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Dynamics of distributed leadership during a Hospital Merger

Abstract

Purpose - Mergers have become an influential part of public hospital development, and the successful implementation of such mergers requires skillful management. Recent studies have pointed to the impact of the distribution of leadership tasks amongst employees for implementing planned radical changes, yet this lacks examination with regard to hospital mergers. This article investigates the emergence of distributed leadership and this leadership's influence on the implementation of a hospital merger.

Design/Methodology/Approach - The emergence of distributed leadership is examined through a qualitative case study of two Danish hospital units in the context of a large hospital merger. The data consist of 21 interviews and documents collected over a 3-year period.

Findings - Our findings suggest dynamics of widened and restricted distributed leadership being influenced by and influencing the merger at hospital and local-unit levels, respectively. Importantly, the perceived purpose of widened and restricted distributed leadership mediated the actual effects of widened and restricted distributed leadership on the implementation of a merger. Moreover, our findings show that mergers on both the hospital and local level lead to variations in top-down and bottom-up distributed leadership across pre-merger organizational boundaries.

Practical implications – Perceived purposeful widening and restriction of distributed leadership at various hospital levels enables merger integration and collaboration across organizational boundaries and hierarchies.

Originality/value - The paper addresses the need to understand the complex dynamics of widened and restricted leadership distribution in a merger context.

Keywords - Distributed leadership dynamics; Merger level; Management; Health care; Qualitative research

Paper type - Research paper

Introduction

Many public sector organizations are currently undergoing profound organizational mergers to make welfare services more efficient and keep costs down (Fulop et al., 2005; Pinheiro, Aarevaara, Berg, Geschwind, & Torjesen, 2016). In the health care sector, hospital mergers have been undertaken to enhance quality and reduce costs; yet many such mergers face implementation difficulties due to limited resources, divergent cultures and, in particular, lack of leadership (Comtois, Denis, & Langle, 2004; Fulop et al., 2005; Weil, 2010). It has also been proposed that a gap between managers and health professions is a central cause for merger failures in health care (Denis, Lamothe, & Langle, 1999; Kitchener, 2002). A line of research that comprises more plural leadership constellations, in which managers and health professionals work together to carry out merger-related leadership tasks, has however shown positive effects in an increasingly complex public sector, where the ability to bring about change is dispersed across loci and professions (Chreim, Williams, Janz, & Dastmalchian, 2010; Harris & Harris, 2008; Harris, Leithwood, Day, Sammons, & Hopkins, 2007; Leithwood et al., 2007). The implementation of a merger specifically concerns the establishment of novel routines and cooperation and integration of expertise and services across different locations and professions (Pinheiro et al., 2016; Yu, Engleman, & Van de Ven, 2005). Thus, a wider distribution of leadership tasks beyond that of the formal leaders may be effective for implementing a merger. However, the effects of health professionals taking on merger-related leadership tasks has been investigated only to a limited extent (see Choi, Holmberg, Löwstedt, & Brommels, 2012; Günzel-Jensen, Jain, & Kjeldsen, 2016).

While some studies of plural leadership constellations subscribe to a classical normative approach regarding the positive effects of such leadership constellations, we also wish to combine this point of view with a more descriptive approach of the contextual conditions for distribution of leadership tasks to emerge (c.f. Bolden, 2011; Jones, 2014). A

recent study (Chreim, 2015) highlights the need for a closer investigation of situations in which the potential distribution of leadership tasks, as well as its assumed positive effects, fail to materialize. This is relevant for a closer examination of situations in which the distribution of leadership tasks does or does not emerge, the conditions for such (lack of) emergence, what form a potential distribution of leadership tasks takes, and what purposes it may serve. Based on a combined normative and descriptive approach, we thus propose a dynamic relationship in which the distribution of leadership can influence the implementation of a merger, but where the context of the merger also determines whether or not and how the distribution of leadership tasks emerge. We also argue for the necessity of examining how a merger is implemented at various organizational levels, i.e. at a higher hospital level and a more local-ward level, and how this affects the emergent distribution of leadership tasks. Although, as mentioned above, the distribution of leadership tasks can take place across different locations, and hospital mergers often focus on merging expertise and services from different locations, the specific influence of locations or different organizational *levels* of the merger has, to our knowledge, been little dealt with (see however Yu et al., 2005). This is despite arguments that top-down mergers initiated at the hospital level often evolve into conflicts between managers and professionals at the local levels (Choi, Holmberg, Löwstedt, & Brommels, 2011; Denis et al., 1999). We therefore also wish to examine the merger and related distribution of leadership tasks at different organizational levels, i.e. hospital and local-unit levels. Thus, our research question guiding the presented study of distributed leadership emergence dynamically affected by and affecting a hospital merger, and taking place at different organizational levels is:

How does distributed leadership emerge and affect the implementation of a hospital merger at respectively hospital and local-unit level?

This question is empirically examined by means of a qualitative, longitudinal case study consisting of documentary material and semi-structured interviews with Danish hospital staff at one of Scandinavia's largest public hospitals, which was established following a major hospital merger in 2011/2012.

