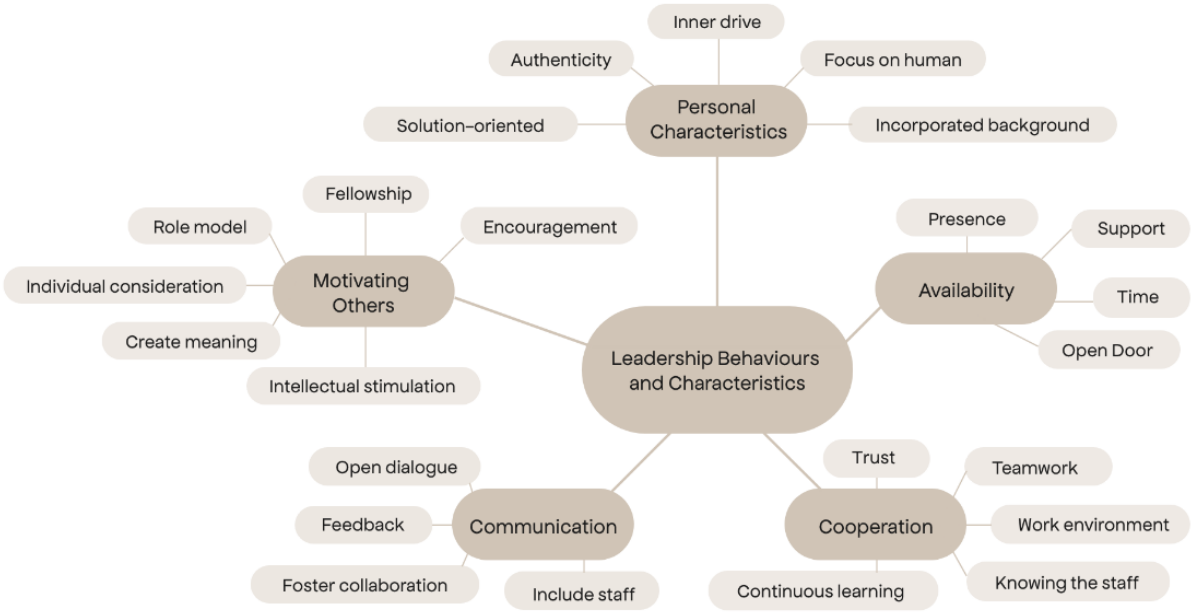

FIGURE 2. *Thematic network - Leadership Behaviours and Characteristics*

The fourth step of the process was to describe and explore the thematic network, as Attride-Stirling (ibid.) notes, “thematic networks are a tool in the analysis, not the analysis itself” (p. 393). I returned to my original text and made sure that the organising themes involved basic themes that captured all aspects I intended to cover. I started identifying different patterns and added descriptions to the network.

The fifth step was to summarise the thematic network, and the sixth and final step was to interpret the patterns found in the thematic network analysis against relevant theory in order to explore the various themes and structures that emerged in the text.

4 Results

The research aim for this thesis is to explore the leadership behaviours and characteristics of award-winning leaders in healthcare. In this chapter, I will present the findings from the interviews I conducted and review the themes presented in the previous chapter - *personal characteristics*, *availability*, *cooperation*, *communication,* and *motivating others*. The focus is on the actual exercise of leadership, but I will also present why the leaders found different elements to be important. The findings are described, and quotes from the participants are used to emphasise key points. Where the participants have expressed themselves in a particular oral manner or repeated themselves, I have shortened the quotes; this is marked with [...] in the text. I conducted the interviews in Norwegian and have worked tirelessly to translate them to the best of my abilities. Nonetheless, I acknowledge that some meaning may have been lost in translation.

4.1 Personal Characteristics

The leaders interviewed have a clinical background as medical practitioners and did not plan to become leaders. They were head of their respective department when they received their leadership award, but do not have any formal management education. They described ending up in management positions by chance. One of the leaders describes her way into leadership as such:

> *“It was a coincidence, it wasn't like I was applying for the job or anything, but I've always wanted to be able to do something. I'm not happy to just go to work and go home. I wanted to do something good for patients and the hospital. It’s in my core, it’s in my mind. That's why I said yes to the job.”*

A recurring pattern in the participants' stories was that initial entries into management were characterised by informal ways of recruitment. They recounted that the inner drive for wanting to change and improve patient care disposed them towards engaging in management. One participant describes this ‘inner drive’ as one of the main reasons someone should become a leader:

“If you are a committed person and have an inner drive to change things, and not because you want to make yourself look good, but where it is a genuine thing, you should continue with what you are doing, and you will probably end up as a leader in some context.”

The leaders described themselves as very committed to their respective clinical field and are motivated to help their discipline develop. They wish to make a valuable contribution to society and to do *the right thing*. One leader said:

“I hate to see things not working and can't stand just to let it pass. [...] You can say that it is my conscience that is the main driving force in my leadership practice.”

Several participants described feeling discomfort if something was not working well and linked it to patient safety and quality of care. They describe having a day-to-day approach while keeping their vision in mind and believe it is important to focus on opportunities, rather than limitations, and quality and employees' well-being, rather than the economy. One leader said:

“I’m very concerned about the patient perspective and the employee perspective and believe that you ruin patient care if there is too much financial focus. [...] When you focus on the economy, the consequence might be that you get a lot of waste and become ineffective. If you focus on patient care and on how employees work best and listen to the employees, then the economy will follow.”

The leaders I spoke with portrayed themselves as knowledge-seeking, creative, and solution-oriented, and emphasised the importance of incorporating their clinical knowledge into their role as leaders. One leader said:

“I think my professional background is essential for being a good leader in healthcare.”

