Power relations between managers and politicians: The resign of managers in conjunction with university hospital mergers

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Abstract
The purpose of this article was to analyse how power relations drive hospital managers to resign in conjunction with three university hospital mergers in Sweden. Interviews were carried out with leading politicians and managers during two studies of mergers. In a third study, a paraphrased text from a previous study was used. Discourse analysis of the interviews revealed power struggles between politicians and managers, leading to situations of distrust. As the merger processes were additionally perceived to entail negative consequences for the patients and staff in the mass media the managers' positions were undermined and they were in all the cases forced to resign by politicians. By using the notions of power relations and subjectification this power mechanism worked was analysed. Three themes emerged from the analysis; collision between values, displacement of responsibility and the resign of the manager. When leading politicians built alliances with leading professions in criticizing the hospital manager publicly, the manager lost trust.

Introduction

In Swedish public healthcare, the position of hospital manager is governed by assignments decided on by politicians. Previously it was regulated in Swedish law. This position itself seems vulnerable in connection with radical changes such as hospital mergers (McNulty & Ferlie 2004, Choi et al. 2011).

Healthcare management is hardly characterized by trustful relations either concerning the relation between management and professionals or between managers and the political board, rather there seems to be distrust between leading actors in healthcare (Bazzoli et al. 2002, Ackroyd et al. 2007). Managers are expected to use hospital mergers to implement radical organizational change, which seems to be problematic because distrust between managers and professions is a challenge in conjunction with hospital mergers (Choi 2011, p. 46). Another problematic relationship, which is focused in this article, related to hospital mergers is the board-manager one (Alexander et al. 1993). Distrustful relations between leading actors mean that management has a low degree of control over the merger process, and that the achieving of merger goals often fails (Bazzoli et al. 2002, Bringselius 2012).

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In previous research into hospital mergers Alexander et al. (1993) consider leadership instability as a long-term characteristic of hospitals. Tollgerdt-Andersson (1995) discusses leadership and trust in politically controlled county councils in Sweden. The university hospital's social structure is characterized by different role expectations on the hospital manager, and by conflicts that may give rise to a feeling of an impossible task (Grünberg 1996). Hallin (2002) studies how leadership in a merged university hospital was established. He shows how different political cultures and different values among the employees have an impact on how leadership is established and to a certain extent destroyed. One norm is that the hospital manager has to keep the budget frame in the meaning to show that he has control. Otherwise the manager will lose his mandate to act in a powerful way (ibid. p. 154-155).

The work of the top manager in conjunction with the post-merger process of a university hospital is analyzed by Choi et al. (2011). Nordgren (2012) shows how the hospital manager was 'consumed' during mergers of hospitals in Sweden. According to Öhrming (2008, p. 150) top managers in hospitals in Sweden tend to come and go. While there has been done research on the relations between the professions and managers no research focuses on how the power relations between hospital managers and the politicians works, especially the board-manager one, in conjunction with hospital mergers.

One theoretical way of understanding how power is exercised is to use the Foucauldian notions of discourse, power relations and subjectification (see the section of theoretical perspectives). The study of discourses and power relations is relevant to the field of management research (Chia 2000, Grant & Hardy 2004, O 'Reilly & Reed 2011). The purpose of this study is to come to an understanding of how power relations according to Foucault work between the leading politicians and hospital managers, in conjunction with hospital mergers. The research question reads: How do power relations between hospital managers and leading politicians induce managers to resign in conjunction with university hospital mergers?

Method

Three mergers of Swedish public university hospitals were carried out between 1997 and 2011.[1] One of them took place 1997, one in 2004 and the third in 2010. These three mergers are discussed in this article. In that aspect this study is comprehensive. Using a qualitative approach based on discourse analysis, studies were carried out of two of these university hospital mergers in Sweden. In order to make the studies comprehensive concerning the three mergers of university hospitals in Sweden in addition a paraphrased text from a previous study of a politically-controlled university hospital merger in Sweden was used. In order to achieve a good validity of the study open-ended interviews with managers and leading politicians were conducted and supplemented by a document studies. Observations were inappropriate to do because the studies involved a historical process. The respondents showed no problems in understanding and answering

the questions. The author had the opportunity to ask follow-up questions to get explanations for certain statements.

In studies 1 and 2, the leading actors' (the political representatives of the owner and the responsible managers) accounts were collected via deep interviews based on semi-structured questions. Each interview took about two hours each to complete. The aim was to obtain statements (narratives) concerning their experience of the mergers in order to be able to do discourse analysis on these statements. Based on taken notes from the interviews, which were done by the author, the material was written down by the author for each merger immediately after the interview. The interviews were compiled, processed in several laps and anonymized. They were then processed into one cohesive story for each case, which is presented in this study. Material which was not in line with the purpose of the study was not included in the story (Silverman 2001). In a study based on discourse analysis it is important that the material is rich in qualitative terms with a focus on statements. Therefore there was a focus on analyzing statements in this study.

