Managerial communication practices. Health care managers' everyday structuration

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Abstract
The aim of this article is to describe and analyse observed managerial communication. The research questions concerned: What characterizes managerial communication practices and the organizational consequences? We make use of structuration theory and view communication as a social interaction process in which temporary structures are negotiated. Ten first- and second-line managers were shadowed. The managers used a combination of structuration of caring, interdependency and accountability typical of health care organizations. The communication practices were related to how new norms of reputation management were institutionalized through structuration. The types of structuration were sometimes contradictory and productive communication was rare or non-existent. The managerial communication practices had consequences for the power and domination and for which issues were signified as part of the agenda. The conclusions can be generalizable to other professional organizations.

Chefers kommunikationpraktik. Strukturation i sjukvårdschefers vardag
Syftet med denna artikel är att beskriva och analysera observerade chefers kommunikation. Forskningsfrågorna var: vad kännetecknar chefers kommunikationspraktik och organisatoriska konsekvenser av kommunikationen? I studien använder vi Giddens struktureringsteori och ser kommunikation som en social interaktionsprocess där tillfälliga strukturer förhandlas. Tio första och andra linjens chefer skuggades. Cheferna använde en kombination av strukturering av omsorg, ömsesidigt beroende och ansvarighet som är typiskt för hälso-och sjukvårdsorganisationer. Kommunikationspraktiken var relaterad till nya normer för förvaltning av anseende som institutionaliseras genom strukturering. De olika typerna av strukturering var ibland motsägelsefulla, produktiv kommunikation var dock sällsynt eller obefintlig. Chefernas kommunikationspraktik hade konsekvenser för makt och dominans och vilka frågor som gavs signifikans som en del av dagordningen. Slutsatserna är generaliserbara till andra professionella organisationer.

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Introduction

In several countries public health care has gone through reforms termed New Public Management (Christensen & Lægreid, 2007). This has generally involved introducing market mechanisms and increased pressure of organizational transparency, effectiveness and efficiency. The reforms have thus been used to change norms in the organizations. As professional norms are strong, management of professionals demands the use of specific legitimation practices (see for example Larson, 1977; Freidson, 1994). Health care organizations are good examples of professional organizations with strong norms. However, as in other organizations, the knowledge of current work practices is limited (Barley & Kunda, 2001; Tengblad, 2006).

Here we take a specific interest in managerial work practices, focusing on their communication. Previous studies of health care management show that multiple logics collide when managers trained as health care professionals negotiate an administrative and political system in the organizations (Wikström & Dellve, 2009, Llewellyn, 2001). The managerial work studies tradition has inspired us, including Henry Mintzberg's (1973), Rosemary Stewart's (1982) and Stefan Tengblad's (2006) studies. A detailed "shadowing" study of ten managers' work activities lays the base for the study of their communicative handling of the co-existing norms within the organizations.

Within the managerial work tradition methods to research everyday activities have been developed (Czarniawska, 2007; Hales, 1999; Noordegraaf & Stewart, 2000). In the studies managers' basic work activities were observed and the findings highlighted that a large portion of managerial work consists of communication. Discussing information was shown to be a fundamental part of managerial work. Communication was also part of activities such as: negotiations, decision making, networking and handling requests. Managers also communicated while performing ceremonial and non-managerial work, when socializing, being solicited as well as while scheduling their own and others time (Carlsson, 1951/1991; Florén, 2005; Kurke & Aldrich, 1983; Mintzberg, 1973; Stewart et al., 1980; Stewart, 1982; Tengblad, 2006). Finally, a recurring theme has been the degree of agency that managers have in their work. The study of managers in different positions can contribute to this tradition and its' debates (Mintzberg, 2002).

In our study communication is used as a starting point for an analysis of managers' everyday activities. Theoretical developments in communication studies distinguish between viewing communication as an act of *transmitting* information as a neutral commodity, versus viewing communication as a *social interaction process* in which temporary structures are negotiated and produced (Deetz, 1995 p. 25). In this article we also make use of structuration theory to focus on the producing and re-producing of both structure and agency in managerial communication (Giddens, 1984). As reforms change norms in health care, current knowledge about the transformation of everyday communication practices and the connection to structuration is important. The development of new

communication conceptions offer possibilities to study managerial work as well as its' consequences while also embedding the debate into a broader context of institutional reforms. This can further our understanding of how the practices are part of changing norm systems.

In the managerial work activities tradition, the studies have primarily built on the conception of communication as transmission. To analyze communication instead as a type of social practice means to focus on the connection between communication, power/control and legitimacy/acceptance. As norms change, persons, groups or institutions can lose legitimacy, power relations will also change and they find it difficult to become heard (Palazzo & Scherer, 2006). The aim of this article is to describe and analyze the health care managers' (HCMs) communication activities observed in our study. The specific research questions were: What characterizes structuration in the current communication practices? What are the organizational consequences of the managerial communication practices?

