Social Science & Medicine 390 (2026) 118878

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

The double nexus of clinical management - hybrid doctor-manager roles in Danish hospitals

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A B S T R A C T

This study investigates the impact of a recent management reform in Danish hospitals that introduced the managing consultant as a new, hybrid doctor-manager role. Rooted in the framework of professional restratification, this paper examines how the reform, spearheaded by the Danish Medical Association and the Danish Regions, reshapes professional hierarchies and redefines boundaries between clinic and management. Drawing on qualitative interviews primarily with doctors in management positions across three hospitals following the implementation of the reform, we analyze micropolitical negotiations around personnel management, financial responsibility, and professional expertise. On this basis, we introduce the Double Nexus Model, which captures two axes of tension: clinical expertise versus managerial accountability (the source of authority and responsibility), and daily operational concerns versus long-term strategic orientation (the horizon of leadership practice). The model illustrates four ideal-typical articulations of the managing consultant role: the Organizational Strategist, the Clinical Strategist, the Clinical Lead, and the Organizational Executor. Each role presents opportunities and challenges, from strategy integration to safeguarding autonomy and supporting the team. Highlighting these ideal types, this study deepens sociological understandings of professional restratification and hybridization in healthcare management, while also offering practical insights into the work of connecting professional and managerial priorities within hospitals.

1. Introduction

Integrating doctors into management positions is increasingly seen as a strategic response to global healthcare challenges, including staff burnout, talent attraction and retention, and balancing quality with limited resources (Jacobsen et al., 2019; Panagioti et al., 2018; Ministry of the Interior and Health, 2023; Prætorius et al., 2024). This has led to a proliferation of hybrid roles that bridge the gap between clinical practice and managerial responsibilities, typically connecting professional groups or subsections with the wider organization (Noordegraaf and Van der Meulen, 2008; Fulop, 2012; Waring, 2014). Evidence shows that doctors' involvement in governance and strategic decision-making enhances both the care quality and organizational performance (Goodall, 2011; Clay-Williams et al., 2017) as their medical insight strengthens strategic decision-making (Simonen et al., 2009; Bäker and Goodall, 2021). As Llewellyn (2001) notes, hybrid roles can function as 'two-way windows,' enabling a mutual exchange of perspectives between clinicians and managers. Hybrid roles are significant because they shape not only the interactions but also the valuations and boundaries between organizational and professional modes of working (Schuurmans et al., 2023; Waring, 2014).

Hospital leadership has developed historically through various management reforms and is extensively studied (Kirkpatrick et al., 2011; Numerato et al., 2012; Noordegraaf, 2020; Jakobsen et al., 2015). While sociological research has thoroughly explored how hybrid doctor-manager roles mediate tensions between professional and managerial logics (e.g., Waring, 2014; Lepori and Montauti, 2020; Faulconbridge et al., 2021; Cecchini et al., 2022), less is known about how such roles are introduced and articulated in practice – especially outside Anglo-American contexts. In particular, the micropolitical processes through which hybrid roles are articulated - who takes them on, how tasks are delegated, and how these positions are legitimized - remain underexamined (Alvehus et al., 2021; Numerato et al., 2012). Recent debates on protective versus connective professionalism emphasize that professional roles are enacted through relations and connections rather than in isolation (Adams et al., 2020; Noordegraaf, 2020). We contribute to this debate with empirical insights and a conceptualization of how intra-professional connectivity among doctors is reshaped through a new hybrid role introduced by a management reform in Danish hospitals in 2021, showing how connective work not only bridges professional and managerial logics, but also clinical work and strategic leadership.