- In study 1, the hospital manager and his political chairman were interviewed. These interviews were done in 1998.
- In study 2, the regional director, who was comprehensively responsible for managing the merger and his political chairman, were interviewed. It was not possible to interview the hospital manager, who was indisposed for an interview. These interviews were done in the summer of 2012.
- In study 3 a paraphrased text concerning the work of management in conjunction with a university hospital merger was used (Choi et al. 2011). The 18 members of the top management group and the 4 key members of the nonexecutive hospital board were interviewed in this study, which was performed during 2005-2007.

The focal point of the interviews was issues focusing on the management of the merger, leadership, financial aspects, and how and why managers resign. The focus in the third study, complementing the other studies on order to make the study comprehensive enough, was how the power relations between the top manager, the clinical heads and the politicians worked. This third study illustrates how counter-discourses enable resistance from the clinical staff against merging the hospitals.

Studies of official documents from the respective organization were conducted in order to understand the background, the process and the political decisions concerning the mergers. These documents were however not used for the discourse analysis.

• The first step of the analysis of the interviews was inspired by discourse analysis (DA), which is about systematically analyzing a selection of texts, characterized by a high grade of validity in relation to the purpose (Grant & Hardy 2004, Silverman 2001). DA is against the assumption that researchers

can treat accounts as true or false descriptions of 'reality'. On the contrary DA is concerned with 'participants' constructions of 'reality' in versions and stories (Silverman 2001, p. 179). Those statements were chosen from the interviews, which were valid for the purpose and the research question (Silverman 2001). The second step was to analyze power relations between the leading politicians and the senior hospital managers (see the section of 'Theoretical frame: discourse, power relations and subjectification'.A tool for the discourse analysis inspired by Foucault (1972) consists of the following steps.

1. Who (which subject) is speaking and from which subject position? This is done for every chosen statement in the analysis.

2. Identifying statements reflecting discourses. Are there any contradictions or associations in them which indicate that several discourses are active?

3. Identifying dominating themes among the statements.

The statements were analysed by using the notions of power relations and subjectification (in the next section the theoretical frame is presented). The thematic analysis was then done by analysing repeated themes, which emerged in the statements. These themes are summarized in the section 'Dominant themes'.

Use was also made of the author's own experience of power relations as a hospital manager in politically - controlled hospitals and as a consultant involved in hospital mergers. During his period in health care, the author systematically made observations and notes regarding events, seminars, and conferences, and regarding important communications from the field. According to Czarniawska (2007, p. 13) this can be seen as a form of participant observation, i.e. a manager or an employee may also serve as a researcher. A pivotal aspect of research is the researcher's own relationship with his/her understanding of the phenomenon being examined. During his years serving as a manager in healthcare services, the author frequently came into contact with talk and texts of the kind that most health managers will come into contact with on a regular basis. By experiencing these texts first hand, the author has been influenced, just like other managers, by the transformation of discourse and practices within healthcare. An interpretation of a text is always affected, to some degree, by the researcher's own understanding of its meaning. By using the theoretical frame proposed in this research, the author will strive to distance himself from previous interpretations. However there still is a risk that the hospital manager´s perspective will become favoured in the analysis of the statements as a result of the author´s own experiences.

Theoretical perspectives

With the aim of creating an understanding of how power relations induce managers to resign in conjunction with university hospital mergers, the notions of discourse, power relations (divided into power struggles and resistance) and

subjectification constitute the used theoretical perspectives. Moreover a short overview of knowledge concerning hospital management is presented.

Hospital management discourses

The management of hospitals can be described in terms of care, cure, control and community, representing four discourses that are represented by nurses, physicians, managers and politicians as professional identities (Mintzberg 1997, Glouberman & Mintzberg 2001). These discourses seem to be difficult to combine within common values and are therefore capable of creating inadequate levels of understanding between groups (Norbäck & Targama 2009). As the cure discourse aspires to independence in relation to other discourses, this paves the way for power struggles (Nordgren 2003). Inadequate collective problem-solving is seen as a consequence of meetings between the discourses of 'cure' and 'control', which lack a focus on common action (Mintzberg 1997, p. 17). Thus, one challenge for leadership concerns translating between the discourses in order to create understanding. Moreover it seems to be crucial for leaders at politically - controlled hospitals to understand that politics can be described as a world that consists of communication and trust (Tollgerdt - Andersson 1995 p. 71, Mintzberg 1997).

The public hospitals in the Swedish healthcare system are said to be governed by politicians and controlled, mostly, by management-educated hospital managers, while professionals, mostly physicians and nurses, serve as operational managers responsible for caring and curing (Nordgren 2012). Hospital managers are hired and fired by politicians. Brante (2012-10-04) speaks, in line with Freidson (2001), of 'attempts to professionalize top management in health and medicine, social services, schools and universities'. Freidson (2001) argues that the bureaucratic and market logic, i.e. management, is superseding the professional logic in the welfare sector (see also Nordgren 2010). Moreover, as an effect of the performativity of the management discourse on organizational discourse and the constant strength of and resistance from the professional institutions, there seems to be an increased level of distrust between managers and professionals (Ackroyd et al. 2007, Nordgren 2008).