Participants believe that their professional background helps them in multiple ways, especially when it comes to decision making. One participant mentioned that

having experienced what it is like *working the floor* and having knowledge of the field also helps to gain respect:

> *"I still want to be a part of the clinical work because it allows me to make the right decisions. [...] I think it's about respect, especially in a business with specialised expertise - if you don't have any knowledge yourself, I think you will be less respected."*

Another participant said that her clinical knowledge helped her influence higher-level managers to get support for her views. It had resulted in positive outcomes regarding budget and resource allocations, and she believed that helped her gain credibility among peers:

> *"I have won some battles in terms of resource allocation here at the hospital, I have managed to influence different professional fields nationally. I think that makes people trust the things I am saying."*

4.2 Availability

The leaders described that a typical day consists of many meetings where they address issues, open-up for questions, and discuss patient-related matters. Outside these meetings, they described using a lot of time to walk around and check if everyone has the staff they need and to make sure everyone is doing well. Several pointed out that by showing their face, it made it easy for people to talk to them. One of the informants said:

> *"It is important to have a group around. I think it is dangerous if you are removed from the ones on the floor. I think that contact is very important in order to get feedback right away about things that do not work."*

The leaders said that, by walking around, they could make sure that the people working feel seen and appreciated. They can get feedback to get a sense of where things are working well and where it is not. Some leaders pointed out that this also helped them be ahead of problems. Participants talked a lot about the importance of being present in the environment and showing the people they worked

with, that they are there to support them, both emotionally and with expertise. They described that although they are not regularly involved with patient care themselves, indirect patient care through discussions and consultations is a daily matter. They described having an open door, and one leader said he was available to his employees also after work hours:

> *"I'm available 24 hours, even at home by phone. [...] I'm there if they need me. I never say that I do not have the time, or if I'm busy, I will get back to them."*

4.3 Cooperation

Questions concerning cooperation got a lot of attention in the interviews. The informants found it to be important for many reasons - the most obvious reason might be as one leader put it: *"You cannot do everything yourself"*, and explained that a leader has either the time or the knowledge to do so:

> *"If you are going to succeed and not be tied to a table and chair just to carry on administrative tasks, then you depend on having a staff that makes that possible."*

The leaders emphasise that a collective effort is crucial to deliver quality patient care, as one leader said:

> *"It is the collective knowledge that matters, everyone works in a team, or should acknowledge that they work in a team. It is the collective knowledge which matters in relation to a patient, not your individual, your individual is, after all, just a tiny part of it."*

The participants described that it is the sum of all the contributors that will yield results and that the workplace consists of people with different strengths. They point out many factors are at play when it comes to making a group of people work as a team:

> *"You have to know the people you work with before you can make them work as a team."*

The leaders described that by knowing the people they worked with on a personal level, they were able to identify strengths in each individual and utilise them. One of the leaders said she often micromanaged team composition:

> *"I have an overview of the doctors, I know what capacity they have, I know what kind of competence they have, I know what kind of expertise they have, I know who is not suitable to work together and what will become a poor multidisciplinary team, so I manage that in detail."*

Since she knows her people on a personal level, she believes she is able to create a high-performing team. The participants told me that they trust that the employees organise the work themselves and even though they might micromanage team composition, they do not micromanage the activities. One leader said:

> *"Leadership is not about controlling everything. You are not supposed to be a control freak and get all the numbers to correspond with those who are above you. You should make sure the people in the system are doing well. I believe that if you make sure that the people you are working with are doing well, a lot of the other parameters will follow directly - it is just a matter of time."*

The participants pointed out that leaving room for jokes and talking about other things than work helped to create a good work environment. They highlighted that a good working environment was important to create productive workers:

> *"It is very important to create a good working environment. When people are happy, they do more, they are more creative in finding solutions."*

The leaders desired a pleasant environment where people work well together. They described trying to create a culture where people are not afraid to ask questions and can learn from each other as well as from their own experiences. One of the study participants pointed out that if you are always at the same place, things might become a routine: "*you continue doing things the same way you always have been, and it gets more difficult to see what should be done differently*". She suggested to stimulate the employees, as well as herself, intellectually through job training (in Norwegian: hospitering) in order to foster motivation and to make it easier to come up with new ideas:

“You have to stimulate the employees. If we are not able to figure something out, I am for job training, that applies to myself as well. I travelled all over Norway, spent my vacation time, and visited the departments. It is so important to see how others do things and take back the things they are doing well and to tell other departments what we do a little differently and see if there is something they can benefit from. [...] Even Europe, see how things are done outside Norway. We have to learn from each other.”

The participants believed that they should facilitate an environment where people can develop themselves and that leaders must do so too. One leader said:

“There must be continuous learning, and each day, I learn something new. When I come home, I ask myself ‘what did I learn today?’, ‘What did I do that I could have done better?’ Leaders also have to develop themselves”.

As described, the leaders I spoke with trusted their employees to organise the work themselves. The leaders were keen to be well acquainted with their employees and described trust as a part of being able to cooperate well. They felt that they had gained the trust of their followers in different ways, but all agreed on that trust is something that must be built and maintained. They believed that by being open and honest with their employees, they were able to create an environment where people dare to question already established working methods or bring up new ideas. They pointed out that trust is a time-consuming process and something that goes both ways - you must give it to get it. One of the leaders said:

“The people who work here know that there are some laws and regulations I adhere to if I need to, but that there is a lot of trust. A lot of what we do is based on trust - our working hours, courses, professional development, etc. I think they know that if they follow the rules and understand the game, they will gain trust in return. [...] I often talk about leadership and power, authoritarian power lasts for a short while. If you come in with stars and stripes on your shoulder it only lasts a while, but in the long run, power is more about personal power, reference power, how you talk to people, support people, and join them.”

4.4 Communication

I have written about how the leaders I spoke with emphasise teamwork. According to the study participants, open communication is crucial in order to make people work well together.

> *"For a leader, it is very important to have good communication both across, up and down in the organisation. People usually have good intentions, but sometimes that is not communicated. Having the ability to communicate is a very important part of leadership."*

The leaders believe that visions must be communicated in a motivating way and that discussions and different perspectives are essential to decision making, as one leader said:

> "When discussing things that will ultimately affect employees, it's a good idea to include the employees in those discussions."