Building on Giddens' (1984) structuration theory we will argue that managerial communication is characterized by three different structuration processes: a) structuration of caring, b) structuration of interdependency, and c) structuration of accountability. Using concepts from structuration theory we will claim that the communication practices in turn are related to the signification of issues and domination of interests within the social structures that are being (re)created through the communication.

The continued paper consists of four sections beginning with building a theoretical framework on previous literature on managerial work in general as well as managerial work in health care and on theory of communication and structuration. After describing the study's methods and setting, the findings section elaborates on the meanings that were attributed to the studied communication activities. The paper concludes by discussing the implications of the study for furthering the understanding of everyday managerial communication practices and how it is related to societal changes as well as implications for practice.

Managerial communication

Managers in health care share a work situation that today consists largely of meetings and immediate interpretations and decisions rather than predetermined and calculated acts and judgments (Arman et al., 2009;Wikström et al., 2011). This general tendency is illustrated in several other observational studies of managers in Sweden and in different organizations (Tengblad et al., 2012). Tengblad concludes that managerial communication today is largely a matter of interpretation of immediate situations and making judgments based on what is considered "appropriate".

In this context, reflections on important priorities in line with co-workers and other managers are a central feature in managerial communication. Accordingly, in their communication managers are meeting key challenges of defining and regulating the activities that have goals, needs and expectation-driven con-

flicts and negotiating with various types of constitutive processes of structuration which is expressed in managerial communication. The managers' work communication and the concept of structuration will be explained in this section.

According to Giddens (1984), even repetitive and routine, day-to-day experiences in one place contribute to the reproduction of structures that extend over much longer periods of time and space. Choices are available even in rule bound situations because a person can intervene or refrain from action, thus having the capacity to resist structure and transform society through agency (Kaspersen, 2000; Prasad, 2005). Also, in the previous studies managerial control was related to their communication activities (Kotter, 1982). However, managerial communication was described as mainly having to do with "information". Mintzberg (1973) even described managers as "information processing systems" (p.72). The idea was that an important part of managerial work is to direct, control and influence the flow of information.

Mintzberg's (1973) study pointed out the importance of the forms of the communication – planned, unplanned, short, long, interrupted, one-on-one, formal, informal, over the telephone, etc – for its' content, be it delivering gossip or strategizing about future developments. In an analysis of NHS district managers' power bases Stewart et al. (1980) similarly used a specific category called "control over information". Further, Kotter (1982) acknowledged that an important dilemma inherent in managerial work is "figuring out what to do despite great uncertainties, great diversity, and an enormous quantity of potentially relevant information" (p. 77). Besides information handling, earlier studies have shown how managers communicate in order to give and receive not just different types of information but also forms of influencing, e.g. suggestions, requests, persuasions, demands, coercion, manipulation and "cajoling" (Arman et al., 2009; Kotter, 1982; Kurke & Aldrich, 1983; Mintzberg, 1973; Tengblad, 2006).

Recently, the descriptions of "informational activities" in the study of managerial work seem to have changed, e.g. it is suggested that control over information might be much harder to gain due to the IT development (Tengblad, 2006) and the focus on legitimation and interpretations of meaning in communication seem to have increased (see e.g. Tengblad, 2012). To develop these changes further, we propose that the performativity of language is recognized and explored further in the context of managerial communication. Hence, in this study we adopt the social process conception of communication and agree with the statement that "Communication is about transformation, not information" (Deetz, 1995, p. 81). Using this conception the question is developed further from "what managers do" when they communicate (the form, content and purposes of their activities as studied within in the managerial work tradition), to how these activities came to be and how social structures are (re)produced as a consequence of the communication.

Traditionally it can be said that health care management has a responsibility to guarantee quality and safety in healthcare. But HCMs must also handle the overlapping of regulating systems, e.g. that of the management system (Öfverström, 2008; Östergren & Sahlin-Andersson, 1998). There are also conflicts of

power embedded in the relationship among the administrative, managerial and professional domains (Degeling, et al. 2003; Dellve & Wikström, 2009). It is especially emphasized that economic directives seldom agree with medical and care priorities (Llewellyn, 2001). Compound identities, loyalty commitments and professional interests thus shape the conditions for HCMs work (Dellve & Wikström, 2009; Ferlie et al., 1996).