Theoretical frame: discourse, power relations and subjectification

According to Foucault (1972) discourse is described as the rules of formation and the practices that are producing meaningful statements, concepts and discourses in different historical periods. If a certain linguistic usage is legitimised by language users in certain societal positions and situations, it will have the power to influence people's everyday spoken and written language (ibid.). The discursive formation of such linguistic usage emanates from discourses. Discourse signifies all statements within a certain discursive formation, on the way in which new institutions develop within organisations (ibid.). The conditions to which objects, mode of statement, concepts and thematic choices are subjected are called the rules of formation (ibid.). The fundamental element in the rules of formation is the statement, which forms an authorized account of formulation

and narration (ibid.). Discourse encircles those who have the right to speak within that particular discourse and excludes those who do not (Foucault 1993). Discourses constitute the individual in certain subject positions (Foucault 1972). This means that the discourse creates ways of subjectivity shaping the individual in a certain position, i.e. discourses are active and work on the subjects in the ongoing organizational power play. This process of creating subjectivity is named subjectification, that is what a subject position offer in particular ways of thinking, behaving and feeling (Foucault 1976, 1977, 1980).

Foucault understands power as 'the multiplicity of force relations immanent in the sphere in which they operate and which constitute their organization; as the process which, through ceaseless struggles and confrontations, transforms, strengthens, or reverses them, as the support which these force relations find in one another' (Foucault 1976, pp. 92-93). Power relations can be analysed 'in terms of struggle, conflict and war' (Foucault 1980, p. 90). It is not possible to study the persons per se; rather, the discourses and practices producing the individual and organization can be studied (ibid.). In organizations varied games are in play (Clegg et al. 2011). There is always the possibility of resistance in power relations. Otherwise there would be no power relations at all (Foucault 1984, p. 292). This means that power and resistance are always interlinked (Scott 2008). Various forms of knowledge, often known as discourses (as medicine), are said to be linked to power as they function in a disciplining way by specifying what is right to do (Foucault 1980, 1993). The professions are said to be responsible for the 'true' knowledge because of its scientific base and it is reasonable to define professions on the basis of scientific knowledge (Brante 2011).

Power relations can also be studied as power mechanisms. Certain expert elites, such as physicians, are occupying institutionalized powerful positions in structures of domination (Scott 2008). Expert elites derive their power from the discursive formation of signifying and legitimating principals and subalterns (ibid. p. 32). These elites have an interest in attempting to manage the discourses through which the status quo is protected, reproduced and transformed (O'Reilly, D. & Reed, M. 2011). Moreover, the power of any elite is seen as open to challenge from the resisting counteraction of its subalterns (Scott 2008).

As mentioned above power can be studied by using the notion of subjectification (Foucault 1976, 1977, 1982). To subjectify is the process of making subjective or to identify with a subject or interpret subjectively. Foucault (1982. p. 781) claimed that 'there are double meanings of the word 'subject', subject to someone else by control and dependence; and tied to his own identity by a conscience or self-knowledge'. In the sense 'subject to someone else', the subject is classified and constrained through discourses and practices applied within various institutions (Foucault 1982, 1993, 1997). In line with Foucault Butler (1997, p. 83) underlines that power acts on an individual in order to 'activate' a subject.

In summary the analysis uses the concepts of discourse, power relations and subjectification as the framework in the analysis of statements in the interviews. This was done in two steps. The first step was inspired by discourse analysis.

The second step was to analyse power relations between the leading politicians and senior hospital managers.

Presenting the mergers

Each study is shortly introduced then followed by a summary of the interview.

Study 1 Merging three university hospitals

Three university hospitals were to be merged in 1997. A manager was recruited externally who would lead the organisation under the aegis of a political board. The owner placed the financial demand on the hospital, without discussing it with the hospital manager. The manager estimated the level of cost-cutting to be double that demand, as the hospital was suffering from a structural deficit. Once insight into this financial situation had improved, the political system started closing ranks and the conflicts became increasingly visible to those involved. A political election was approaching and nervousness ahead of this led to conflicts and political manoeuvring. The owners decided at last to inject more money, subject to pledges made by the manager.