The participants believe that feedback is important to-give, and, important to-get, to make their organisation run as smoothly as possible. As mentioned earlier, the leaders believe that the contact with their employees is vital in terms of getting feedback on things that do not work, so that they can direct their focus on change. The study participants describe trying to create a culture where people are not afraid to speak up, and one leader pointed out that in order to get feedback the system has to be designed in a way that makes that possible:

> *"You need to have some kind of system in place that gives you feedback on trends, system errors, and personal errors. You should not have informants, that is not what it is about, it is more that you have a system where people can report [...], and when you discover these system errors, you can then go in and do something about them immediately."*

The leaders I spoke with also highlighted the importance of giving feedback in order to encourage or correct. They described positive feedback as 'essential' in terms of motivation and negative feedback to be necessary in order to correct

undesirable actions or behaviours. They describe trying to be honest when giving feedback. One leader said:

> *"You have to give feedback, so people know if they are doing well or not. It is very important to give honest feedback. Sometimes that can be hard because you do not want to upset someone."*

The study participants admitted that giving negative feedback sometimes could be challenging. One of the female leaders said:

> *"I might sometimes shy away from conflicts, I dread having to engage in difficult conversations and I postpone them, [...] on the other side [...], I use time to prepare for the difficult conversations, and then I think I make fewer mistakes than I would otherwise do."*

Although she finds it difficult to give negative feedback and sometimes postpone engaging in difficult conversations, she also believes that it benefits her to "think things over". Another leader described having found a way to make it a little easier to deliver negative feedback:

> *"If someone does not deliver or do something that they are not supposed to, I will try to look for something he or she is doing well so that I can start a conversation telling them what has been done well and then continue with what is not working. I believe that if you confirm what people are doing well, then they know that you have seen it and then it is easier to give feedback on what is not as good."*

One of the study participants pointed out that although being able to communicate well with the employees is excellent, leaders also have to make sure that employees who work together or departments who have a lot to do with each other have the opportunity to do so too. This leader believes that it is the responsibility of a leader to facilitate an arena where these people or departments can come together and discuss things that can foster collaboration between them.

4.5 Motivating Others

Several leaders considered motivating and satisfying employees to be their main task. According to the participants, having motivated employees is a responsibility that comes with being a leader. They describe that motivating employees is necessary in order to get them to invest effort in their professional practice and organisation. They see themselves as role models for their employees and explain that they try to lead by example. One informant said:

> *"Leaders should be aware of their responsibilities. You have taken on the job as the leader, so you must take responsibility. It is important that you are a role model because everyone looks at you. I am used to working a lot. When people see that you work for the department and the patients, others will follow. If you are never present, how could you lead others?"*

They want to inspire people to work by "walk the talk". One study participant described multiple factors in play to get and to keep the employees motivated:

> *"It is about the goals we set for the department, what kind of patient groups we work with, the professional content of the assessment and treatment we provide. You have to be able to present it as an interesting field, establishing career paths, such as the opportunity for research, specialisation, and professional development. You have to create a sense of pride in coming to work."*

The leaders describe wanting employees to feel seen and to help the individual employee feel a sense of belonging and to know that they are a part of a community within the organisation. They give praise to show the employees that good efforts are recognised and try to promote an innovative and creative attitude within their employees. They believe they can boost creativity by creating room for reflection and encourage employees to think independently. They described an environment consisting of different people with different personalities. Two of the leaders explain that the individual differences were something that they had to consider when trying to motivate or support and that it was important to have an understanding of how to meet each employee. One leader pointed out that if you can

identify someone's incentives, whether that is the opportunity to attend congresses or courses, money or leisure time, it is easier to give the support they need and keep the employees motivated.

The leaders also brought up that many employees were resistant to change. One of the female leaders said:

> *"People don't like change. I explain that we must make changes if something is not working. I tell them that we must find a new way of doing things and that we do not know if the new alternative is good or not, but that we must try and then we will evaluate. We evaluate, depending on the case, but maybe after a year and if it has not worked, then we have to find another solution or go back towards the old way. [...] and then people want to join, if it doesn't work, we won't continue, and we can make adjustments along the way."*

She described that an important step in the change processes is to create a common understanding of the need for change, to create meaning, and to evaluate. Later she added that there is to be too little time set aside for evaluation in the Norwegian hospital setting. She believes it is important to gather everyone together and discuss if a new way of doing something made it better or if they must try something else, and believes evaluations make people more positive towards changes. Two other participants pointed out that older employees were more resistant to change than younger employees. As one leader put it:

> *"Automatically, there comes some flexibility with younger doctors. Senior doctors who have been in the system for 30-40 years are starting to get a little tired, they have seen all kinds of bullshit throughout their lives and are not taking it as quickly. [...] they've heard it before and haven't seen any results, so we have to convince them."*

The informants admitted that they spent a lot of time convincing people, telling people why things should be done differently, and trying to motivate them towards new goals. Some leaders found it challenging to convince and motivate employees, and described having section managers, unit managers and employees working on remote locations.

“You are completely dependent on the managers below you, that they are doing their job and that they are able to pass on to the employee. I find it difficult [...] I noticed that sometimes the goals, or what the department or clinic want to achieve is not communicated quite correctly. It may not be communicated in a motivating way. They can just say that it is I who have decided. I have to be honest, as a leader, I am not so fond of distance management, leading employees from a remote location. I like to be very close to the employees, where they feel seen and feel that I appreciate them. If someone says they cannot do something, you can just ask a question - can we do it differently? Do you think we can change this? Then you manage to motivate new thinking. If we just do something because it has always been done that way, we won't get better.”

The study participants expressed that some leaders could be challenging to work with, and believed some leaders were too protected by the structure of the public sector. They also addressed other limitations with the public sector. One participant said:

“It is much easier to replace people in the private sector, there is a lot of protection in the public sector. You have to make a lot of mistakes before you can get fired, so people stay. Another thing is, that even if you are the head of the department, you do not sit with much authority. It is the hospital that decides - budget, everything. Sometimes you think to yourself that if we just invested a little more, we could have improved a lot, but you can't because you don't have the budget for it.”

5 Discussion

This chapter covers a review of the main findings, which links the findings to the theoretical frameworks (chapter 2). To acquire a greater understanding of the findings presented, some additional literature is introduced, as well as methodological considerations.

The results show that the award-winning leaders share similar characteristics and have a similar leadership style. Although there were individual differences, there were repeating patterns in how the participants got into management, what they focused on, and which influence strategies they used.