Theory: The emergence and effect of distributed leadership during organizational mergers

Mergers are an important part of modern public sector strategies, many with the goal of creating competitive, low-cost organizations (Pinheiro et al., 2016; Weil, 2010; Yu et al., 2005). This also holds true for the health care sector, where hospital mergers have been established to cut costs and integrate the expertise of high-quality services (Fulop et al., 2005; Weil, 2010). However, despite such strategic aims, mergers are often difficult to implement (Cartwright & Schoenberg, 2006). This is also the case in the health-care sector, where mergers have proven difficult to implement due to problems of merger legitimacy, limited resources and integration of divergent cultures (Comtois et al., 2004; Denis, Lamothe, & Langley, 2001). As a response to these merger problems, the role of leaders in creating successful organizational mergers has attracted some attention (Choi et al., 2011; Denis et al., 1999; Geisler, Widerberg, Berghöfer, & Willich, 2010; Kitchener, 2002). Mergers have been found to increase employees' feelings of uncertainty and the need for strategic implementation of novel work routines and cooperation across organizational systems and cultures. In response to such reactions, leaders often tend to tighten control and power in an attempt to manage human and organizational factors (Cartwright & Schoenberg, 2006; Schweiger & DeNisi, 1991). However, contrary to a leader-centric approach, recent studies of hospital mergers show that in complex political environments managers are limited to create merger legitimacy, initiate the change and risk being scapegoats in the context of multiple

stakeholders, including politicians and health professionals (Choi et al., 2011; Kitchener, 2002). It is emphasized that leaders face a difficult situation if they plan to merge different cultures and staff through top-down management from hospital to local-ward level without the involvement of the health professionals (Choi et al. 2012). Thus, classic top-down management and individual leadership may be an important obstacle to the integration of different clinical practices following a hospital merger. Instead, plural leadership constellations that involve all staff and different cultures seem important for a positive merger outcome. However, in an organizational merger context, the emergence of plural leadership constellations in which actors beyond the formal leader partake in leadership practices has received little attention (see however Choi et al., 2012; Günzel-Jensen et al., 2016). More research is therefore needed to not only identify the outcomes of, but also the conditions for and processes of engaging employees in leadership tasks directed at coordinating merged organizations' cultural values and practices.

While hospital mergers have been investigated to some extent, little attention has been paid to the organizational *level* of the merger (Yu et al., 2005). This is important because it has been argued that the boundaries of mergers in terms of time and context are difficult to define (Fulop et al., 2005). As mentioned above, recent studies of hospital mergers also emphasize that top level merger decisions are apprehended differently at the local level and will often evolve into conflicts between top leaders, managers and health professionals (Choi et al., 2011, 2012; Denis et al., 1999). In their study of hospital mergers, Yu et al. (2005) show how managers address the merger-related integration within a unit differently from integration across other parts of the organization. Based on such differentiation at organizational levels, we argue that the defining characteristics of the hospital-level merger (of different former hospital organizations) and local-unit level merger (of former sections) and how this influences the distribution of leadership tasks need to be investigated.

In terms of plural leadership constellations comprising concepts such as shared, pooled and distributed leadership, we find the concept of distributed leadership particularly useful for investigating the interaction of formal leaders and employees in giving direction to and influencing others in the process of integrating merged units and sections. This is because, in comparison with e.g. pooled leadership (comprises leadership constellations within management groups) and shared leadership (comprises the mutual leadership in groups or teams), distributed leadership has a particular emphasis on leadership being distributed across hierarchical levels of formal leaders and employees and across the structural boundaries of an organization (Denis et al 2012). In relation to hierarchical levels, the studies of distributed leadership also more specifically emphasize a latent agency aspect of leadership, where distributed leadership is not only initiated top-down as a formal leader strategy but can also be initiated bottom-up by certain employees that find purpose and opportunity to take on leadership responsibility and tasks (Jønsson, Unterrainer, Jeppesen, & Jain, 2016). This corresponds well with the perception that mergers are inherently challenged by having to cross the boundaries of pre-existing organizational units and hierarchical orders. Distributed leadership as a concept also pays attention to describing what the actual distribution of leadership tasks among agents entail. Distributed leadership suggests that varieties of expertise are distributed across the many, not the few (Bennett, Wise, Woods, & Harvey, 2003: 7). Gronn (2002) wrote that distributed leadership is best understood as a unit of analysis comprising leadership as “concertive action,” where two or more actors work jointly on a leadership task through reciprocal coordinated efforts. Thus, distributed leadership involves multiple actors working jointly to coordinate their expertise on leadership tasks of decision-making, goal setting and resource allocation across different hierarchical levels and structural boundaries of the organization. Studies have shown that distributed leadership contributes positively to planned radical change and transformation in school and health care

organizations (Harris & Harris, 2008; Harris et al., 2007; Leithwood et al., 2007). In their study of distributed leadership in health care, Chreim et al. (2010) found that individuals with different skills and from different levels pool their expertise and resources to induce and manage change. Similar positive effects of distributed leadership may be assumed for implementing hospital mergers, which can be defined as a certain kind of planned radical change. However, more studies are needed to confirm this.

These perspectives on the positive effects of distributed leadership have however been moderated by a stream of more critical research. As an example of this, Jones et al. (2014) found in their study that distributed leadership can have various impacts, ranging from social regulation to radical change. White et al.'s (2014) study even shows that distributed leadership is not always perceived as useful; for example, in situations of change when work routines are absent and uncertainties and conflicts flourish, formal leadership hierarchies, as opposed to distributed leadership, are often found purposeful to return to. Therefore, the usefulness of distributed leadership cannot be taken for granted but must be measured through the perceptions of the various actors. Bolden (2011) suggests that future studies should pay more attention to the various purposes of distributed leadership before assuming any positive change outcomes.

Critical lines of research have also questioned the seemingly straightforward development of distributed leadership and have instead emphasized the contextual conditions necessary for the actual emergence of distributed leadership. It has been demonstrated that the emergence of distributed leadership in health care is restricted by contextual conditions, such as the complexity of professional and policy institutions (Currie, Grubnic, & Hodges, 2011; Currie & Lockett, 2011) and pre-existing hierarchies (McKee, Charles, Dixon-Woods, Willars, & Martin, 2013). Currie et al.'s (2009) findings suggest an alternative approach, which we subscribe to, of analyzing the emergence of distributed leadership as varying on a

continuum from more widened to more restricted forms. A widened form implies numerous transient leadership agents, and a restricted form places the ultimate responsibility for organizational performance with the formal leader—although others do make suggestions and help implement possible solutions.