The hospital manager's story (study 1)

> Academia was not governable in the traditional way; it has many loyalties and hospital interests very often have a low priority. The political power structure was divided. The decision-making processes were frequently disrupted by a very complicated grounding and negotiation process on the part of the owners. This became apparent when the level of frustration over the financial realities increased. A hospital manager wasn't a safe thing to be. The political system always has the upper hand, with many channels of its own towards professions and individual co-workers. Due to the consequences of the restructurings, the cost-savings and proposed measures went all the way to the top of the political system. Other executives and politicians, too, were drawn upwards. Would I go all the way up in the system myself? Special interests are cultivated and defended in all possible ways and it's a tricky game. The focus ends up on one person. A lack of understanding on the part of the media regarding complexity and change work doesn't facilitate long-term endeavours.

> The major problem was that gigantic savings were added without any calculations or realistic pre-requirements for coping with the assignment. The political conflict surrounding the deficit was one of the major problems. I quit after two years swimming upstream and being hung out to dry in the press, talking about a bad atmosphere at the hospital, about patients who did not receive care, and about deficits. Am I about to sacrifice my family…. Is it worth the cost?

A limited-duration project assignment would have worked better than permanent employment; however, at the time of being hired, I was unaware of the risks and the stressfulness, attached to this assignment. I lacked candid political statements supporting the process and few of my co-workers supported the merger publicly. There were also chief medical officers and also some politicians, who did not support restructuring.'

The politician's story (study 1)

… Which interests do I have to defend as a politician, really? It's difficult to explain the complexity of the organisation to people. It has too many levels and the roles are unclear. .. It's a game and no one wants to hold the losing card. But none of this has been due to ill will, there were no nasty games.

It's a major problem when people go to the press ... You can't discuss the issue via the newspapers … There are major differences in mentality between the hospitals. … Several chief medical officers are taking action, but there's one in particular. There's a limit to what we can put up with. The papers have been used ruthlessly by the staff.

… There should have been stronger leadership and there should have been one or two people from the old culture. He worked too much on his own. As the manager had been promised a hospital that was in balance financially, it was discovered too late how serious the financial crisis was. The truth about the financial position and the structural deficit emerged after a firm of consultants had gone through everything. The forecasts fluctuated and that´s how it is. Then the hospital manager almost worked himself to death trying to turn the financial situation around. No one wants hold the losing card. The hospital manager was tired at the end of the project and chose to resign. It was logical to quit. He did not live here but should really have moved in here. Not doing that created a sneaking distrust against him …

Study 2 – Merging two university hospitals

After previous attempts at coordinating the two university hospitals, the regional assembly decided, in 2009, confirmed by a further decision in 2010, that a joint administration would be established. Previously, several coordination endeavours had been carried out between clinics during a profiling endeavour, identifying a need for shared routines, standards, policies and collaboration with the university. It was not until political management had started pushing the issue, and a new Regional Director[2] had been recruited, that the work of merging got

under way. The Director was given the formal right to decide on the structure and to appoint a new hospital manager. In 2010, the new hospital was started up.

The Regional Director's story (study 2)

> The aim was to gather competence and development. The management of the university bought this. The Divisional Managers at one of the hospitals were also on board. Level structuring is needed – not everyone can do everything. There's a lot of understanding for this, fundamentally, among the professionals. The hospital managers had a task to carry out but nothing happened. How will you then be able to coordinate activities? I asked them. They then came up with the name of the project, with 13 fields of activity. However, no proposals came from further down in the organisation. Political management was entirely behind the merger. The opposition, however, was against the merger.

> There's a very special culture here which you have to understand. There was, quite simply, no desire to merge … You've no business coming here from another city wanting change. The merger per se went quickly and straightforwardly. But there was some debate in the social media, which perhaps should have been handled more aggressively on the part of the Region. Management spread massive amounts of information about the merger, within the hospitals, too. The local press has a great deal of influence … we dealt with that professionally.

> I was persuaded to stay on for a new period and asked the Chairman of the Regional Board for the contents of the assignment.The Chairman did not stand firmly by a rebuild of the hospitals, instead talking to the media about a vision of growth ...

A phase of conflicts began to arise between the Chairman's and the Director's ways of managing, leading to the phasing out of the Director:

> I became weaker as a manager after the conflicts. I had come very close to the hospital. The politicians were also sullied by this as things quickly turned negative in the media.

The Chairman also wanted to task the Regional Director with phasing out the hospital manager, something that the Director resisted.

The politician's story (study 2)

> The Regional Director chose one of the hospital managers to manage the new hospital. It was natural to choose him; however, in reality, it wasn't that good as he represented one of the hospitals. However, on the whole, he coped with things in an open way and amalgamated the

hospitals in spite of everything. It's reasonable to believe that you're exhausted following a merger and have to look for something else afterwards. If some suitable person only had a number of years left to go, it would be appropriate to give him the assignment ...

The Director resigned because he doesn't have the right values. He keeps out of the way and avoids conflicts and discussions. Also, there was no story to turn to, and no communication plan ... Following a candid discussion, we agreed that he would leave. We didn't have the same basic outlook and he was not reading me the right way. Anyway, the hospital manager was going to finish on a pension, and he carried on for 6 months longer than planned.