In several studies, researchers have used various concepts to describe the processes of managerial communication in the health care context. In some studies managerial communication has been described as a hybridization process when managers are trying to combine several practices in integrated activities (Choi et al., 2010; Ferlie et al., 1996; Wikström and Dellve, 2009), of mediation and translation (Llewellyn, 2001)**,** of negotiated order when several logics are combined as a strategic narrative of a single activity (Doolin, 2002), of buffering when the focus is narrowed to one logic at a time (Mintzberg, 2002; Wikström and Dellve, 2009), or of collaboration when each logic remains intact (Reay and Hinings, 2009). These concepts all have in common that they describe the result of the complex meetings between representatives from healthcare professions and managers at different levels as a growth of new work practices where the clinical and administrative styles are combined to create a new and unique way to think and act as a manager.

Previous studies of management in the specific field of health care have thus shown how managers adopt and adapt to different sets of logics that exist simultaneously within the organizations (see e.g. Llewellyn, 2001; Doolin, 2002). We find it reasonable that these logics are also related to different types of processes creating social structures in the managers' activities. Using our theoretical framework, another way to describe the previous studies is that they show how different types of structuration come to be through and within communication that managers take active part in. However, previous studies have focused on the personal consequences for the managers and their position in the organization while our concept of communication guides us to include the more general social structures that they are part of and the structuration process in everyday activities. Structuration is power and value-laden (Giddens, 1984). Similarly, we understand communication as a kind of social practice in terms of production and reproduction of meaning and social relations.

To analyze these kinds of social practices we choose to focus on the structuration processes through the acceptance and the production of a moral order (legitimation), which is also connected to interpretation (signification) and power/control (domination). Communication that is primarily oriented to imposing norms, consequences or sanctions, cultivate structures of domination. The (re-)production of meaning is also fundamental to social structures through the use of e.g. interpretive schemes that are part of the signification process (Giddens, 1984). Giddens' (1984) modeled these three overlapping modes of structuration that we will use to study managerial communication. The previous studies of management in health care seemed to find important processes involving agency of the individuals in relation to structures such as managerial identities, profes-

sional group norms or interests and management systems of control. The focus in this study is on this structuration work in HCMs everyday communication practices. In the following section we will discuss the methodology that has been used in the study.

Methodology

Design

The study was conducted within a research program and the purpose of the program is to understand and support a sustainable time-use among HCMs, using a semi-structured observational method. The observations in this study were non-participant. Structured, anecdotal, unstructured and interpretative data was collected simultaneously. The participating managers were also interviewed. This article discusses the findings from the unstructured observations. The theoretical thrust of the study is abductive in nature, iterating between theoretical concepts and empirically observed phenomena (Charmaz, 2006).

Study setting and sample

The data collection was carried out in the Western Region of Sweden beginning October 2007 and ending February 2008. The regional government manages all public health care in the area, primary and secondary. In Swedish health care, first- and second-line managers represent the part of the formal hierarchy that has direct contact with the operative level of care delivery. The study sample consisted of 10 managers who were purposely selected. A variation in age, position, profession of origin, experience as manager and type of health care setting was sought. Eight of the managers were women and two were men. Their ages varied between 44-62 years, with an average age of 52. Four worked in outpatient settings; four managed hospital wards whereas the remaining two managed both wards and outpatient units. Somatic, psychiatric and primary health care settings were all included. Most of the managers were experienced, averaging nearly 10 years in their position. All participants were selected through human resources departments; human resources managers and a general e-mail to managers.

Each manager was observed during three and a half or four work days, which is similar to other managerial work studies (Hales, 1999; Tengblad, 2006). The sample size and intensive data collection allowed for a detailed ana-lysis of HCMs everyday work. The time of the study included end of the year administrative activities and beginning of a new year, such as deciding salaries for employees. However, no performance reviews were observed, either with employees or between the managers and their own bosses.

Recording time use and activities

Permission was obtained to "shadow" the manager during his or her work day and make notes on what was seen and heard (Czarniawska, 2007). The researchers could be asked to leave at any time by the participants. This seldom hap-

pened and only occurred during discussions that were considered to be of a very sensitive nature such as employee rehabilitation. The researchers made every effort to record events naturally and not interpret any given situation while in the field (Adler & Adler, 1994). However, it was acknowledged that it was impossible to observe everything and to record all of the observer's perceptions during the research. In order to make the observations comparable to earlier studies the same structured categories were used to focus the observer's attention and simplify the recording of the information (Mintzberg, 1973; Tengblad, 2006). This method is described as valid and sufficiently reliable for the chosen empirical focus (managerial work) and the qualitative nature of the research (Noordegraaf & Stewart 2000, p. 432).