Drawing on Freidson's theory of professional restratification (Freidson, 1985, 2001; Waring, 2014; Kirkpatrick et al., 2023), this

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https://doi.org/10.1016/j.socscimed.2025.118878
Received 14 January 2025; Received in revised form 20 November 2025; Accepted 13 December 2025
Available online 16 December 2025

paper explores two interrelated questions: How do micropolitical dynamics shape the articulations of the new doctor-manager role? And how do these articulations reshape professional hierarchies and redefine boundaries between clinical practice and organizational management in Danish hospitals? Focusing on three managerial domains - personnel management, financial responsibility, and clinical expertise - we unfold the micropolitical negotiations about the new role, drawing on qualitative interviews with doctors in managerial positions at three hospitals in 2021 and 2023. Although interprofessional leadership relations, especially between doctors and nurses, remain an important field of inquiry, the 2021 reform mainly reconfigured intraprofessional hierarchies within medicine. Our analysis therefore examines how boundaries and authority are renegotiated among doctors themselves. From this, we propose the Double Nexus model, conceptualizing a vertical nexus as negotiations of authority between clinical expertise and managerial accountability, and a horizontal nexus as negotiations between operational concerns and strategic leadership. Together, the study and the Double Nexus model respond to calls for more nuanced understandings of doctor-manager roles beyond the control-resistance binary (Waring et al., 2020; Alvehus et al., 2021; Cecchini et al., 2022; Møller and Cecchini, 2023), offering empirical insights into micropolitical negotiations and a conceptual vocabulary to articulate these dynamics (cf. Numerato et al., 2012; Sarto and Veronesi, 2016; Sartirana et al., 2018).

2. Theoretical framework: the politics of stratification

For more than four decades, doctors have become increasingly involved in hospital management, a process Freidson (1985) theorized as professional stratification. To maintain autonomy and authority, medical doctors restructured into three strata: 'rank-and-file', 'knowledge elite', and 'administrative elite' (Freidson, 1985). The rank-and-file comprises doctors working in the clinic with direct patient care. The knowledge elite comprises doctors working in medical education or research who establish the standards against which the rank-and-file doctors will be evaluated. The administrative elite comprises doctors in management roles responsible for oversight and coordination. Elites are responsible for the content (knowledge) and the context (organization) of medical work, and are consequently embedded in an internal hierarchy. Their position is, however, justified by their ability to protect the collective interests and autonomy of the profession (Freidson, 1985). Freidson's strata were subsequently adapted by Waring (2014) to focus on the profession of medicine's connection to spheres outside the core professional organization. In the Danish case, the reform also reflected broader hospital challenges, such as increasing organizational complexity and demands for leadership capacity (Ledelseskommissionen, 2018; Dahl Pedersen et al., 2019). From a restratification perspective, these developments formed the context, but the profession's agency lay in shaping the response through the creation of a new managerial stratum.

Sociological and organizational scholarship on connections between the medical profession and management has long debated whether the growth of hybrid roles stems from the medical profession defending its position or from a policy context that promotes the managerialization of healthcare. Studies suggest that doctors in management careers embrace management values and logics and become 'willing hybrids', keen to align (medical) professionalism with 'managerial organizational and policy contexts' (McGivern et al., 2015; Kurunmäki, 2004). While some describe the increase in hybrid roles as a process of de-professionalization that hollows out the medical profession's autonomy and authority (Waring, 2014; Kirkpatrick et al., 2023), other studies understand the increase as a process of re-professionalization. Currie et al. (2012), for example suggest that doctors engage in management activities and reform their own status hierarchies to ensure their continued professional dominance and retain influence, thus affirming the relevance of Freidson's work (Currie et al., 2012; Jones and Fulop, 2021). Increasingly, however, contemporary sociological and organizational studies are wary of the protective/connective dichotomy (Alvehus et al., 2021), arguing that connectivity may be a prerequisite for autonomy (Faulconbridge et al., 2021) and that the autonomy and authority of some segments of doctors vary substantially. Similarly, Waring (in a joint paper with Adams et al., 2020) argues 'we might see a new cadre of professional elites that are well connected (and well protected), and in turn a new "rank-and-file" that is poorly connected (and unprotected), save for the protection provided through the intra-professional connections to the new elite' (p. 243). This approach does not conceive of hybridity as a matter of a more or less successful fusion of roles, but rather as ongoing connections between the medical profession and the surrounding world (Adams et al., 2020; Noordegraaf, 2020), which we propose can be analyzed as 'connective work'. Considering the prospect of such developments in organizations, we argue, in concordance with Lepori and Montauti (2020) and Waring (2014), that more nuanced understandings are needed of how connections between professionals and the organizations are enacted, as well as of their constitutive consequences.