5.1 The Leaders' Use of Transformational Leadership

The leaders interviewed have no formal management education and have still been able to show great results. As described, each study participant has received an award for their leadership because they, in a jury's point of view, have been able to demonstrate excellent management towards both financial and professional goals (Baugstø, 2019). They have been nominated to the award by their employees, which is an evident indication that employees are satisfied with the job these leaders do.

In the theory section, the theory of transformational leadership was introduced. According to Bass (1985), the employees of transformational leaders trust, admire, respect and are loyal to their leaders, and they are even motivated to do more than what is expected. I sought to examine whether the participants' success in their roles as clinical managers was characterised by transformational leadership. As explained, there are four components to this style of leadership (the four I's); idealised influence, inspirational motivation, intellectual stimulation and individual consideration. Transformational leaders tend to use one or more of these, and the findings revealed both behaviours and characteristics which can be classified as transformational. The participants in this study appear to embody several, if not all, components of transformational leadership.

The results show that the leaders seem to focus particularly on the factor of intellectual stimulation; they describe wanting to challenge the status quo; they explore different perspectives; they invite employees into discussions and decision-making, and believe it is vital to do so in order to make the right decisions. Moreover, the leaders encourage their employees to engage in non-traditional thinking and promote creativity (Bass & Riggio, 2006). Ideally, these focus areas generate an environment where innovation thrives and where employees, as well as themselves, can grow.

According to Hughes (2014), intellectual stimulation is a factor of transformational leadership which is "engrained naturally within the social sector because employees are often attracted to certain non-profits because they are cognizant of the direct impact they can make" (p.9). Kao (2015) points out that healthcare professionals are driven by more than extrinsic motivation; they like helping and want to do *the right thing*. By stimulating the employees intellectually, the leaders in this study appear to foster intrinsic motivation. This fits well with self-determination theory (Ryan & Deci, 2000), which claims humans are inherently directed towards activities that satisfy basic psychological needs (e.g. the need for competence). Consequently, the actions taken by leaders who consider these psychological needs facilitate intrinsic motivation.

Kanter's (1977) theory of structural power highlights people's desire to improve their expertise. Structural power refers to an individual's ability to access and mobilise information (e.g. knowledge and expertise), resources (e.g. supplies, personnel, and funding), and support (e.g. guidance and feedback) from his or her position within the organisation. Kanter claims that individuals will act differently depending on whether certain structural elements related to power and growth opportunities are in place. He argues that people who do not have access to structural power and growth opportunities (e.g. opportunity to improve skills and expand knowledge), will experience feelings of isolation and frustration and consequently be less committed to the organisation.

The study participants are passionate about helping their discipline develop, and believe that motivated employees are necessary in order to reach their goals. Several leaders consider motivated and satisfied employees to be their main task

and describe that motivated employees invest effort into the professional practice and the organisation. The leaders point out that establishing career paths, such as the opportunity for research, specialisation, and professional development, is their responsibility, and that giving the employees the opportunity to attend courses and congresses help to keep them motivated. The leaders interviewed described a desire to facilitate a culture where people could learn from each other, as well as from their own experiences. Furthermore, several leaders pointed out that answers to problems can be found through cooperation inside the organisation as well as outside (e.g. through job training).

A study by Smothers and his colleagues (2016) on the role of intellectual stimulation in the supervisor-employee relationship in a healthcare setting has been conducted. One of their conclusions was that "followers who communicate openly with their supervisor will feel more empowered, but only if they experience high intellectual stimulation which can improve their job performance and patient safety overall" (p. 479). Although their study investigated the relationship between nurses and their leaders, I believe that their findings apply to medical practitioners and their leaders as well. Smothers and his colleagues' results seem to correlate with the study participants' belief about the importance of good communication and continuous learning to keep employees motivated to work towards improved patient care and patient safety.

As previously introduced, Richards and Engle's (1986) definition of leadership states that "Leadership is about articulating visions, embodying values and creating the environment within which things can be accomplished" (p.206). This definition fits well with the four components of transformational leadership and correlates with how the participants view leadership and their role as leaders. Although their main focus seems to lay on intellectual stimulations, the leaders also utilise other factors of transformational leadership. Findings show that the study participants had a relatively large focus on vision as several leaders describe using the vision as a guideline and in communication with followers to motivate. They portray themselves as enthusiastic, describe speaking optimistic about the future and admit spending a lot of time trying to create meaning and convincing their followers why changes are to be made. These aspects characterise inspirational motivation (Bass & Riggio,

2006). The challenges facing healthcare organisations are many and complex, by embodying inspirational motivation, the leaders seem to foster motivation and thus maintain optimism.

The study participants see themselves as role models for their employees as they describe leading by example, showing up and displaying determination and high work ethic. They express trust in followers and emphasise transparency and honesty. They also describe wanting to appear welcoming and hard-working and encourage their employees to behave the same. According to Bass and Avolio (1997), these aspects describe someone who possesses idealised influence. Glasø and Thompson (2013) note that idealised influential leaders are driven by more than self-interest. This correlates with my findings as well as the participants describe wanting to "do the right thing", and are committed to having ethically sound operations. They have an inner drive to change, improve and create a better future for patients and staff, and are motivated to help both employees and clinical field to develop.

The last component of transformational leadership is individual consideration, and several of the participants could be characterised as individually considerate leaders. The leaders interviewed recognises, and accept, that people are different and describe that they are keen to be well acquainted with each individual in order to understand their needs, identify their strengths and to have an open line of communication. They practise "management by walking around" and show a willingness to engage in dialogue (Bass & Riggio, 2006).

5.2 The Leaders' Use of Power Bases

Northouse's (2010) definition of power, is "the ability to affect others' beliefs, attitudes, and courses of action" (p. 7). Due to the scope of the thesis, I chose to focus on which strategies each leader, 'the agent', uses to influence their followers, 'the target'. Findings revealed that the leaders in this study appear to influence their employees by drawing on personal power, rather than power through their formal authority as managers. This correlates with Yukl's (2013) findings which suggest that effective leaders tend to rely on personal power rather than position power. This is

because these power bases might be more likely to produce the commitment and compliance a leader seeks from followers. As noted in the theory section, personal power is the types of power a leader can access regardless of their managerial position and includes referent and expert power. Leaders who influence their followers because they have charisma, a great relationship with their followers or people who look up to them have referent power. People with high-level education, such as the participants in this study, have expert power because they have skills, experience, and knowledge others would like to access.