Of particular relevance to an organizational merger situation is Bolden's (2011) call for a better understanding of how the boundaries and cultural differences between different organizations influence the emergence and purposes of distributing leadership tasks. In line with this, Chreim (2015), in a study of corporate acquisitions, finds that the process of distributing leadership is top-down controlled by acquiring managers in superior positions and dependent upon levels of conflict between the acquiring and acquired organizations. Thus, although distributed leadership may emerge bottom-up, the opposite may also be the case, and conflicts between the merged organizations may be influential regarding the emergence or restriction of distributed leadership.

Consequently, the more critical lines of research, which we are inspired by, imply that more attention should be directed to the *dynamic* emergence and influence of distributed leadership. Such dynamics of distributed leadership require, on the one hand, that widened and restricted distributed leadership influences the implementation of a hospital merger. On the other hand, this dynamic implies that the emergence, or restriction, of distributed leadership is conditioned by the merger context. This merger context can be characterized by the different organizational levels of the merger, the cultural boundaries and divergent objectives of the merged units and the leaders' and employees' perceived purposes of widened or restricted distributed leadership in times of merger.

Methodology

Our study of the emergence of distributed leadership in a merger context took place in a Danish setting in one of Scandinavia's largest public hospitals. The hospital went through a large structural and financial reform involving the merger of four small regional hospitals into the HME (Anonymized hospital name), and resulted in an overall 10% reduction of the total regional health care spending between 2012 and 2014. The reform was passed by the politically elected regional board in 2011 and was implemented in the spring of 2012. This planned change initiative can be characterized as a top-down reform involving profound restructuring and centralization of medical specialties and functions, which—due to the attached savings plan—involves ongoing change processes across hospital units at the HME.

We have chosen a realist ontological and epistemological approach and thus consider the participants' and our generated knowledge to be a social and historical product of a complex social reality (c.f. Robson & McCartan, 2016). In line with this approach, we conducted a qualitative, longitudinal case study in selected hospital units at HME. The case study method is particularly useful and much used in connection with exploratory research questions aimed at extending theory (Yin, 2013). In the present case, we traced the planned organizational merger over a 3-year period (2011-2014). We analyzed semi-structured interviews with unit managers and clinical staff in two selected hospital units, A and B, and they were collected as panel data with the first round of interviews in the spring of 2013 and then again in the autumn of 2014 (total n=21). The interview data are supplemented by documentary data (meeting minutes, strategic documents, HR policy documents, and newsletters 2011-2014) to provide context information regarding the planned changes following the hospital merger and the introduction of the savings plan. Overall, this unit of analysis is ideal for our qualitative longitudinal case study because the context allows us to focus on emerging distributed leadership and organizational change dynamics.

As summarized in Table 1, Units A and B are of similar size and function. Neither of them were physically merged with other units as a consequence of the merger. However, in connection with the hospital merger, local mergers of sections took place in both units. In the autumn of 2014, a merger of two bed wards located in the same hallway and on the same floor almost doubled the size of Unit A. In terms of distributed leadership, this had a radical unit-level effect on the interaction between the formal unit managers (i.e., head nurses and leading physicians) and the regular staff. This local merger, which was adopted and officially announced by the hospital management in the summer of 2014, was a consequence of the hospital merger and saving plans implemented from 2012 to 2014. Moreover, they experienced spillover effects from the hospital merger in terms of new types of patients entering and leaving the units that required ongoing changes in work routines, goals, and resources.

At a greater hospital level, novel restructurings involving Unit A and B also took place following the merger. Most notably, the hospital merger entailed a restructuring of the acute hospital functions by means of the redistribution of staff, resources, and patients from “the old hospital units” to a new general acute ward located at the HME (blinded reference, 2011). The planned upgrading of the acute ward was gradually implemented from 2013 to 2017 and involved the allocation of more resources (personnel and beds) from the various units (including Units A and B) to the acute ward to enable it to take in more patients needing a wider variety of medical competences. Another important change was that one of the smaller hospitals that had organizationally merged into HME became a special “center of excellence,” taking care of routine surgeries and treatments and leaving the more complicated patients to Unit A or Unit B (blinded reference, 2011).

[insert Table 1]

In line with purposeful sampling (Miles & Huberman, 1994), we interviewed the same persons in 2014 as in 2013 whenever possible to investigate the perceived impact of the merger over time. Key topics in the interview guide were “the merger-related change process,” “development of distributed leadership” and “cooperation and conflicts.” The second round of data collection focused on following up on any interesting themes from the first round of interviews.

Analysis and coding strategy

The qualitative analysis of the interviews and relevant documentary material on the merger consisted of several analytical steps and coding phases in keeping with our realist approach. The qualitative research software NVivo was utilized to systematize the coding and analysis of our material. Initially, we conducted a focused coding of the interviews from both data collection rounds using key topics from the interview guides as guidelines while continuously adding emerging themes relevant to our analytical purpose of exploring the dynamics of organizational change and distributed leadership. This approach produced 29 main codes (cf. the paper’s online Appendix). During the data analysis process, members of the research team worked individually on data coding and then met to discuss and agree on the analytical categories. Interview data were triangulated with the documentary material to produce “thick” descriptions of the distributed leadership/change dynamics that contributed to the credibility of our findings (Miles & Huberman, 1994).