Two different researchers conducted the data collection. One researcher at a time observed the manager during his or her work routine. In total 359 hours of observation were conducted. For the structured observations, each activity that the manager took part in was noted. The unstructured notes contained descriptions of what (and how) the managers talked with people that they met. Depending on the speed and quantity of what was being said we were able to record as close to verbatim as was practical. In some situations the researchers own summary of what had been said and topics covered was recorded with only occasional expressions or direct quotes included. The unstructured notes thus vary in quality. Approximately 70% of the registered communication activities contained enough data to be useful in the analysis of legitimation in this article.

Analysis and presentation of data

The qualitative analysis in this study is based on content analysis of the communication activities, inspired by constructivist grounded theory (Charmaz, 2006; Silverman, 2001). Coding and analysis was carried out in three steps or progressive rounds. After the observational period, coding was first undertaken to interpret the purpose of each activity. Mintzberg´s (1973) categories were used and the activities were grouped as informational, decision-making, requests and solicitations, administration, secondary; by Mintzberg considered as non-managerial activities. A second analysis was then performed of the subsection of "informational activities". In this analysis the emic expressions of the content of giving, receiving and reviewing information was explored.

Going back to literature concerning structuration and communication, the theoretical framework was developed. In doing so we started introducing new etic concepts into the analysis. We then especially became interested in the uses of different structurations that could be interpreted as a process within and as a consequence of the communication. The third and final coding process was then conducted, using this framework as a guide, now including all the studied verbal managerial talk. This third re-coding and extraction process resulted in a document into which raw-data communication situations were systematically organized. 53 pages of passages from the material were categorized as being mainly related to structuration of caring, structuration of interdependency and structuration of accountability, also using several subcategories.

Finally, a synthesis was created through paying special attention to these categories of structuration. It is the results of this analysis and the final synthesis that is presented in the next section of this article. The presentation of examples contains descriptions of the different types of structuration from the analysis including some direct quotes or examples of communication practices. The selection of examples and quotes is aimed at being illustrative of the interpretations (see Silverman, 2001). It is worth noting that previous managerial work studies primarily used Mintzberg's (1973) categories to quantify the qualitative patterns studied. Only one or two examples were usually given to illustrate the content of the categories used (notable exceptions are Kotter, 1982; Noël, 1989; Stewart, 1982). The empirical findings in this article are presented in another style, in order to make use of the full qualitative potential of the managerial work activity studies.

Results

The managerial communication described

Using Mintzberg's (1973) original categories, the study showed that spoken communication activities took up most of the managers' time at work, approximately 66 % excluding any clinical work performed and breaks. HCMs mostly communicated with subordinates and other managers. Less time was spent communicating with patients, staffing or service department employees, external agents and superiors. In fact, the managers had almost no time alone with their own boss, which could be explained by the fact that we were not present during any formal performance reviews (see Arman et al. 2009). This still shows that more informal contacts were unusual on a daily basis. External agents were for example temp-agency representatives or persons from other organizations contacting the manager with questions, and vice versa.

The studied conversations took place under many different circumstances: planned, unplanned, in meeting rooms, during coffee breaks, while walking about, during stressful crisis's, relaxed chatting, in friendly atmospheres or during conflicts. There were many short exchanges and fewer long discussions. Most meetings were short one-on-ones (Arman et al. 2009). A typical example of this was the many times scheduling was discussed. For many of the first-line managers, making sure that shifts were covered took up much of their time. Longer group meetings still took up the largest proportion of the managers' communication time (Arman et al. 2009). Many of these meetings were in recurring, regular groups while others met to resolve a certain issue or discuss a temporary project. Typical examples were when all unit managers of a department or all present employees of a unit met to discuss current issues.

Eight of the ten managers had at least one, what we categorized as "major" challenge which they were facing during the week. These challenges ranged from intense searching for ways to solve a chronic lack of appropriately trained staff before the summer vacations to negotiations about the number of beds at a ward and mergers with other wards. One of the managers faced a short term

crisis caused by a temporary overflow of patients during the week. The remaining two managers seemed to have their work week mainly filled by routine handling of relatively non-problematic issues. Both of these managers were very experienced and worked in first-line positions at out-patient units with a stable staffing situation. Yet, all of the managers took part in structuration of their work activities, as part of their communication.

Table I. Summary of different categories of structuration and examples

Structuration	Subcategories	Examples
Care	Caring for patients and quality of care	Lending a hand Analysis of critical incidents Solving conflicts: "Convenience is a bad argument, compared to medical safety."
	Caring for employees	Negotiating fairness in raises of salaries "It is a lot to balance and take into account." Follow-ups with employees who had been on sick-leaves Creating a good atmosphere, e.g. remembering birthdays
Interdependency	Interdependencies with the management system	Extra administrative tasks outside own unit Preparing CEO visit: "we have so much to show off!" Joking with peers about the employees Collaboration across boundaries: "We are all part of a chain and must respect each other's work"
	Interdependencies with a professional group or a unit	Decisions affecting professionals autonomy: "There has been a decision and agreement about this matter among us managers, but that will not help unless all practitioners are on board." Struggle for resources: "It is clear that [upper management] hold back and then blame us, and they can't!" Selective support: Organizing de-briefing for own professional group.
Accountability	Reputation management	Successful projects: "This will give us a good example to display to others." Giving the media importance.
	Audit trails	Open house for the general public, displaying an "image". The CEO assigning blame: "He is fast as a ferret!" Use of evaluation systems: "The analysis will show who was not listening. You will see, and the medical part of it can be judged."