2.1. A micropolitical perspective

We employ a micropolitical approach to understand how articulations of hybrid doctor-manager roles shape broader questions concerning the strengthening or weakening of medical professionalism. The articulation of hybrid doctor-manager roles happens at the interface of professional and organizational activities (Waring, 2014). Hybrid roles occupy a liminal and fluctuating space (Llewellyn, 2001; Waring, 2014) that evokes instability about the nature of such roles as they can be articulated differently with diverse implications (cf. Moreira, 2011). Consequently, the articulation of hybrid roles is political in the sense that it has constitutive consequences not only for the individual doctor-manager but also accumulatively for the medical profession and hospital management at large. Similar to Waring et al. (2023), our approach investigates micro-politics as events that co-constitute reality, rather than trying to explain micro-politics via macro-political structural interests. In contrast to Waring et al. (2023), we regard micro-politics as negotiations that shape how things are 'made to matter' rather than a practice inhabited by actors who are (becoming) political (Gibson et al., 2020) or 'made to count' (Dussauge et al., 2015). We are specifically interested in the way new management responsibilities are enacted in everyday practice, and how these enactments have micro-political effects on professional strata and the redefinition of boundaries between clinical practice and organizational management. By drawing on this micro-political approach, we aim to bring nuances to the sociological debate on professional restratification in two ways.

First, we provide insights about the micropolitical articulation of a new middle-manager role that is hierarchically placed in between the rank-and-file doctors and the administrative elite in Danish hospitals, i.e., the clinical directors (see Fig. 1). The vast majority of doctors in management occupy such middle-manager roles. These doctor-managers must navigate both the vertical nexus between professionalism and management and the horizontal nexus between daily operations and strategic leadership (Spehar et al., 2015). Concurring with Spehar et al. (2015) and Alvehus et al. (2021), we argue that exploring how middle-manager roles are articulated adds important nuances to the understanding of intra-professional stratification within hospitals. Second, we examine how restratification unfolds in negotiations over specific tasks at the intersections between management versus professionalism and rank-and-file doctoring versus administrative elites. As Schrøder et al. (2022) argue, examining how specific tasks are handled can help us explore if or how hybridization is taking place. As noted by Schuurmans et al. (2023), task reallocation is known to cause intra-professional conflict (see also Martin and Waring, 2012). We argue that by investigating how tasks are delegated, we can both illuminate the authority and autonomy of hybrid roles and examine how and why hybrid roles are co-constituted in organizational and professional