... The political side surprised everyone with its decision to merge, and that the decision went through. The Operational Managers weren't on board at all initially, and were surprised. There was no political debate about the merger, the decision was just made. Things should have been done differently and there should have been a deeper analysis of what the merger entailed. This would mean cutting the cake differently. University healthcare was to be lifted out, making up 10-15% of activities. The four acute hospitals were to be kept. Ever since the other hospital became a university hospital, there's been a state of balance which has now started to be disrupted and a number of clashes have surfaced.

Both managers brought their deficits from their respective hospitals into the merger, they would cope with that. No new demands were made as regards savings. There was also overconfidence in what large organisations can implement. Historically speaking, nothing happens here to hospital managers when there is a deficit. Exactly what the hospital manager is able to be responsible for has to be analysed first, but the university hospital is usually in the red.

The decision to merge was tumultuous. The professions resisted it and discussed it extensively. The press made use of simplified clashes of interest. It was a dream scenario for the press, which was able to make use of these clashes between the professionals and the politicians. This affected the process. Management was not prepared to counter this ...

Study 3 Merging two university hospitals (paraphrased from Choi et al. 2011)

The hospital was formed in 2004 by the merger of two university hospitals, closely affiliated with the medical university. The Director had been the director

at one of the hospitals for the previous two years and had held top management positions in private industry. The Director halved the number of managers and selected a top management group primarily on the basis of loyalty with the director, and commitment to a managerial role. Members of the group, mostly with a medical background, agreed to put their medical roles behind them.

The story

When the regional government announced its decision to reduce the capacity of the Acute &Emergency department at one of the hospitals the medical Divisional Heads considered it a ''*disastrously bad decision''*, because the quality of patient care would be seriously compromised. Others in the management group, and the Board members, thought that the targets were achievable.

When the Divisional Heads' increased the support of medical priorities, and of the clinical staff, this resulted in their requesting the Director to ask the regional government for more resources in order to carry out the merger. The Director lobbied politicians for more resources and ultimately additional resources were received from the regional government.

When the number of clinical frontline managers was decreased, some clinical leaders began to criticize top management in the media. The Director was forced to respond to inquiries from the media, thinking that, with the support of the board, this disloyalty was incomprehensible and inexcusable. Moreover, with an eye on the election next year, the political opposition publically criticized the Director for having focused on finances at the expense of quality and safety. The Director responded: ''… It's the same damned savings that they're making over and over again. I don't know if we can withstand an entire election campaign …''

The clinical staff at several departments prevented or delayed management's efforts to implement the new organizational structure. Some clinical leaders criticized top management at staff meetings and complained in the media. The Divisional Heads abandoned their commitment to economic efficiency and began to defend the clinical staff and the medical priorities. They forced the Director to stop making additional cuts.

The pressure exerted by the clinical staff, the media, and the political opposition made it difficult for the Director to follow the original plans. Moreover the Director realized that the public complaints about the merger process had made top management an easy target in debates about the upcoming election: ''Yes, it's an election year, and then I think one of those false claims has been made that we've spent more time on finances than on patient safety ...'' After the election, a new political majority decided to retain the merger in spite of criticism. The Director was dismissed a few months afterwards by the politicians.

Analysis

Following the analytical model and drawing on subjectification and power relations, the statements was analysed. Certain dominant themes emerged from the

analysis. The following sections are divided on the basis of the notions of subjectification and power relations.

The subjectification of the hospital manager

One aspect of managing mergers is to understand the complexity of the assignments. In the three cases it was about managing publicly-owned hospitals characterized by cultural differences and by different operational discourses, which were difficult to combine in shared understanding (Norbäck & Targama 2009). As the politician (study 1) put it: 'It's difficult to explain the complexity of the organisation to people.' and 'There are major differences in mentality between the hospitals'. As the Regional Director (study 2) said: 'There's a very special culture here which you have to understand.' Managing mergers is not straightforward, which is particularly the case when the organization is the result of a merger between surviving cultures (Clegg et al. 2011). It is not the manager who leads the culture, rather the manager is subjected by the different cultures because the subject is classified and constrained through discourses and practices applied within various institutions (Foucault 1982, 1993, 1997). According to Hallin (2002) different political cultures and different values among the employees have an impact on how leadership is established and can be destroyed.

In organizational terms, hospital management positions itself in-between the politicians, the professionals, and the media. As the state, county councils, and professional organisations develop regulations that have to be adhered to, management is forced to legitimize its actions vis-à-vis several stakeholders (Östergren & Sahlin-Andersson 1998, Choi et al. 2011), something which the statements confirm. In that way the manager is subjected to someone else by control and dependence, i.e. the manager is not free to act.

In both study 2 and 3 the hospital manager previously had been the manager at one of the hospitals. This was said to become a problem in both of the studies, because of the risk at being seen as a representative for that specific hospital. The position of hospital manager often corresponds to a role characterized by different and contradictory expectations (Grünberg 1996). Thus the manager becomes subjected by these expectations.