The article now continues with the results of the qualitative analysis of the communication activities using the framework developed mainly from Giddens' (1984) theory of structuration, in line with the purpose of the study. Patterns of structuration of "care for patients and care for personal", "interdependencies" and "accountability" were noticed in the communication. In the following sec-

tions each type of structuration in this setting is described further. Table I summarizes these findings.

Structuration of caring for patients and caring for employees

The analysis of the HCMs conversations showed different themes of caring for patients and caring for employees of their activities. The universal health care aim, here called "caring for patients and quality of care", was one. Also, caring for the common good of employees was another type of structuration of caring that was used.

Caring for patients and quality of care

Many examples of how managers showed direct or indirect care for patients and quality of care can be given. This type of structuration occurred in one-on-one meetings with care professionals, during unplanned meetings with staff, when the manager took on clinical work of their own and at regular staff and management meetings. A few of the managers worked with regular patient care as a small or relative large part of their daily work. Even those who did not could sometimes "lend a hand", making use of their health care profession. In one example a first-line ward manager was approached by a nurse who had difficulties performing a technical treatment procedure on a patient. The manager interrupted her e-mailing and checking of invoices to perform the procedure in place of the nurse, expressing pleasure to be of help. Through calling attention to the clinical work that they performed, the communication could be used for the structuration of caring which doing good things for patients involved. The managers showed their willingness to contribute to the work that was morally accepted/expected of their subordinates.

However, some managers did not have direct patient care as part of their job and only got involved indirectly when unusual or difficult situations arose. Most of the managers were involved in re-occurring discussions about events when the quality of care was jeopardized and how to prevent this in the future, so called "critical incidents". At one ward a recent near fatal situation for a new born baby was being analyzed. During the days of shadowing the first-line manager at the ward was involved in many conversations and did several hours of paper-work as part of the "organizational learning" and attempts to prevent similar situations in the future.

The managers worked with general preventive measures but could also solve problems, because of their knowledge of direct patient care mixed with administrative skills and knowledge of the organization. One example was a conflict between two wards over how to fill out the list of prescribed medications in the patient records. A second-line manager stepped in and suggested the physicians make a list of the problems they saw with the other wards behavior. She reminded them: "Our convenience is a bad argument, compared to medical safety." Here arguments for caring about quality were asked for by the manager for the list used for communicating to the other ward.

Caring for employees

The caring for employees and the work place was showed by talking about how to improve work conditions. Many of these discussions were between managers, talking with their own peers or with staffing officers. An especially heated example was when ten unit managers met with their mutual second-line manager and a secretary from the HR-department. During the meeting the managers negotiated to find a fair way to increase salaries, all competing over a set amount of money. Thus, the managers were to negotiate between each other to find a fair way to reward their employees. Some argued that the female employees needed to get their salaries raised. Some argued that certain low-payed groups should be better rewarded for their hard work. Others thought the opposite that those with a more advanced education deserved more. The manager that we shadowed commented afterwards that there were many things to take into account:

> It is a lot to balance and take into account. Both this about men and women and as you also heard, now it is also about the university trained people that should be prioritized.

The arguments used showed care for the employees, though all in different ways, and demonstrated use of structuration of caring for employees. Another example of when the managers expressed their care for the employees' wellbeing and health was the recurring meetings that the first-line managers had with employees at their units who were in rehabilitation programs. These were employees coming back to work after having been on extensive sick-leaves and were regarded as having special needs. For example, one first-line manager at a psychiatric clinic encouraged such an employee to take part in the planning of treatments of new patients, in order to become more included in the team. The employee answered that she had tried to mention to colleagues that she wanted to join them, unsuccessfully. The manager then offered for her to join the work with a new patient that the manager herself was taking on. At these meetings the managers also communicated care for the employee's health and suggesting or instructing them to work at a suitable pace.

Another expression of caring for employees and creating a good work-place was the managers' conversations about improving work conditions and atmosphere. This involved things like organizing Christmas lunches, celebrating birthdays, and sending post-cards to employees who were away and taking part in social activities. An example was when a manager went around her unit to find employees to congratulate a nurse who had her birthday that day, in the middle of the busiest time of day. "Who has time to sing happy birthday for X?" Many came to sing and congratulate the colleague and then literally ran back to their tasks with the patients. Communicating using structuration of caring for employee's well-being was part of the manager's work practices.