As described, my findings revealed that the study participants utilise transformational leadership and especially the component of intellectual stimulation. Since power resides with expertise through knowledge and skills in hospitals (Mintzberg, 1979), professionals naturally want to develop skills and increase their knowledge. The study participants emphasise the importance of motivated employees and seem to draw on power bases that can enlighten intrinsic motivation in their employees.

They describe using their background to influence and create a commitment to goals. They express a belief that by incorporating their clinical knowledge and experiences from working together with the front-line staff have helped them to gain trust, respect, credibility, and support for their views. Although participants described engaging little, or not at all, in clinical work themselves, they point out that indirect patient care through discussions and consultations is a daily matter. The leaders sought to be professional role models (e.g. consult surgeons). They have access to expert power, and because employees appear to seek that expertise, it seems like the leaders tend to use this power base. However, the leaders also appeared to use referent power. This involves that they want to be role models in a more general term (e.g. display high work ethic). They describe being there for their employees, going in difficult situations for them and thereby facilitating growth. Referent power is about likability; people follow those who use this power base because they want to (Yukl, 2013). Doing something because it is enjoyable in itself is described as intrinsic motivation (Ryan & Deci, 2000).

In the theory section, I mentioned that there is a lack of research on the concept of power in a healthcare setting. The participants in this study are formal

managers, meaning that they do have access to position power. My impression is that they do not appear to rely much on position power, and I would suggest future research to examine the reasons behind this observation. A couple of the leaders I interviewed expressed that they felt restricted by the system, and that being a leader in the public sector did not give them much autonomy to take own decisions - everything had to go through higher-level management. This suggests that position power might be harder to access. In addition, Mintzberg (1984, p. 211) argues that highly trained and mobile professionals are more loyal towards their own professions than to their organisation. Since expertise is tied to the profession, it might suggest that study participants draw on expert power to maintain their status and position in the professional hierarchy.

5.3 Implications for Leadership Development and Training in Healthcare

Increasing expectations towards effectiveness and quality of care have led to a growing interest in recruiting clinicians to management positions in healthcare in order to control costs and resource use (Fulop & Day, 2010; McKimm & Swanwick, 2011; Neogy & Kirkpatrick, 2009). As described, there are multiple positive effects of utilising transformational leadership. Findings in this study imply that it can be a useful style of leadership in the healthcare context and that it might be worth implement this style of leadership in leadership development and training.

According to the literature, transformational leadership can be taught and learned (Bass & Riggio, 2006, p. 134). To some people, this style of leadership seems to come more natural than it does to others. Glasø and Thompson (2013, p. 115) point out that research suggests that individual differences (e.g. personality, abilities, genetics) have an impact on transformational leadership and that these should be taken into account when developing leaders. To what degree these individual differences influence the leadership style is uncertain due to, among other things, the methods used in previous studies exploring the concept. However, Glasø and Thompson point out that research implies that women may seem to have an advantage in mastering transformational leadership. That does not mean that men,

or people who lack the “optimal” composition of success criteria, cannot become proficient transformational leaders, but rather that they might have to put in a more significant effort to achieve it.

It could be useful to give young leaders training in transformational leadership. Learning about the style of transformational leadership might be different compared to how it is experienced in practice. To get the best result from leadership training I suggest to give young leaders the ability to follow proficient leaders for a few days so they can see, and then reflect upon, how these leaders act and how these actions affect those around. I perceived the leaders I spoke to as self-reflective individuals, they know what strengths they have, but they also realise that there are things others can do better than themselves. They describe being dependent on the people they work with, delegating tasks and responsibility to colleagues and trusting their decisions and ways of completing the tasks. This implies that an essential prerequisite for succeeding with leadership is characterised by relationships based on trust. I believe the ability to reflect critically on oneself, identifying one's own strengths and weaknesses, followed by finding ways to improve, should be implemented to the leadership training. This supports Blumenthal and his colleagues’ (2012) suggestion that residency training programs should teach non-traditional skills, such as self-reflection and self-awareness. To be aware of how one act and how this affects those around could help developing good team players, and consequently help people earn the trust of team members.

5.4 Methodological Considerations

5.4.1 Reflexivity

Human aspects influence the research process and are something the researcher has to take into account (Finlay & Gough, 2003). Reflexivity is about acknowledging and understanding your preconceptions and features and how this can affect the research. Researchers cannot isolate their own backgrounds and interests from the conduct of a study. One always has expectations for the research, and it is vital to contemplate oneself, and the decision one makes throughout the process (Malterud, 2011, pp. 18-19). Being honest and transparent about one’s own

subjectivities allow the readers to draw their own conclusions about the interpretations that are presented through the research (Austin & Sutton, 2014, p. 437). Because I had read leadership literature and done research on the participants prior to the interviews, I had some thoughts on what might show up. I knew the concept of reflexivity and reflected on own presuppositions in the interviews, as suggested by Kvale (1996, p. 33), and sought that results would be based on data and not my personal thoughts.

Kuper, Lingard, and Levinson (2008) point out that the power balance between interviewer and interviewee might shape the data being collected. Kvale (1996) argues that since the interviewer defines the situation by introducing topics and asking questions, there is an asymmetry of power that could lead to a reduced level of trust and openness. As described, the study participants do not have any formal management education. I, on the other hand, will soon have a master's degree in health management. However, I do not have any experience of working in healthcare, and neither was I invested in any particular outcome of the study. Not being associated with a particular profession might have legitimated the fact that I was not invested in any specific outcome, and I believe it helped me to create a safe space where participants could discuss their work freely. I made sure to be open with the participants from the beginning. I presented myself as a master's student collecting data for a master's thesis, I explained the aim of the study and told the participants that their accounts and experiences could be helpful to gain a better understanding of what it takes to be a successful leader in the context of healthcare management. Although we had different levels of power, I do not think they perceived me as an "inferior".