The position of hospital manager has been responsible, during recent decades, for unpopular organizational changes and cost-cutting (Nordgren 2003, 2012). If they fail to implement these changes, they may be criticized by their own principals, or by the political opposition. This was most evident in study 3: 'public complaints about the merger process had made top management an easy target in debates about the upcoming election'. Managers may thus become unable to act with the security appropriate for the assignment: 'A hospital manager wasn't a safe thing to be.' (the hospital manager, study 1). In study 1 the owner placed incompatible financial demands on the manager, who lacked the tools to be able to meet these. At the same time, there was a requirement for this manager to shape consensus among the various groups at the hospitals. So the manager was subjected to the political forces at work, but also to the medical discourse through the actions of some Chief Medical Officers.

The position of hospital manager seemed to become more and more vulnerable as the respective merger process progressed. As the hospital manager in study 1 said: 'I lacked candid political statements supporting the process'. This was accentuated when restructurings failed to lead to the expected savings as a financial result. The primary merger motive was efficiency, which was apparent in all the studies (Choi et al. 2011). Cost-cutting seems to have been caused by central management introducing structural changes without engaging in a dialogue with managers and professionals. Moreover the hospital was suffering from a structural deficit since the period before the merger. The consequence of this and of the merger was increasing deficits in budgets. As politicians seemed to be unprepared for the negative consequences mergers give rise to, managers were made directly responsible for outcomes. Using the notion of how discourses are subjectifying individuals to act in a certain way, it is now possible to understand how a certain leadership discourse accentuates the major importance of management in creating good financial results within each hospital. This is in line with Hallin (2001 p. 154-155) who shows that it was a norm that the hospital manager has to keep the budget frame in the meaning to show that he has control. Otherwise the manager will lose his mandate to act in a powerful way

Further aspect of subjectification concerns the support from politicians. If managers lack the support of their political management, they become weak. As the Regional Director in study 2 put it: 'I became weaker as a manager after the conflicts.'? As people, managers come into focus as a consequence of the worry that characterizes changes. As the hospital manager in study 1 put it: 'The focus ends up on one person', working under high internal stress. The hospital managers face emotional pressure when trying to balance parallel discourses (Choi et al. 2011).The cost borne by management in 'mergers in politically ambiguous environments' seems to be very high (ibid. p. 21).

One finding of the analysis was that the scope for hospital management was limited as it is difficult to fully understand how medical operations are being conducted at hospitals (Norbäck & Targama 2009). As the chairman in study 2 stated: 'There was also overconfidence in what large organisations can implement.' Thus, it is a challenge for management to shape consensus regarding the change as a whole. According to the chairman in study 2 the hospital manager showed this ability: 'he coped with things as a whole and amalgamated the hospitals, in spite of everything.

Power relations
The interviews essentially concerned how the actors manage their power relations and their degree of trust in each other. The analysis is divided into power struggles and resistance.

Power struggle
As a result of different discourses power struggles can be expected (Ackroyd et al. 2007, Arman 2012). In the studies, these struggles manifested themselves in

the actors using these different discourses (care, control and community). It was also a matter of power play, as in a political arena, e.g. creating alliances which can, however, be unstable and assume different forms (Clegg et al. 2011). These are characterized by a moderate, limited, and relatively stable conflict (Clegg et al. 2011). One form is a triad, which can be seen as a relationship between three parties and which can be characterized by tensions between closeness and distance (Simmel 1971 in Wolff, KH 1964). There were various formations of alliances. One might be politicians and Senior Medical Officers forming an 'unholy alliance', which can be seen as a power relationship (Brante 2011) calling into question the position of the hospital manager. Another might be Senior Medical Officers combining within a collegial group to work against the merger (study 3). A third might be some Chief Medical Officers using the press as a means of exerting an influence on public opinion and politicians in their decision-making (study 1). According to the politician (study 1): 'It's a major problem when people go to the press…. You can't discuss the issue via the newspapers' This was also the case in study 2, with the politician stating: 'The professions resisted it and discussed it extensively…. It was a dream scenario for the press, which was able to make use of these clashes between the professionals and the politicians.' A similar story became apparent in study 3: 'some clinical leaders began to criticize management in the media. The Director was forced to respond to inquiries from the media'. The theme in these three statements concerns how the politicians (in study 1 and 2) appear to distance themselves from personal responsibility and enactment by blowing up the mass media and professionals who together counteract the merger. This distancing and this displacement of responsibility can be seen as a recurring theme in the statements.

Power play can occur between management and professional discourses, for instance when financial directives counteract medical prioritizations (Arman et al. 2012). This is what happened in study 3: 'The Divisional Heads' increasing support of medical priorities and of the clinical staff resulted in their request that the Director ask the regional government for more resources to carry out the merger. The Director finally submitted to the Divisional Heads and lobbied the politicians for more resources.' In this power play, the force of the medical discourse based on medical priorities won the power struggle, combatting the management discourse, i.e. the manager had to act in line with (was subjected by) the request from the clinical staff. This was also in line with what happened in study 1, when the owners decided to inject more money subject to pledges from hospital management.