Structuration of interdependency

In the managers' talk, several types of structuration of interdependency relationships were used: one that shows the interdependencies with superiors and the management system and another that shows the interdependencies with particular professional groups or the managers' own unit.

Interdependencies with the management system

In aligning with the management system the managers needed the approval of their superiors, leading to a kind of personal reputation management. One way was to take on extra administrative or organizational duties outside of their own unit. Several of the managers had done this: one was responsible for creating statistics of salaries at the whole department, one ran a group that coordinated summer vacations at the whole hospital, one chaired a cross-functional group that discussed the long range vision of the hospital, one was very active in a regional project to increase collaboration with the municipalities and another was a mentor and back-up for a new colleague at a neighboring unit who was substituting as a manager.

One specific example of reputation was when a second-line manager wanted his units to show off their good work to the CEO of the hospital who was planning a visit:

Second-line manager: Who wants to receive him?

First-line manager: The chronic pain treatment ward, perhaps?

Second-line manager: You mean our new business concept? You are right; we have so much to show off!

The managers also took part in structuration of interdependency relationships amongst their peers: other managers within their own departments, whom they communicated often with (see Arman et al. 2009). This was done for example by making themselves out as a separate group, in their common communication. One way of doing this was by joking about the employees, or complaining to each other about their behavior. For example, during a meeting with a group of first-line managers one manager said that assistant nurses "work in flocks, they are herd animals". Another manager added: and nurses just "inject and run". There were also several conversations between managers in which employees were described as difficult to deal with and stating that "they don't understand", something the managers seemed to agree on.

Also, the managers communicated their interdependency with the technostructure of the organizations such as audit/finance and the HR-departments. For example, during a one-on-one, two managers exchanged stories about the new administrative tasks given to the managers and how to deal with or get around them. The interdependencies were made clear in this communication.

In another example a quality control director complained at a management team meeting that the line managers were not reporting on time for an annual

report. The department head chided the line managers, saying: "We are all part of a chain and must respect each other's work". She thus used structuration of interdependency for the activities of the whole management system, of which her own work was a part.

Interdependencies with a professional group or a unit
Many discussions that the managers took part in were about the constant objective to save money, also showing their interdependency with the management system. Forwarding the demands top-down, the managers often asked their employees to offer suggestions on ways to save money, showing interdependency with them. At one ward, when a question was raised by employee professionals about the financial responsibilities for intra-organizationally shared patients, the manager answered: "There has been a decision and agreement about this matter among us managers, but that will not help unless all practitioners are on board." She was referring to the fact that if physicians admitted the wrong type of patients, the costs would be unfairly distributed. This was out of managements' control. Here the structuration of the interdependency with the management system was communicated, while at the same time pointing to the interdependency with non-management.

Conflicts with top management sometimes resulted from interdependencies within a unit. There were examples where managers protected staff against cuts, spoke up to their bosses and were critical of upper management's distancing to practice. This was often discussed during one-on-ones with other managers. An example was when a first-line manager told a peer about how she needed more doctors at her unit and struggled to get support from upper management and her colleagues: "It is clear that they hold back and then blame us, and they can't! I had to tell them to support me in this. I had to sharpen my tone."

Similarly, the managers were also involved in tensions between professional groups. The typical conflict was between physicians and nurses or other professionals at the units. In the same example as mentioned above, where the manager was dealing with the aftermath of a nearly fatal incident, her staff felt that the quality of care and communication between nurses and doctors had been poor during the critical incident. The manager, who was a trained nurse, had also immediately organized debriefing sessions but came under criticism for only inviting nurses and not the physicians involved. The critique was communicated both in one-on-one impromptu meetings and during a general management meeting. The manager told the critical doctors that she did not have any good communication channels to them, further indicating the structuration based on the interdependencies with her own profession as a nurse.

Structuration of accountability
In the managerial communication, structuration of accountability was more difficult to trace, compared to the other two types. Many structuration processes involving accountability elements overlapped or were integrated with structu-

ration of caring and structuration of interdependency. However, two sub-categories of structuration of accountability will be described: accountability as a form of reputation maintenance and accountability in the shape of audit trails for negotiating responsibility. Both of these types of structuration involved efforts to make the managerial work comprehensible, understandable and predictable, often for many simultaneous audiences (see e.g. Power, 2007). This part of the managerial work was often directed towards the organizational level as a whole, instead of only their own position, personal activities or that of a certain sub-group.