5.4.2 Internal Validity

Internal validity is described by Kvale (1996) as "the degree that a method investigates what it is intended to investigate" (p. 238). It is about whether the method and findings provide a representative view of reality in accordance with the research aim. Several strategies were used to improve validity. As described in chapter 3, I concluded that a qualitative approach using semi-structured interviews would best serve the thesis. I interviewed both female and male leaders and

interviewed a jury member from the Norwegian Medical Association as part of the preparations. I avoided leading questions and study participants gave answers that illuminated the research aim. As described above, I reflected on my biases and predispositions and how they might have influenced the research process and conclusions. I also discussed ideas, methods and results with my supervisor, who gave me a different perspective on things and helped me establish a greater sense of reliability within my findings.

People will often try to present themselves in the best way possible to an interviewer. Mathison (1988) suggest combining multiple research methods to increase validity. Observations could have had confirmed the accounts given in interviews. Limited time and restrictions the COVID-19 pandemic created made this difficult. Although observations, or interviews with the study participants' employees, could have exposed if there was a gap between how the leaders portrayed themselves and reality, I will argue that the leaders are highly credible. They have been nominated to the leadership award by their employees, and the jury member I spoke to confirmed that these leaders were worthy of the prize.

I found repeating patterns in the interviews, but I will still argue that saturation was not met. Data saturation is when the researcher think new inputs will not lead to further enlightenment (Malterud, 2011, p. 60). As described earlier, the recruitment process was impacted by the pandemic. It is also safe to say that there are not many award-winners to recruit since these awards only get handed out once a year. Malterud (2011) argues that the adequate number of participants in qualitative research depends on several factors, and it is not “the more, the merrier”, as the aim is an in-depth and thorough analysis (p. 59). I would still have prefered to interview some more award-winners to gain an even deeper understanding.

In retrospect, I believe that narrowing the aim of the study and, for example, focused on how the leaders communicate or how they motivate would have helped uncover some aspects that this study was not able to. On the other hand, by having a broader focus, I believe I was able to discover some unexpected interrelated aspects of leadership.

5.4.3 External Validity

I conducted this study in a Norwegian hospital setting, but I believe the findings can be transferable to other settings as well. My results correspond with research on transformational leadership and the participants in this study personify several, if not all, components of transformational leadership. The jury selected the leaders I interviewed based on similar conditions to other recipients of these leadership awards, suggesting that other proficient leaders share some of the same traits, and have a similar leadership style. Spehar (2014) points out that “even if the management structure in healthcare differs across countries, doctors share a similar base of knowledge and enjoy a similar status in society” (p. 54). That suggests that medical practitioners who are regarded as good managers will draw on the same power bases to influence regardless of country.

5.4.4 Ethical Considerations

The participants received an e-mail with an attached consent form (appendix II) containing information about the project and their rights as a participant prior to the interview. They were also informed that the project was approved by Norwegian Social Science Data Services (NSD)(appendix III) and that participation was voluntary. The participants received thorough information about the project and the purpose of the study before I conducted the interview. I pointed out to them that I had chosen award-winners from recent years who had received their price from either The Norwegian Medical Association or Akershus University Hospital, and that due to this, readers might be able to figure out who participated. I told them that I would do my best to ensure that no statements could disclose their anonymity, and have presented the participant and result in careful manners to do so. I described to the participants that the information they gave would be handled strictly confidential, and that only my supervisor and I would have access to the collected data. I explained that audio recordings would be deleted after transcription had been completed and that consent letters were stored separately from transcriptions. Written consent was ensured before I began the interviews.

6 Conclusion

The overall aim of this study was to explore the leadership behaviours and characteristics of award-winning leaders in healthcare. The results of this study indicate that transformational leadership might be an effective strategy to employ in a healthcare context. By facilitating growth and self-development, the participants of this study appear to have created a base of followers driven by intrinsic motivation and consequently raised the level of achievement in their respective department.

The study participants provided me with a deeper understanding of leadership in healthcare, and it could be interesting to observe them for some time to see if they display leadership behaviours and characteristics that the interviews were not able to cover. There are limitations related to the single-source (self-report) design (Mathison, 1988), and an observational study could uncover if there is a correlation between what the leaders say they do and what they actually do.

The participants in this study seem to influence followers by drawing on personal power, rather than using their formal authority as managers. Future studies could investigate if there are cultural differences related to the use of power. A study conducted by Nelson and Shavitt (2002) examined cultural conducts in Denmark and the United States to see if achievements and related values were viewed differently. Their findings suggest that American culture embraces the importance of “being the best” (p. 448) and that Americans are likely to communicate, share and display their success, while the Danish culture instead emphasises “an equality that is reinforced through prevailing social codes and social and economic institutions” (p. 447). Nelson and Shavitt argue that an unwritten social modesty code, the Law of Jante (in Norwegian: janteloven), influences behaviours and attitudes in Nordic countries. The Law of Jante is derived from a 1933 novel by Aksel Sandemose, and includes 10 rules where the essence is that *you are not supposed to think that you are special or better than someone else*. The Law of Jante is weaved throughout the behaviours and principles of Scandinavians, and Nelson and Shavitt argue that this has created norms against showcasing or boasting oneself. A study comparing leaders in Norway to leaders in a country where there is more hierarchy between managers

and employees (e.g. the United States) could examine if the use of position power is more prevalent in a country where managers and employees are less egalitarian.

The relationship between transformational leaders and power could also be further explored; it could be interesting to examine if it is possible to "strengthen" or "weaken" the degree of transformational leadership by using certain types of power.

Research on transformational leadership theory suggests that the style of leadership has few drawbacks and that it is applicable to nearly every situation and organisation (Glasø & Thompson, 2013). This might cast a shadow on other styles of leadership, making us ignore and discredit the value of these. The theory of 'servant leadership' proposed by Robert Greenleaf (1970) could be interesting to examine in a healthcare setting since, as its name implies, servant leadership is about serving others. Servant leaders share similar perspectives as transformational leaders. The servant leadership theory is people-oriented, involve elements of respect, trust, delegation, vision, and influence on followers (Lynch, 2012), and the results of this study indicate that all these elements are important for leadership effectiveness.