In the second stage of analysis, we systematically analyzed the core analytical categories from the initially developed coding hierarchy—most notably “distributed leadership emergence,” “distributed leadership tasks and outcomes,” and “merger changes”—and compared their coded contents both within and across the two hospital units. Inclusion of theories about the development and potential of distributed leadership made it possible to

inform the content of these categories and make an analysis comprising examples of widened and restricted distributed leadership and related contextual conditions. In our analysis, we operationalized the concept of distributed leadership as incidents, where one or more persons, either not being formal leader(s) or being middle manager(s) vis-à-vis top leader(s), took initiative to work jointly with other engaged persons in coordinating their expertise on a task requiring leadership (c.f. Gronn 2002). Such leadership tasks were strategic work and decision making regarding, for example, allocation of resources, structuring the treatment, and assignment of patient groups in newly merged wards and units as well as influencing co-workers and creation of direction in relation to integrating former separate units. This is in line with how Chreim (2015) and Chreim & MacNaughton (2016) operationalize distributed leadership practices. We paid analytical attention to making sense of instances, where, and on what organizational level, such distribution of leadership emerged, and where it did not, and the related reasons for - and consequences of such (lack of) emergence, which relates to our notion of the dynamics of widened and restricted distributed leadership and hospital merger implementation. Moreover, we created case memos to develop the meaning and comparison of key quotes on the emergence of distributed leadership. As described by Charmaz (2014), the case memos became the pivotal intermediate step between collecting data and writing the cases presented in the section below.

Findings

Hospital level manager-professional conflicts of uneven leadership distribution

At the greater hospital level, the health professionals primarily expressed concerns regarding the merger in terms of the establishment of the general Acute Ward and the placement of the Center of Excellence at one of the merged hospitals. Following the establishment of the Acute Ward, the interviewed nurses and physicians in Unit A and B complained that they did

not receive fewer patients even though they had to contribute resources to the Acute Ward.

They entered discussions with the Acute Ward regarding whether or not they should receive patients and whom they felt belonged to the Acute Ward in the first place.

The physicians at the Acute Ward are supposed to make decisions regarding all patients, and we try to be nice when they call us and ask. But what they do is trying to get rid of their patients, and then they send us some patients for whom we have already handed over beds. We say that “we are not going to treat these patients anymore” (...) and the nurses get frustrated when the patients return anyway when we have given up two nurses and four beds. So, do you think it is going well? (...) The hospital executive board has taken over the unit management. I can say to [the head of department] that I think this and that would be a good idea, but then he comes back to me and says “This is no good.” Then I ask, “Is this because you went and asked someone?” and he says, “Yes, and they don’t like it.” This shows that we do not have any delegation on important matters anymore. (IP4(2) – Chief physician, Unit A)

In particular, the shortage of specialists among the Acute Ward physicians was regarded as a major problem. To leverage resources across the new organization, the leading physician decided that, if necessary, Unit A physicians should be prepared to shift quickly to the Acute Ward. Already during the first round of interviews, the physicians knew that this might create resource difficulties in Unit A, and this negative consequence continuously created tensions between the health-care professionals (most notably the physicians) and the HME’s top administrative management. Although the physicians in Unit A had tried to regain influence and involvement in important strategic leadership decisions in relation to the unit’s future in the post-merger structure, no changes took place during 2013 and 2014.

The interviewees in Units A and B further expressed concerns that the patients received after the merger had more complications and therefore were less profitable than the patients received at the Center of Excellence located at the other merged hospital. The affected units pointed out the perceived imbalance in workload between two of the merged hospitals to the hospital management, apparently in vain. It was suspected that the top management and the politicians had reasons not to fully merge the Center of Excellence with Units A and B to prevent the smaller hospital from being closed down.

I would like us to be completely merged [the Center of Excellence and Unit B]. The money we're missing is the profit of the Center of Excellence. They are very well financed. It's a prestige project. [I: Have you raised the issue higher up in the system since we last spoke?] Yes, but it's a political decision and that's the way it is. The bright ones fool the less bright. (IP9(2) – Chief physician, Unit B)

These examples show that the merger-related organizational placement of the new Acute Ward and the Center of Excellence was established as a formal top leader decision. This formal leader decision was, however, not perceived as feasible. Instead, some of the physicians tried in vain to obtain more distributed leadership tasks in terms of gaining influence on the organizational strategies regarding the Acute Ward and the Center of Excellence in order to retain the units' own decision-making with regard to patient allocation. Thus, the professionals perceived the current situation as restricting some, but not all, units' distributed leadership of allocating patients, providing little room for these units to offer strategic ideas and advice regarding the hospital level of organization based on their professional expertise. Furthermore, although distributed leadership theoretically is perceived as also potentially emerging bottom-up (Jönsson et al., 2016), the physicians (unsuccessfully) tried to create bottom-up distributed leadership. Importantly, dissatisfaction with such top-down restricted distributed leadership centered on experiences of the *uneven* top-down distribution of leadership. This meant that some professionals at some hospital units in the merged HME (the Acute Ward and the Center of Excellence) were granted enhanced opportunities to make leadership decisions regarding resource allocation on behalf of other units, where such distribution of leadership decisions was restricted. This dynamic of simultaneous and uneven widening and restriction of distributed leadership across the different units involved a lack of reciprocal and coordinated concertive actions (c.f. Grønn, 2002) among the health professionals across the merged hospitals and novel established units and centers. Overall, the top management was criticized for not ensuring a more comprehensive "full" hospital merger that would allow all the wards and units to cooperate

more closely. Instead, the merged units continued to work as relatively separate units. In regard to the merger, it thus seems that the professionals did not raise a conflict over having to implement the hospital merger *per se*, as prior studies have proposed (Choi et al., 2011; Denis et al., 1999). On the contrary, they accused the top management of not working towards a more substantial merger, where all health professionals *across* the merged hospital units could collaborate more fully and engage in widened and evenly distributed leadership tasks of implementing the merger.