Reputation management

Within the communication we found that the managers worked for legitimacy of their units and organizations, trying to make them acceptable, understandable and inviting. Audiences indicated were top-management, politicians and the general public. For example at a management group meeting, a manager discussing a development project explained that it was developed in answer to a recent negative public evaluation from the National Board of Health and Welfare. His superior pointed out: "This will give us a good example to display to others."

Systematic evaluation tools played an important role in these legitimations, offering a sense of comprehensiveness. The news media's reporting was also given importance. One manager told a colleague that she had tried to get a reporter that contacted her to write about the positive changes made at her department. Another manager was contacted by e-mail and telephone by a lobby association working to promote specific specialized care units at a national political level. The lobby organization was asking for persuasive information and "good examples" for a public report.

The awareness about reputation and this structuration process was also evident in conversations within the organizations. During a coffee break a head doctor at one unit told a manager that he was taking a course about how to deal with media/press. As a participant he had been sent four cases to study, including instructions about what to do in such situations. He gave the manager examples of the kind of things "media will do" to get information that they want, even if it is classified. Managers thus talked with each other and their employees about how to manage media but also about what "looks good" in others eyes.

In another example at a management group meeting, the head of the department compared the "brand of the hospital" to that of a retail store chain that currently experienced a highly publicized scandal in the media. At another unit an "open house" was being planned for the general public as a way to manage the relations to the local stakeholders. Discussing this open house, the second-line manager that we shadowed asked her first-line management-team what "image" the unit wanted to display. In these conversations, structuration of accountability of the managers´ activities can be traced as they used arguments concerning the importance of a good reputation.

Audit trails

Accountability in the form of traceable audit trails is also considered as a structuration category in this study, because they were used to show comprehensiveness to audiences within and outside the organizations. The audit trail structuration included discussing ways to assign responsibility and blame for "risks" and mistakes. At one meeting the middle manager discussed the fact that the CEO of the hospital questioned management as soon as the patient turn over statistics were not up to par: "He is fast as a ferret!" she said, indicating her perception of the intensity and speed of his scrutinizing of the reported numbers.

Different forms of reporting were used to distribute blame in what was described as extraordinary situations. This structuration process of accountability was implying that mistakes were made and if only normal procedure was followed this would not happen. For example, in the dispute between nurses and doctors at a unit concerning the critical incident mentioned above, the superior manager referred to an internal systematic accident analysis as a useful tool: "The analysis will show who was not listening. You will see. And the medical part of it can be judged."

Similarly, in another example a new system for handling patient complaints was described as a learning opportunity and comparisons were made with the efficiency of a private company, thus promoting the "transparancy" that the system offered through the creation of an audit trail. However, one manager complained to her development secretary that it was the managers that were held responsible if employees did not report statistics like these as intended.

In sum, the analysis of the managerial communication practices showed structuration of caring in their activities when referring to patient as well as employee welfare and well-being. Also, structuration of interdependency could be traced when conversations referred to the varying interdependencies: with the management system, the top-management, the unit or a professional group. Finally, structuration of accountability was interpreted in the conversations referring to reputation and creation of transparency through audit trails. Many of the managerial communication practices also showed that these conceptually derived types of structuration in practice could be integrated or competing during the same event.

Discussion

Our analysis has shown that the first- and second-line managerial communication involves constant participation in structuration processes which have particular characteristics. HCMs jobs do not involve carrying out a clear mission with some adaptations to different situations, but instead involve an active participation in uncertain communication practices. The study shows examples and consequences of different types of structuration on a daily basis. Furthermore, it is important to recognize the central conflict that may exist for managers, inherent in structuration. The communication shows how both social structures and agen-

cy e.g. in the form of individual norms, perceptions of meaning and attitudes are important for the managerial communication.

Our results show that the managers in their communication faced key challenges due to change, defining and regulating the activities that have goals, needs and expectation-driven conflicts and immediate interpretations, negotiations and judgments. They balanced the need and wish to show care, while taking part in various interdependencies and accountability processes, all as part of their everyday communication. This is in line with previous managerial work studies (see Tengblad, 2012). According to our results managerial communication is also about dealing with "future risk" as communication is used to protect and create good reputation (Arman et al. 2012). Furthermore, managerial communication is important in situations when there are conflicts between different structuration practices and if there is uncertainty about different accountabilities and priorities.

In previous interview based studies managers have been shown to vary in their choice of base for structuration as care professionals and members of the management system (Llewellyn, 2001). Sometimes it was experienced as an inner conflict (Dellve & Wikström 2009). The communication in our study showed the co-existence of both logics. In the findings managers referred to their own professional knowledge to solve problems, while doing clinical as well as administrative work. The studied HCMs tried to prove themselves within the norms of the administrative system, while negotiating multiple interdependencies with both professional groups and one's own unit. However, this study also contributes to the managerial work studies tradition with a focus on the organizational structuration that is the consequence of managerial communication. In this way it adds to the individual focus on managerial control strategies in previous studies. The following discussion considers the relationship of the studied structuration practices first to signification and domination in the work place, secondly to the macro structures of health care reforms and the emergence of a risk society.