I will also recommend future researchers to explore questions related to gender. Important questions to consider are whether there are differences in how proficient female and male leaders in the healthcare system lead and whether expectations to female and male leaders differ.

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Appendix

Appendix I: Interview Guide for One-to-One Interviews (in Norwegian)

Appendix II: Consent Form (in Norwegian)

Appendix III: NSD Approval (in Norwegian)

Appendix I: Interview Guide for One-to-One Interviews (in Norwegian)

Generelt

- Hvordan/hvorfor ble du leder? *Tilfeldig? Noe du alltid har ønsket?*
- Hvor mange er du leder for? *Nå og da du vant lederprisen*
- Hvordan definerer du ledelse? *Hva er ledelse for deg?*
- Hva er dine viktigste oppgaver som leder?

Lederstil og egenskaper

- Hva har du tidligere jobbet med/som? Hjelper den bakgrunnen deg i den posisjonen du har nå? På hvilken måte?
- Hvordan vil du beskrive din egen lederstil? Har du noen eksempler på situasjoner der din lederstil kommer frem?
- Har du jobbet som leder i ulike avdelinger? Tror du det er noe som skiller ledelse på dette fagområdet/ i disse avdelingene fra andre i helsevesenet?
- Hvilke personlige egenskaper vektlegger du spesielt? Hvorfor synes du disse egenskapene er viktig? *Både hos deg selv og hos ansatte*

Kommunikasjon, visjon

- Hvordan kommuniserer du med dine medarbeidere?
- Prater du optimistisk om fremtiden? Synes du dette er viktig?
- Hvilken visjon har du for din avdeling? Fremmer du visjonen ofte? (*Prater mye om det du tror på/verdier*) Hvordan kan du være rollemodell i så måte? *Leve og handle etter visjonen osv.*

Motivasjon og intellektuell stimulering

- Hvordan motiverer du dine ansatte? Hvordan gir du dem tilbakemeldinger?
- Hvor viktig er det å være kreativ og nytenkende, og hvordan arbeider du med dette? *Ny teknologi, nye metoder, organisering etc.*
- Hvordan utfordrer du dine medarbeidere med tanke på oppgaveløsning?

Støtte

- Hvordan forsøker du veilede den enkelte medarbeider?
- Hvor viktig er det at det er tillit mellom deg og den enkelte medarbeider? Hvordan bygger du denne tilliten?

Utfordringer

- Uten å nevne navn, kan du fortelle om en konflikt du har vært involvert i, og hvordan du håndterte den?
- Føler du det ligger begrensninger ved å lede i offentlig sektor? Noen fordeler? *Rammer, betingelser, byråkrati, politisk styring etc*

Selvutvikling

- Er det noe du gjør annerledes som leder nå, sammenlignet med da du var ny i lederrollen?
- Er det noe du skulle ønske du var bedre på, og hvorfor?
- Hva gjør du for å bli en bedre leder? *(Delta på kurs, lese bøker om ledelse etc.)* Og fikk du noe lederopplæring før du inntok din stilling?

Hvilke tips ville du gitt en fremtidig leder?

Er det noe mer du eventuelt vil legge til?

Appendix II: Consent Form (in Norwegian)

Forespørsel om å delta i forskningsprosjektet

"*Leadership in Healthcare*

- A Qualitative Study of Award-Winning Leaders"

Dette er et spørsmål til deg om å delta i et forskningsprosjekt hvor formålet er å studere god ledelse i helsevesenet. I dette skrivet gir vi deg informasjon om målene for prosjektet og hva deltakelse vil innebære for deg.

Formål

Jeg er masterstudent ved Universitetet i Oslo og skal gjennomføre et forskningsprosjekt. Veileder på prosjektet er Ivan Spehar, førsteamanuensis ved Universitetet i Oslo.

Hvem er ansvarlig for forskningsprosjektet?

Universitetet i Oslo

Hvorfor får du spørsmål om å delta?

Du er blitt valgt til å delta i dette forskningsprosjektet på bakgrunn av at du har en leder som har mottatt en lederpris.

Hva innebærer det for deg å delta?

Deltagelse i et masterprosjekt innebærer at du vil bli intervjuet i ca. én time. Intervjuene vil bli gjennomført av masterstudent Tonje Skog Flathus, og vil være en åpen dialog med særleg fokus på din opplevelse av å være leder. Det vil bli benyttet båndopptaker til opptak av intervju, som kun masterstudenten Tonje Skog Flathus vil ha tilgang til. Masterprosjektet er underlagt taushetsplikt og alle opplysninger blir behandlet konfidensielt.

Det er frivillig å delta

Det er frivillig å delta i prosjektet. Hvis du velger å delta, kan du når som helst trekke samtykke tilbake uten å oppgi noen grunn. Alle opplysninger om deg vil da bli anonymisert. Det vil ikke ha noen negative konsekvenser for deg hvis du ikke vil delta eller senere velger å trekke deg.

Ditt personvern – hvordan vi oppbevarer og bruker dine opplysninger

Vi vil kun bruke opplysningene om deg til formålene vi har fortalt om i dette skrivet. Vi behandler opplysningene konfidensielt og i samsvar med personvernregelverket. Det er bare veileder og masterstudent som vil ha tilgang til resultatene.

Hva skjer med opplysningene dine når vi avslutter forskningsprosjektet?

Prosjektet skal etter planen avsluttes 15.12.2020. Lydfiler fra båndopptaker vil overføres til passordbeskyttet PC og slettes ved prosjektets slutt, senest 15.12.2020.

Dine rettigheter

Så lenge du kan identifiseres i datamaterialet, har du rett til:

- innsyn i hvilke personopplysninger som er registrert om deg,

- å få rettet personopplysninger om deg,
- få slettet personopplysninger om deg,
- få utlevert en kopi av dine personopplysninger (dataportabilitet), og
- å sende klage til personvernombudet eller Datatilsynet om behandlingen av dine personopplysninger.

Hva gir oss rett til å behandle personopplysninger om deg?
Vi behandler opplysninger om deg basert på ditt samtykke.