The occurrence of power games was indicated by the following statements: 'Special interests are cultivated and defended in all possible ways and it's a tricky game. The focus ends up on one person.' said the manager of the university hospital (study 1).'It's a game and no one wants to hold the losing card, but none of it has occurred through ill will, there were no nasty games,' (politician study 1). However, the games are not evil. Rather they are characterized as sensing the positions (Foucault 1974, 1980).

The political skill seems to be ultimately in command: 'The political system always has the upper hand, with many channels of its own towards professions and individual co-workers' (hospital manager study 1) and: 'The political side surprised everyone with its decision to merge and that the decision went through. The Operational Managers weren't on board at all initially and were surprised by the decision.' (Chairman study 2) As in all power struggles, the actors have to be able to use the rules of play well in order to be able to survive (Clegg et al. 2011). The manager is expected to be able to play the game so that the actions are understood by his/her setting. Therefore, there is a requirement for: 'maneuvering, shrewdness, deal making, playing things close to the chest, and so forth, with all the associated political skills' Mintzberg (1997, p. 16).

The manager must enjoy the trust of political management (Tollgerdt-Andersson 1995, Mintzberg 1997, Ackroyd et al. 2007). Because politics is about trust, trust must be earned. The position of hospital manager is thus created by means of trust being given by the political board, as the manager's primary loyalty is focused on this (ibid). However the manager also needs trust from the co-workers as the manager in study 1 said: '… few of my co-workers supported the merger publicly**.** If the trust is lost the manager will lose the power (Tollgerdt-Andersson 1995).If politicians avoid communicating what happens during the political play with the hospital manager, which occurred in study 1, then a standstill will ensue and an impossible situation will result for the manager. On this uphill slope, the hospital manager was abandoned by the politicians, and decided to quit. In studies 2 and 3 as well, there was said to be a lack of political support during the latter stages of the mergers, which undermined the management positions.

Mergers of hospitals with different cultures, as in study 1, seemed to give rise to conflicts, manifesting themselves as statements made by critical medical officers, resulting in an impact in the press and among some critical politicians who had previously been in favour of the decision to merge. As the politician in study 1 said: 'It's a major problem when people go to the press…. You can't discuss the issue via the newspapers…..''The politician in study 2 also showed dissatisfaction regarding communication 'Also, there was no story to turn to, and no communication plan' as did the Regional Director 'But there was some debate in the social media, which perhaps should have been handled more aggressively on the part of the Region?

In study 2, a conflict arose between the Director's and the Chairman's leadership styles and values, which they did not share. According to the Director, a phase of conflicts entailed the phasing out of the Director: 'The Chairman did not stand firmly by a rebuild of the hospitals, instead talking to the media about a vision of growth ….' This was confirmed by the Chairman: 'He didn't have the values that were needed. I noticed that over the course of an entire year…. following a candid discussion, we agreed that he would leave.'

The financial situation may also give rise to conflicts in the political system, as was shown in study 1, where the political system started closing ranks and conflicts became visible to those involved. When the political election was ap-

proaching, nervousness led to conflicts and manoeuvring between the political parties. The hospital manager in study 1 expressed it: 'The political conflict surrounding the deficit was one of the major problems.' The same mechanism seemed to be at play in study 3 when the director was openly criticized by the political opposition in the press before the election. The directors in both studies realized the situation and were aware of that their positions were threatened.

Resistance

According to Foucault (1984) there is always the possibility of resistance in power relations. Resistance was explicit in the relations between politicians and managers, for instance when the Regional Director resisted dismissing the hospital manager (study 2), and when Chief Medical Officers criticized the merger in the media (study 1): 'Several Chief Medical Officers are taking action, but there's one in particular. There's a limit to what we can put up with. The papers have been used ruthlessly by the staff.' How the professions criticised one merger in the media was also expressed by the Chairman in study 2: 'The professions resisted it and discussed it extensively….'

As shown in study 3, it was the regional government's decision to reduce the capacity of the A&E department at one of the former hospitals that triggered massive protests among the clinical staff, who vented their frustration at top management. The medical Divisional Heads also considered it a: ''disastrously bad decision''. Similarly, both the political opposition in the regional government and the clinical staff criticized the Director in the media for having focused too much on finances at the expense of care quality and patient safety. Another example of solid resistance in study 3 was when: 'Some clinical leaders criticized top management at staff meetings, complained in the media and wrote letters to management. The Divisional Heads abandoned their commitment to economic efficiency and began to defend the clinical staff and the medical priorities.' The resistance was manifested in different counteractions by the clinical staff in the form of preventions, delays, criticism at meetings and letters to management and by the divisional heads in defending the clinical staff and the medical priorities.