Local unit-level widened distributed leadership: Integration of merged sections

Following the merger, a number of local changes, including the merger of two bedridden sections in Unit A, were about to be implemented. Within Unit A, the nurses in particular described a certain culture of allowing everyone to express his/her own opinions in the former Section A1. “I think that’s the culture of this unit—giving space to make it possible. So, you always have the possibility to be heard or to participate” (IP12 – Nurse, Unit A (former Section A1)). As far as the professional hierarchy was concerned, the physicians gave the nurses—mainly the more experienced nurses—wide discretion regarding, for example, the dosage of pain-reducing medicine to patients because it was often difficult to get hold of a physician. Following the merger of Sections A1 and A2, the nurses were curious to see what would happen because they had a distinct perception that the former Section A2 was more hierarchically organized with less room for distributed decision-making across professional hierarchies.

To the physicians and the ward management, I say that “we [in the former Section A1] have always done it this way and we haven’t killed anyone yet so you might as well loosen up.” Because we can clearly see the difference between the physicians who are used to Section A1 and those from Section A2; they [physicians at the former Section A1] know that we can handle it. (IP23 – Nurse, Unit A)

This nurse described her efforts to continue the distribution of decision-making regarding medical treatment in her cooperation with new physicians and ward management. This shows how distributed leadership practices in a hospital unit evolved due to sub-organizational restructuring, in the sense that the more widely distributed responsibilities at the former Section A1 spread to the former Section A2. Furthermore, in the period between the first interviews in the second round of data collection in Unit A and the final interviews in the unit, the nurses from the former Section A1 in particular seemed to have found some locally-initiated opportunities to establish closer bonds to their colleagues across the merged sections. An important concern among the nurses was how to support each other in times of unequal work pressure in the new Unit A. Prior to the merger, the two sections were considered separate work groups, but the nurses took leadership initiative to create and fulfill a goal of braking down the mental and physical walls between the two sections.

And this thing with the sections being divided and located at each end of the hallway. That is not how it is anymore. Now we sit in the shared office and this means a lot because you can instantly spot if a group is behind schedule, or if a group is under heavy pressure – then you are quick to ask for help. Nobody kind of thinks, “Oh, is it okay for me to ask?” That is not how it is. You just ask right away “can any of you help us, please?” And you also accept it if a colleague says “I really do not have the time right now.” Well, fine. She has her reasons to say no, because I know that if she had the time she would have helped. ... It’s almost like the breakdown of the Berlin Wall. We started drinking coffee together after a staff meeting last Monday where we agreed that this was what we were going to do. And now it has become very obvious that something has changed, for instance last weekend we were very busy, but after serving dinner in Section A1, I decided to go down there [to Section A2] and ask if they needed help, and I ended up staying there the rest of the evening. A year ago, this would not have happened – unless someone had told us to. (IP26 – Nurse, Unit A)

In Unit B, a new head nurse had recently replaced the former head nurse, who had resigned during the merger of the former sections B1 and B2. The new head nurse in Unit B also seemed to create room for more distributed leadership regarding the organization of work across the professional boundaries of chief physician (top local leader) and head nurse. She had electronic boards installed in Unit B (similar to other units and wards) (HME Newsletter,

week 34, 2014) that offered highly detailed follow-ups on patients' and employees' whereabouts and statuses. This ensured efficient patient flow in a unit with heavy work pressures following the merger and the allocation of "heavy" patients. Some of the physicians indicated that they preferred more informal planning through conversations during unit rounds:

In Unit B, the chief physician responsible for the unit rounds is now also responsible for running the electronic boards. But there is also responsiveness – for instance, last week the head nurse brought some evaluation forms and then we evaluated it. It's a pretty new thing [the boards] and we were not part of the decision. But on the other hand we don't have to be part of everything, because if everything has to be discussed, ideas will die. It's okay as long as they listen to our critique, but besides that, I think this is just another example of us wasting our time on the wrong things. (IP29 – Junior physician, Unit B)

As the quote indicates, the physicians acknowledged that their critique was being heard and that some decision-making and strategic development in areas that were formally the chief physician's responsibility should be distributed to the head nurses due to the demands for efficiency and for meeting the goals set for the unit after the merger-related new allocation of patients. A chief physician in Unit B further explained how they were constantly told by the hospital management and the politicians that they needed to become more efficient and, "*if electronic board meetings is what it takes, then we comply with it*" (IP14(2) – Chief physician, Unit B).

The empirical findings show that at the level of local units, the merger involved the leadership task of deciding how to integrate previously separated sections' work routines as well as creating novel ways of cooperating on new patient groups, thereby balancing the work pressure after the merger. These leadership tasks were distributed involving concertive actions (c.f. Gromm, 2002) of creating novel directions for collaboration across the former structural and professional boundaries of the now-merged sections. This distribution of leadership emerged bottom up by the nurses as well as laterally by the head nurse in relation