På oppdrag fra Universitetet i Oslo har NSD – Norsk senter for forskningsdata AS vurdert at behandlingen av personopplysninger i dette prosjektet er i samsvar med personvernregelverket.

Hvor kan jeg finne ut mer?
Hvis du har spørsmål til studien, eller ønsker å benytte deg av dine rettigheter, ta kontakt med:

- *Ivan Spehar, førsteamanuensis. E-post: ivan.spehar@medisin.uio.no, tlf: 976 08 146*
- *Tonje Skog Flathus, masterstudent. E-post: t.s.flathus@studmed.uio.no, Tlf: 930 22 913*
- *NSD – Norsk senter for forskningsdata AS. E-post: personvernombudet@nsd.no, tlf: 55 58 21 17*

Med vennlig hilsen

Ivan Spehar
Prosjektansvarlig
Veileder

Tonje Skog Flathus
Masterstudent

Samtykkeerklæring

Jeg har mottatt og forstått informasjon om prosjektet, og har fått anledning til å stille spørsmål. Jeg samtykker til delta i intervju, og at mine opplysninger behandlet frem til prosjektet er avsluttet, 15.12.2020.

Jeg samtykker til at mine opplysninger behandles frem til prosjektet er avsluttet, 15.12.2020.

Signatur prosjektdeltaker, dato

Appendix III: NSD Approval (in Norwegian)

NSD NORSK SENTER FOR FORSKNINGSDATA

NSD sin vurdering

Prosjekttittel

Leadership in Healthcare - A Qualitative Study of Award Winning Leaders

Referansenummer

901384

Registrert

19.01.2020 av Tonje Skog Flathus - tonjesfl@uio.no

Behandlingsansvarlig institusjon

Universitetet i Oslo / Det medisinske fakultet / Institutt for helse og samfunn

Prosjektansvarlig (vitenskapelig ansatt/veileder eller stipendiat)

Ivan Spehar, ivan.spehar@medisin.uio.no, tlf: 97608146

Type prosjekt

Studentprosjekt, masterstudium

Kontaktinformasjon, student

Tonje Skog Flathus, t.s.flathus@studmed.uio.no, tlf: 004793022913

Prosjektperiode

01.09.2019 - 15.12.2020

Status

10.02.2020 - Vurdert

Vurdering (1)

10.02.2020 - Vurdert

Det er vår vurdering at behandlingen av personopplysninger i prosjektet vil være i samsvar med personvernlovgivningen så fremt den gjennomføres i tråd med det som er dokumentert i meldeskjemaet den 10.2.2020 med vedlegg, samt i meldingsdialogen mellom innmelder og NSD. Behandlingen kan

starte.

MELD VESENTLIGE ENDRINGER
Dersom det skjer vesentlige endringer i behandlingen av personopplysninger, kan det være nødvendig å melde dette til NSD ved å oppdatere meldeskjemaet. Før du melder inn en endring, oppfordrer vi deg til å lese om hvilke type endringer det er nødvendig å melde:
https://nsd.no/personvernombud/meld_prosjekt/meld_endringer.html

Du må vente på svar fra NSD før endringen gjennomføres.

TYPE OPPLYSNINGER OG VARIGHET
Prosjektet vil behandle alminnelige kategorier av personopplysninger frem til 15.12.2020. Prisvinnere vil kunne identifiseres i oppgave/publikasjon i kraft av sin stilling. De vil bli informert om dette før de samtykker til deltakelse.

LOVLIG GRUNNLAG
Prosjektet vil innhente samtykke fra de registrerte til behandlingen av personopplysninger. Vår vurdering er at prosjektet legger opp til et samtykke i samsvar med kravene i art. 4 og 7, ved at det er en frivillig, spesifikk, informert og utvetydig bekreftelse som kan dokumenteres, og som den registrerte kan trekke tilbake. Lovlig grunnlag for behandlingen vil dermed være den registrertes samtykke, jf. personvernforordningen art. 6 nr. 1 bokstav a.

PERSONVERNPRINSIPPER
NSD vurderer at den planlagte behandlingen av personopplysninger vil følge prinsippene i personvernforordningen om:

- lovlighet, rettferdighet og åpenhet (art. 5.1 a), ved at de registrerte får tilfredsstillende informasjon om og samtykker til behandlingen
- formålsbegrensning (art. 5.1 b), ved at personopplysninger samles inn for spesifikke, uttrykkelig angitte og berettigede formål, og ikke viderebehandles til nye uforenlige formål
- dataminimering (art. 5.1 c), ved at det kun behandles opplysninger som er adekvate, relevante og nødvendige for formålet med prosjektet
- lagringsbegrensning (art. 5.1 e), ved at personopplysningene ikke lagres lengre enn nødvendig for å oppfylle formålet

DE REGISTRERTES RETTIGHETER
Så lenge de registrerte kan identifiseres i datamaterialet vil de ha følgende rettigheter: åpenhet (art. 12), informasjon (art. 13), innsyn (art. 15), retting (art. 16), sletting (art. 17), begrensning (art. 18), underretning (art. 19), dataportabilitet (art. 20).

NSD vurderer at informasjonen som de registrerte vil motta oppfyller lovens krav til form og innhold, jf. art. 12.1 og art. 13.

Vi minner om at hvis en registrert tar kontakt om sine rettigheter, har behandlingsansvarlig institusjon plikt til å svare innen en måned.

FØLG DIN INSTITUSJONS RETNINGSLINJER
NSD legger til grunn at behandlingen oppfyller kravene i personvernforordningen om riktighet (art. 5.1 d), integritet og konfidensialitet (art. 5.1. f) og sikkerhet (art. 32).

For å forsikre dere om at kravene oppfylles, må dere følge interne retningslinjer og eventuelt rådføre dere med behandlingsansvarlig institusjon.

OPPFØLGING AV PROSJEKTET
NSD vil følge opp ved planlagt avslutning for å avklare om behandlingen av personopplysningene er avsluttet.

Lykke til med prosjektet!

Kontaktperson hos NSD: Lisa Lie Bjordal
Tlf. Personverntjenester: 55 58 21 17 (tast 1)