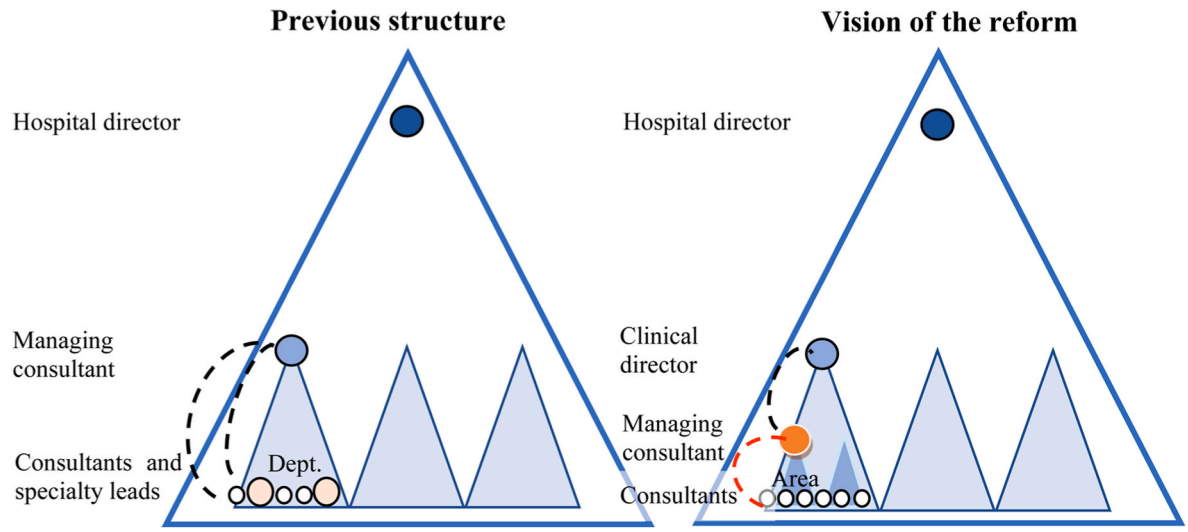

Fig. 1. Illustration of the hierarchical change in doctors' managerial structure after 2021 (simplified).

hierarchies.

3. Case and analytical strategy

3.1. The Danish management reform: A new hybrid doctor-manager role

In 2021, a management reform changed the organizational hierarchy for doctors employed at Danish public hospitals (Bech et al., 2021; Hauge et al., 2022; Hargraves et al., 2024). Operating in a healthcare system with universal access to care, these hospitals employ the vast majority of Danish doctors. The reform was introduced through a collective agreement between the employer and employee organizations. The Danish Regions (in Danish: Danske Regioner, DaRe) is a national organization that represents the five Danish regions, responsible for the administration of the public hospitals. Their counterpart, the Association of Medical Specialists (in Danish: FAS (Foreningen af Speciallæger)), is a subdivision of the Danish Medical Association, the DMA, authorized to negotiate on behalf of doctors working at the level of consultant and above. Organizing through a collective agreement reflects 'the Danish model' for the labor market, which – among other things – rests on a tradition of collective bargaining between employers and trade unions. In 2024, 96 % of all Danish medical doctors were members of the trade union (Danish Medical Association, 2024). The reform, embedded in the 2021 agreement, was promoted by the DMA – the governing elite of the medical profession. As such, the reform can be seen as a form of self-management from within the profession (cf. Waring, 2014).

The reform aimed to strengthen organizational leadership and management capacity within the medical profession at hospitals (Hauge et al., 2022, Danish Regions, 2021). Similar to other countries, Danish hospitals have grown in response to growing healthcare demands, resulting in larger departments and incomprehensible management tasks (Dahl Pedersen et al., 2019; Ledelseskommissionen, 2018). Simultaneously, high levels of stress and sick leave among healthcare personnel have further complicated managerial tasks (Patel et al., 2018; Panagioti et al., 2018), alongside challenges in management recruitment (see, for example, Christensen, 2021).

The managing consultant position [in Danish: Ledende overlæge] established by the reform sits between the clinical directors [in Danish: Cheflæge], formerly known as managing consultants, and the consultants [Da: Overlæge] (Hauge et al., 2022), as illustrated in Fig. 1. Thus, the clinical director manages a department (abbreviated 'dept.') and the managing consultant manages an area within the organization, which can be defined in different ways, i.e. as a unit or a specialty. Following Waring (2014), we consider the organization of professional work as dynamic, shaped by both internal and external expectations. Using the restratification framework, we interpret the managing consultant position as a new professional stratum, potentially reshaping power and status within the medical profession.

The managing consultant position replaces the former role of 'specialty lead' previously held by a senior consultant who oversaw a specific medical specialty or sub-specialty, with no or limited organizational managerial responsibility and no personnel management. In contrast, the managing consultant role is presented as an opportunity to delegate organizational responsibility and reduce the clinical director's span of control (Hauge et al., 2022). Thus, the reform inserts a new stratum that associates status and promotion with organizational leadership rather than professional expertise. Observing the micropolitics surrounding this new stratum provides a fruitful vantage point for analyzing how the management reform reconfigures professional hierarchies and renegotiates clinical and organizational boundaries.