to the physicians. Consequently, some of the nurses took part in the leadership practices of influencing other agents to create novel values and a new cultural understanding of cooperation and resource allocation. This also implied new goal-setting with an emphasis on mutual support across former sections and more horizontal decision-making structures. This widened distributed leadership across former organizational and professional boundaries seemed to influence the local implementation of the merger in such a way that the merged units developed into rather well-functioning integrated organizational entities, where cooperation flourished. Conversely, it also seemed that a shared support of such an emergence of widened, bottom-up distributed leadership was *caused* by the merger of former sections into new units, which brought with it an urgency for integration and cooperation to handle the scarcity of resources and new “heavy” patient groups. These examples thereby show that a certain dynamic evolved in which the merger of former sections caused the need and support for widened distributed leadership, while this widened distributed leadership positively influenced the merger integration. In response to Bolden’s (2011) call for understanding how cultural boundaries influence the emergence of distributed leadership, the cultural boundaries of the merged sections seemed to support a widened emergence of distributed leadership. This was because the nurses’ comparison of different pre-merger cultural values and leadership practices between nurses and physicians created a “window of opportunity” for nurses taking on the leadership task of establishing novel collective values, routines and distributed leadership practices across the professional groups in ways that could enhance cooperation. Importantly, the formal head physicians and head nurses did not hinder such bottom-up distribution of leadership because it seemed that they all worked towards the same purpose of creating ideal collaboration *within* the newly established units. However, in regard to the hospital merger, it also seemed that such bottom-up emergence of distributed

leadership did not influence the greater hospital-level merger but merely held an impact and perceived purposefulness on the local unit level.

Purposeful restriction of distributed leadership: local managers “taking the blame”

In certain situations, the distributed leadership seemed to become more restricted even at the local unit level. Overall, after the local merger of the two sections at Unit A, the nurses in the unit seemed to continue the distributed leadership practices of the former Section A1. The new head nurse (IP24) distributed leadership by forming three strategy groups consisting of volunteer nurses from the two merged sections to develop a new organizational strategy for the unit. The groups strategically developed shared systems regarding future competency development, physical/interior design, long-term duty plans and the 24-hour care routine.

Elaborating a bit on the strategic aspects of the organization of the new care routines following the unit merger, the nurses in one of the groups outlined what they considered the best way to work out a routine, taking into account the nurses' personal wishes and a need for long-term planning. One of the nurses from the strategy group explained:

We have made an agreement that I and xx nurse from [the former Section A1] make a draft for the duty plan. We are the ones making the Sudoku. Then last Monday, our head nurse had a round where she asked about our wishes with respect to weekends, every second weekend, every third weekend or ... and then we wrote it down, and then we just switch if necessary. Everything is left out in the open. (IP26 – Nurse, Unit A)

However, establishing a fair duty plan was a complex leadership task and a potential issue of controversy because it could easily become a point of dispute among colleagues. The head nurse who formed the three strategy groups therefore emphasized that any complaints about the strategy, the routine, and the specific duty plans would be handled by the formal head nurses.

Yes, and in the future when two large sections have to function like one unit with all that it takes as to culture, competency development and all that, then you can say that a key person can take charge of the duty plan. But you have to be sure that right now we

are taking responsibility as leaders. I work out the final duty plan simply because I think it is a leader's responsibility, so I would have difficulties delegating that to an employee. ... Conflicts, competency development, and particular wishes that can or cannot be fulfilled – is simply not something a single employee should be responsible for and thus take the blame for. (IP24 – Head nurse, Unit A)

Thus, the merger did not imply development of a culture and shared practices, where the nurses could take charge of the duty plan. Instead, the head nurses considered it their responsibility as formal leaders to direct the merged sections toward a more integrated unit. This meant that the finalizing and execution of the duty plan, which in many ways materialized potential conflicts and divergent routines between the former sections, was a leadership task that could not be distributed to other informal leadership agents in the strategy groups. The new head nurse of Unit A (IP24) thereby initiated more restricted boundaries of distributed leadership compared with the former head nurse of Unit A (IP1), who, during the first round of interviews, explained that *“The deputy managers make the plan, and a nurse distributes weekends year-round. They do that permanently. I have not spent time on that for many years.”* Yet, it seemed that the nurses in the strategy group acknowledged such emergent changes of more restricted distributed leadership as a relevant leader responsibility “buffer” in regard to their strategic planning: *“And then I and [my colleague] have made this arrangement that all complaints go straight to [the head nurses].”* (IP26 – Nurse, Unit A)

The above findings show that the merger affected the otherwise top-down distribution of leadership towards more restricted forms of distributed leadership. What may distinguish this situation from the merger situation of the two sections, (in which a wider form of distributed leadership was developed), was that this situation was characterized by potential conflicts and the need to protect the strategically involved employees from other colleagues' critique and dissatisfaction with their decisions. In this regard, through more restricted distributed leadership, the head nurse influenced her followers by providing moral examples of how formal leaders should take responsibility for complex decision-making in times of

uncertainty. Yet, while the relevance of restricted distributed leadership was supported by the employees, this was also considered a highly temporary leadership practice following the merger and a situation of heavy turnover. This was the case in Unit B, where distributed leadership was also being restricted. The new head nurse explained:

I have presented them with many new things in my short time here, which was actually not what I had planned. My plan was to slowly get settled and observe how the unit worked and so on. But because so many have left, I had to find new key persons who had not been here that long either. Then I had to revise the introductory program, which has truly been a process of breaking some limits coming from the outside and touching on such core issues in the unit anyway. There hasn't been time to involve anyone, which is really not my style. That is not the way we are going to work in the future, but we had to do it this way now to get it done. (IP25 – Head nurse, Unit B)