Examples were studied where the managers were involved in receiving and giving factual and non-factual information such as news about budgets vs complaining about management as well as employee behavior (see e.g. Mintzberg, 1973; Kotter, 1982). It is however also evident how deciding the very nature of facts and non-facts came under negotiation, which we see as an example of the signification process (see Giddens, 1984). Moral arguments, interdependent relationships, accountability and reputation were all important for the reproduction of structures of meaning in this setting. For example, the meaning of "objective" reports on patient turn over, patient satisfaction and critical incidents were negotiated as managers found ways to use the statistics to serve interests such as opposing staff cuts or to solve conflicts between professional groups in the work-place.

Power and domination, in this context, was exercised as authority so that the different interests were rarely made explicit (Lukes, 1974). The fact that the managers sometimes protested against lack of staff was part of a routinized

communication of interests where the arguments and positions were predictable to the participants (see Deetz, 1995). In the reproducing of the same meanings over and over again, legitimation, signification and domination overlap as part of the structuration process. The repeated meanings (re-)produce a dominating structure (Giddens, 1984).

Other models of communication might be possible, bearing in mind the transformative power of communication and the possibilities that agency affords. "Productive" communication is a participatory model of communication. This model is based on the actors striving to establish dialogue-oriented communication by equally putting forward their different experiences of the service/practice in order to transform conceptions and ways-of-working (Deetz, 1995). However, this model was not observed in the study except partially in one-on-ones between peer managers supporting each other as friends by sharing experiences. Seen from this perspective, the questioning by media and the management system could productively strengthen and clarify the structuration, if the discussions are sufficiently explicit.

However, instead of opening up to differences and thus increasing uncertainties, we have suggested that the findings from this study support a model containing a structuration process of handling of uncertainties through accountability. Michael Power (2007) described this type of legitimation work as a form of risk management. The managers' communication shows legitimation characterized by creating an appearance of transparency and accountability. We found that in the studied health care organizations the struggle for maintenance and repairing of societal legitimacy is pervasive. The media is quick to give attention to negative news about problems. The questioning creates uncertainty for the organizational members, the need to safeguard reputation and blaming drives the need for audit trails, as previously stated in Powers theories (2007).

Risk management practices may lead to attempts at rationalization of processes which could in turn lead to a highly bureaucratic control. Power (2007 has described how abstract talk of risk management encourages self-awareness and a top-down view of organizations. In our study we showed how accountability was used to close down discussions of e.g. caring for patients and employees by instead reporting and assigning blame. This third type of structuration practice can thus be interpreted as counterproductive as it takes resources (time) from development work in the organization. It is then seen as passive and reactive work. Good management would then involve acting as a buffer, translating external pressures and creating a blame-free zone within the operative parts of organizations (Power, 2007). This would however leave the managers alone responsible and exposed to sanctions (another form of domination), as when employees did not use the new patient complaints reporting system.

Continued studies are needed to investigate further the contextual patterns for how the structuration is negotiated, for example through comparative studies in different settings. Also, continuous changes in social norms evident in managerial communication practices are a strong argument for longitudinal and/or historical studies.

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Concluding remarks

By studying what managers do and their structuration practices we can develop a current and multifaceted understanding of managerial communication and how it relates to social structures. The managers used a combination of structuration of caring, interdependency and accountability with several subcategories described above, some of which have been described in earlier studies of health care organizations. The communication practices were also related to how new norms of reputation and accountability management were institutionalized through structuration in everyday practice.

The types of structuration were sometimes contradictory and turned managerial communication work into an act of negotiation. This is a finding that is probably generalizable to many other professional organizations. This shows that the study of work practices and experiences are enriched by an understanding of the negotiated quality of existence, produced in communication (Deetz, 1995). The practical implications of the study bring the need for multiple dialogues to be enabled in settings such as professional organizations. How can managerial work be negotiated openly and productive communication realized? Our study points to the need to recognize the necessary practices and processes in the organizations for these complex tasks.

The practices had consequences for the processes of power and control exercised and for what issues were signified and seen as part of the agenda. Considering the possibilities of productive dialogues, structuration negotiations should be viewed as fortunate, if this means that a diversity of interests are voiced and new ways of handling problems are developed (see Deetz, 2003). This is important to continue studying as new reforms are implemented in the public sector. Such studies have implications for policy-makers and reformers interested in the intended and unintended consequences of reforms.

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