3.2. The study: case selection and participants

This study reports from a qualitative interview study in three hospitals selected for variation in size, regional location, clinical profile, and organizational culture.

The cross-case design allowed us to identify how common challenges of hybrid management unfolded across diverse hospital contexts, while highlighting the influence of local organizational histories and leadership structures on the implementation of the reform. For each hospital, we conducted interviews in 2021 and 2023: individual interviews with hospital directors and group interviews on the additional managerial levels, amounting to 66 informants (see Table 1), including background interviews to address the context of the reform, including the profession's strategic perspective. In selecting candidates for interviews, we aimed for variation in representations of specialties, department sizes, and gender. In 2023, we strived to re-include participants and departments from 2021, but practical constraints prevented us from following individual departments over time. Access was supported by the DMA and the DaRe and planned by the authors in collaboration with the individual hospitals.

All data were handled confidentially and in accordance with Danish legislation. Personal identifiers are omitted from publications.

Table 1
Data overview.

Hospital interviews				
		Hospital A	Hospital B	Hospital C
2021	Directors	1	1	1
	Clinical directors	3	3	3
	Managing consultants	3	3	3
	Consultants	1	0	0
	Managerial colleagues	3	3	0
2023	Directors	1	1	1r
	Clinical directors	3 (2r)	3 (1r)	3 (2r)
	Managing consultants	3	2 (1r)	3
	Consultants	2	1	3
	Managerial colleagues	3	3	3
Background interviews				
2021		DMA	Danish Regions (DaRe)	Regional HR-staff
		3	3	2

(r) = the number of informants who also participated in the 2021 round. Directors were interviewed individually; all others in groups.

3.3. Interviews and analysis

Group interviews were conducted as semi-structured interviews at the hospitals. The interview guide was developed by the study's research team and pilot-tested with two doctor-managers. During the first part of the interview, the participants sketched and presented an organizational diagram, and the managerial positions of the department. In the second part, they discussed managerial roles and responsibilities. All interviews were audio-recorded and transcribed.

We analyzed data abductively, moving between empirical material and theoretical abstractions (Tavory and Timmermans, 2014; Miles and Huberman, 1994). Through ongoing dialogue and interviews about the management reform, we identified the managing consultant as the central analytical focus, as negotiations about how to shape its position and responsibilities also intersected with wider discussions about the roles of other professional groups, including nurses, in hospital management. Initial descriptive coding (Miles and Huberman, 1994) revealed that negotiations clustered around three domains of responsibility: personnel management, financial responsibility, and clinical expertise. These domains were described as both practically consequential and symbolically charged by managing consultants, and clinical directors alike. Moreover, we found that the scope of authority could vary across domains - for instance, the same manager might hold a wide mandate in personnel management but little or none in budgetary matters. Accordingly, we structured the findings around these three domains to show how hybrid roles are articulated differently across distinct areas of managerial responsibility rather than negotiated once and for all.

Through discussions within our research group and with external collaborators, we engaged in a process of 'casing' (Tavory and Timmermans, 2014), using iterative movement between data and theory to refine what our material was a case of. This process helped us settle and further develop our theoretical framework (Miles and Huberman, 1994). Engaging with established knowledge about the challenges of hybrid managers in hospitals, i.e., balancing political and economic pressures against professional needs, and negotiating jurisdictions over everyday medical practices (Freidson, 1985), we expected to see these tensions in our interviews. Indeed, we did, but new patterns also emerged, leading us to further theoretical casing: interviewees also described their position as navigating between the daily operations and the strategic leadership of the department. Existing research often treats these two axes of 'in-betweenness' in isolation, leaving us without an adequate vocabulary for our findings. Engaging iteratively with the data and existing work on hybrids, restratification, and clinical management, we developed the Double Nexus Model (presented in Fig. 2 in the discussion). The model comprises a horizontal nexus, reflecting the tension between clinical expertise and managerial accountability, and a vertical nexus, capturing the hierarchical negotiation between daily operations and strategic leadership. This process of casing thus helped us define four ideal-typical articulations of the managing consultant role, each presenting distinct opportunities and challenges, providing a framework for interpreting hybrid doctor-manager roles.