The above examples show that simultaneously with a local widening of distributed leadership a local restriction of distributed leadership was also emerging. This local restriction of distributed leadership was, by and large, caused by the merger in that new units with different work planning had to be integrated. Furthermore, the upgrading of the Acute Ward resulted in more resource-demanding patients, which increased the nurses' work pressure. Additionally, after the head nurse had left, a rapid turnover among the nurses took place. The examples also show that the local managers questioned the relevance of distributing leadership for the implementation of a merger. They argued that, especially during a merger involving limited resources and potential conflicts in a vacuum of having to re-establish novel routines across merged sections, it may be particularly difficult to find the time to ensure a continued and otherwise perceived purposeful widened distributed leadership among the employees. Thus, restrictions of distributed leadership may be justified by demands of formal leader responsibilities of making hard decisions and solving conflicts in times of merger. What is important is that such locally, top-down-restricted distributed leadership was accepted and even appreciated by the nurses, who found that the restricted distributed leadership and placing the 'blame' on the managers helped them through the merger. The findings thereby

emphasize that the *perceived purpose* of distributed leadership—as well as the purpose of *not* implementing distributed leadership—is important for understanding the consequences of distributed leadership when implementing a merger. In regard to a prior study of managers being ‘scapegoats’ during mergers (Choi et al., 2011), our results add to this theory with an understanding of how leaders that choose actively to become a ‘scapegoat’ in times of heavy merger changes may be considered purposeful for the development of a successful merger *within* the local unit. This is also contrasting the physicians’ perception of restricted distributed leadership at the hospital level, in which the formal leaders were *not* perceived as taking the responsibility for conflicts between units related to the implementation of the hospital merger. Overall, a dynamic relation between the hospital merger and distributed leadership can be seen, where merger-related issues of lacking shared culture and time caused a restricted form of distributed leadership, which in return seemed, due to its perceived beneficial purpose, to affect a positive implementing of the various merger changes.

Discussion and conclusion

Our findings contribute to an understanding of how an ongoing merger influences the potential emergent distribution of leadership and, conversely, how this emergence or lack thereof may affect the implementation of the merger. In line with more critical studies of distributed leadership (Bolden, 2011; Currie et al., 2009; Jones, 2014), our study emphasizes the dynamic emergence of both widened and restricted forms of distributed leadership. Our study further nuances the literature on the contextual conditions of emergent distributed leadership (Currie & Lockett, 2011; McKee et al., 2013) by showing how such emergence is influenced by the merger taking place at different levels of the organization. In regard to the impact of the hospital merger on distributed leadership, we call for more attention to the hospital level, where our findings showed restricted distributed leadership in terms of

professional staff being excluded from the top management and political strategic decisions. Little room was left for distributed leadership to emerge bottom-up by the health professionals in regard to these strategies. This finding is in line with evidence from previous studies of organizational mergers that have shown that more top-down leadership is sometimes installed to secure control over the merger process and to ensure its successful implementation (Cartwright & Schoenberg, 2006; Schweiger & DeNisi, 1991). Our findings further confirm previous studies of hospital merger legitimacy (Comtois et al., 2004; Denis et al., 2001; Kitchener, 2002) that have found that health professionals' dissatisfaction with mergers was related to limited resources and conflicts between stakeholders. However, what our findings add is that this dissatisfaction was not caused, per se, by the merger of the hospitals. Rather, it was an effect of the perceived *uneven* top-down distribution of leadership in the different merged, yet relatively separately working, hospitals and units, where only some units were allowed to make leadership decisions that involved other units. Thus, we suggest, contrary to Comtois et al. (2004) and Denis et al.'s (2001) findings that hospital mergers may not per se fail to gain legitimacy among health professionals. Instead it may more precisely be the perceived uneven and unfair top-down distribution of leadership that causes dissatisfaction. In fact, a more complete merger, where leadership is distributed more evenly across the merged units and wards, seemed to be desired by some of the health professionals. This is in line with Bennet et al.'s (2003) conceptualization of distributed leadership as entailing that varieties of expertise are distributed across the many, not the few. Unfortunately, such distributed leadership across the many was not established at the hospital level. Consequently the perceived top-down, unevenly restricted emergence of distributed leadership had the effect that no concertive actions (c.f. Gronn, 2002) laterally between the merged hospitals seemed to unfold.

The emergence of distributed leadership was quite different at a local-unit level, where the former sections being merged seemed to agree that distributed leadership was an effective way of ensuring collaboration and integration across the merged sections. Such agreement was established through bottom-up initiation of distributed leadership, where hierarchical boundaries of nurses and doctors were transcended and lateral concertive actions (c.f. Gronn, 2002) of coordinating professional, managerial and cultural expertise were created among the nurses across the merged sections and *within* the newly established units. However, in other situations at the local-unit level, a top-down formal leader restriction of distributed leadership also emerged and similarly led to better integration across the merged sections. Our study therefore only partly confirms Chreim's (2015) study of how the distribution of leadership tasks is often a top-down act of certain acquiring leaders. Instead we suggest that while this may be the case at the top-down hospital level, at the local level the formal leaders and health professionals overall seemed to accept both widened and restricted forms of distributed leadership, granted that these forms of distributed leadership were perceived as purposeful 'concertive actions' to create integration across former organizational boundaries. Thus, the place of emergence should be distinguished to fully understand how a hospital merger influences the emergence of more widened and more restricted forms of distributed leadership and specifically what forms of top-down or bottom up agency such emergence implies. A key point here is that restricted forms of distributed leadership can thus also end up producing positive effects. This however needs to be further explored in future studies. Overall, distributed leadership is thereby not merely influencing the implementation of change, in this case a hospital merger, as is suggested in the more normative distributed leadership studies (Chreim et al., 2010; Harris & Harris, 2008; Harris et al., 2007; Leithwood et al., 2007). The emergence of distributed leadership is also influenced by the merger context as indicated by more critical lines of research (Bolden, 2011; Currie et al., 2011;

Currie & Lockett, 2011; McKee et al., 2013). This confirms our call for a novel conceptualization of the *dynamics* of distributed leadership and level of organizational merger to understand the concomitantly contextualized emergence and impact of distributed leadership.