Dominant themes

This section gives an overview of dominant themes emerging from the analysis. One theme was that in connection with the mergers, leading actors got involved in power struggles that were controlled by different discourses. These power struggles created collisions between professional values, management values, politics and media, and led to an unpredictable process of trust between the actors (this is in line with Hallin 2002). Moreover the managers lacked the trust of their political management during the merger processes, i.e. their positions became weak. As the changes were additionally perceived to entail negative consequences for the patients and staff in the media, the position of the managers was undermined and they had to resign. This theme was named *collision between values*.

Another theme was that the uncontrollable resistance and pressure from the clinical staff and the political opposition, often expressed through the media made it difficult for the managers to follow the original plans for the mergers. This theme concerns how the politicians (in study 1 and 2) appeared to distance themselves from personal responsibility and enactment by blowing up the mass media and professionals who together counteract the merger. This distancing and this displacement of responsibility can be seen as a recurring theme for the statements. The theme was named *displacement of responsibility*.

Thirdly the studies indicate that there seems to be a power mechanism in that hospital managers usually have to resign in connection with university hospital mergers when there is lack of trust for the manager from the political board and from the co-workers. In study 1 the politicians unilaterally determined the financial prerequisites, making a shared understanding between the manager and the leading politician of how the changes should be handled impossible. Also this is in line with Hallin (2002), who states that the politicians in this region honors that to keep the budget is the overall norm. When the merger was perceived to entail negative consequences for the patients and staff, the manager quit. In study 2, the Regional Director had to leave due to his values and management style not matching those of the Chairman of the Board. In study 3 the Director had to resign after having been criticized publicly in media by the clinical staff and by politicians. This is in line with the conclusions drawn by Choi (2011) and Nordgren (2012). The interests of operational managers and politicians during the mergers did not primarily focus on supporting the merger process. The operational managers' loyalty primarily seemed to focus on care quality and patient safety, while the politicians safeguarded their interest in winning elections. This theme was named *the resign of the manager*.

Conclusion

This study focuses on the power relations between hospital managers and the politicians work, especially the board-manager one, in conjunction with mergers. By using discourse analysis the purpose was to analyse how power relations drive hospital managers to resign in conjunction with three university hospital mergers in Sweden. Three themes emerged from the analysis; collision between values, displacement of responsibility and the resign of the manager. Politicians exercise power by giving or not giving trust to the managers. In this study politicians appeared to distance themselves from personal responsibility and enactment by blowing up the mass media and professionals who together counteracted the merger.

The conclusion drawn was that there was a power mechanism at work in that hospital managers were forced to resign in connection with university hospital mergers. When leading politicians built alliances with powerful professionals the position of the hospital manager was threatened, lost trust and did not last. As conflicts arose management of the hospitals became the target of criticism and

was forced into the role of the scapegoat (Choi et al 2011). This was also shown by Nordgren (2012) regarding county council hospitals.

To summarize, the power relations between the leading actors were critical. Power struggles during the merger processes created collisions between professional values, management values, politics and media, and led to an unpredictable process of trust between the actors. This is in line with Hallin (2002) and Choi et al (2011).

The studies indicate that the interests of operational managers and politicians during the mergers were not focused on supporting the hospital manager. They also indicate that the politicians were primarily safeguarding their own interests in winning elections while the loyalty of the operational managers primarily seemed to be focused on care quality and patient safety. Moreover the studies reveal power struggles, leading to situations of distrust between politicians and managers, which is in line with Bazzoli et al. (2002) and Ackroyd et al. (2007). Further the studies demonstrate the dilemma faced by hospital managers when implementing radical organizational changes in professional organizations, which are controlled by politicians. The primary role of the hospital manager during a merger process therefore seems to be limited to initiating a transformation (Choi et al. 2011). Therefore it seems reasonable that the task of managing a hospital merger should be of a limited duration, which can be seen as an implication of the study. Another implication seems to be that it is not advisable to place financial demand on the hospitals during the merger process because this will lead to resistance. It is really a paradox that the demands on efficiency even may hamper efficiency.

A limitation of the study is that the results cannot be generalised as there was only done three studies of university hospital mergers and a limited amount of interviews. Another limitation was that there was a risk of favouring the hospital manager's perspective. The study was also limited to Sweden. With a qualitative method of this kind it is impossible to generalise the results, though, if these are unanimous with results of other studies their general importance increase (Kvale 1996). Furthermore, the results of this study could hopefully guide other studies in focusing relevant questions and also inspire the use of different methods. It would be interesting to compare with studies of mergers of other public services.

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Notes

[1] In the 1980s, Uppsala University Hospital and the Karolinska University Hospital were transferred from the state to the county councils of Uppsala and Stockholm, respectively.
[2] The director had previous experience of merging two university hospitals under another county council.