We also provide new knowledge to the studies primarily focusing on the effects of distributed leadership (Chreim et al., 2010; Harris & Harris, 2008; Harris et al., 2007; Leithwood et al., 2007). Responding to Bolden's (2011) and Jones et al's (2014) call for investigating the various purposes of distributed leadership, our findings suggest that rather than merely paying attention to the effects, the various *perceived purposes* of distributed leadership need to be taken into consideration because these purposes mediate the effects of respectively widened and restricted distributed leadership when implementing a merger. More specifically, dependent on the perceived purposes, both widened and restricted distributed leadership could lead to enhanced integration in the merged units. It appeared that the perceived purpose of distributed leadership was based on the felt degree of support and responsibility from formal leaders in times of merger-related uncertainty. At the hospital level, the physicians considered distributed leadership purposeful for gaining influence over fellow colleagues in cooperating units and for gaining influence over otherwise top-down leader decisions because they did not feel that the leaders in any way supported their daily work after the merger caused changes. At the local-unit level, widened distributed leadership was somewhat differently apprehended as purposeful for creating collaboration across merged boundaries. At the same time, on the local-unit level, restricted distributed leadership was also considered purposeful because it was acknowledged that the head nurses acted out of concern for taking on the responsibility in uncertain merger times. This is in line with the research by White et al. (2014) that shows that in non-routine situations where there is much uncertainty or where conflict threatens, a more formal leadership hierarchy is emphasized.

Yet what our findings altogether show is that in situations following a merger, a top-down restriction of distributed leadership is concomitantly perceived as purposeful and distressing. This variance in perceived purposefulness is therefore reliant not only on the merger conditions of uncertainty, but more specifically on the employees' perceptions of the formal leaders' *intentions* or *justifications* of restricting and widening distributed leadership. Although we agree with Choi (2012) that leaders face a difficult situation if they merge cultures and staff through top-down management without the health professionals, it seemed that local managers could succeed in justifying their top-down decisions to restrict influence from the employees.

In response to Bolden's (2011) call for attention regarding how organizational boundaries and cultural diversity may influence the emergence of distributed leadership, we find that at the local-unit level and bottom-up widened distribution of leadership emerged because the employees saw a need for actively questioning pre-merger hierarchies and integrating the merged sections across former organizational and cultural boundaries. We add to Bolden's (2011) call a dynamic understanding of how bottom-up local distributed leadership may be both caused by merger needs for cultural integration and cause this integration of merged cultures to be successful. Due to the widened distributed leadership, the merger of the two investigated sections became successful in establishing integrated and improved workplace collaboration and collegial support through a "breakdown of the Berlin Wall." This finding extends previous studies of how distributed leadership may involve a leveraging of skills and strengths and may contribute positively to organizational change (Chreim et al., 2010; Gronn, 2002; Harris & Harris, 2008; Jönsson et al., 2016; Leithwood et al., 2007) by showing how widened, bottom-up initiated distributed leadership can be particularly beneficial in overcoming cultural boundaries and furthering mutual cooperation among the merged parts. We thereby posit that the present study adds important knowledge

to previous studies having emphasized the problems with overcoming conflicts related to the merging of different cultural values (Cartwright & Schoenberg, 2006; Choi et al., 2012; Comtois et al., 2004; Denis et al., 2001). We suggest that bottom-up widened distributed leadership is a successful remedy for merger integration; yet more studies are needed to confirm this.

The present study does not fully confirm previous studies emphasizing conflictual differences in values and perceptions in merger situations (Cartwright & Schoenberg, 2006; Choi et al., 2012; Comtois et al., 2004; Denis et al., 2001). At the hospital level, the merged hospitals did express different perceptions of the merger situation, while the merged sections in our study all shared the perception of the relevance of respectively restricted and widened distributed leadership for overcoming merger-related difficulties of time pressure and urgent needs of integration. Moreover, there was a shared held belief across the merged sections that the local formal leaders took responsibility for carrying out leadership tasks of buffering potential employee conflicts related to the implementation of change—not because it was their right to do so, but because it was their *duty*. It thus seems that at a local level there was a better foundation for concertive actions in which both formal leaders and professionals across the former sections were willing to coordinate their joint expertise through both taking on and abstaining from leadership tasks for the greater benefit of working together. Thus merger-related problems and potential conflicts are not the same everywhere in the organization, and we call for further attention in future studies to local and hospital levels respectively for understanding the conditions of implementing a merger.

Over all, in regard to previous studies of organizational mergers and leadership (Cartwright & Schoenberg, 2006; Choi et al., 2011; Denis et al., 1999; Fulop et al., 2005; Geisler et al., 2010; Kitchener, 2002; Pinheiro et al., 2016; Weil, 2010), we suggest that more attention be paid to the ongoing dynamics of widened and restricted distributed leadership

and mergers at different levels of the organization. We do so because our study showed that the continuous widening and restriction of distributed leadership, whether perceived as purposeful or not, involved the employees challenged the pre-merger and post-merger organizational and cultural boundaries. This may be important for working towards an integration of merged hospitals and units.

In terms of practical implications, we suggest paying more attention to the purposes and justifications of widened and restricted distributed leadership for implementing a merger. We also find it relevant to consider whether, in a merger situation, opportunities to partake in leadership decisions are distributed unevenly or unfairly among the merged organizations. Such uneven distribution may kindle the fire of conflict unnecessarily. Finally, we suggest that in merger situations some room for local-level bottom-up distributed leadership is important to establish. This creates an opportunity to engage the staff in concertive actions of coordinating professional, cultural and managerial expertise across the merged organizations—which is most often a fundamental concern of implementing a merger.

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