4. Findings

With the collective agreement from 2021, the managing consultant was cemented as a new, formal position with a distinct salary level and employment terms. Despite this formal character, the position was continually involved in jurisdictional negotiations. These battles happened in the formal hierarchy, involving demarcations between the managing consultant, the clinical director, and the consultants, as well as in the professional hierarchy, where informal hierarchies between specialists sometimes collided with the managing consultants' formal position. Our findings of the emerging managing consultant role and its impact on professional hierarchies and boundaries between clinical practice and organizational management are presented under the identified core domains: Personnel management, professional expertise, and financial responsibility.

4.1. Personnel management: connective work through vertical hierarchies

At the time of the reform, clinical directors' span of control could reach 175 employees, including up to 85 doctors at specialized or higher level (Pedersen et al., 2020). A national survey shows that managing consultants now oversee 19.6 employees on average (Kjaer et al., 2024), indicating that they have taken over a substantial part of the line management from the clinical directors. In this section, we unfold the managing consultants' mandate and responsibilities in relation to personnel management, focusing on their involvement (or not) in personal development reviews (PDRs, known as 'MUS' in Danish).

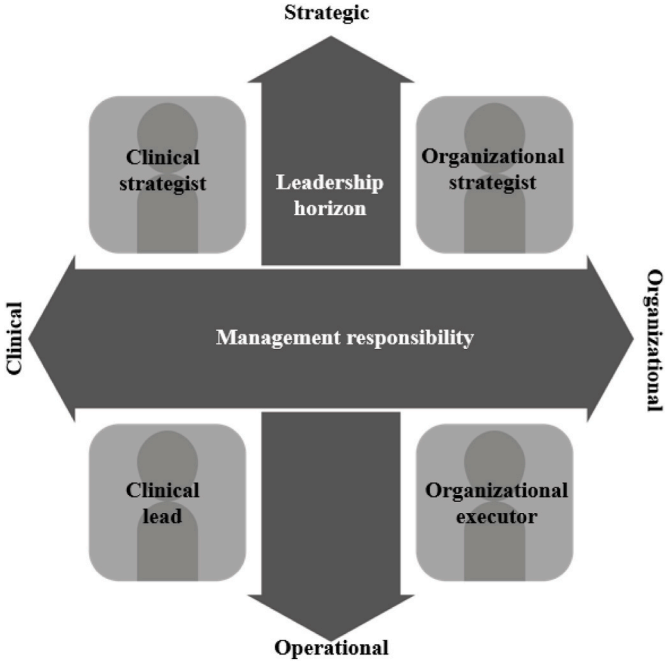

Fig. 2. The double nexus of clinical management.

Our managing consultant interviewees explain that personnel management was a key concern when considering whether to apply for or accept a managing consultant position: the vast majority did not find personnel management an attractive task. Despite their formal role as line managers, indicated by the survey, the interviewees rarely practiced as full personnel managers for other doctors in their departments. For example, one informant somewhat paradoxically says: 'I am the manager of 22 specialized doctors. But I do not have staff management responsibility', implying that managerial responsibility is a spectrum rather than a matter of either/or. In some departments, managing consultants handle PDRs only for junior doctors, while in others, their personnel management responsibilities remain minimal. In most departments, however, the managing consultants were in a process of transitioning into the role of line manager. A newly appointed managing consultant explains:

> In the beginning, I wasn't meant to have any personnel responsibility. But then it gradually slid in nonetheless. [The clinical director], invited me to some PDR conversations with some of the other consultants, so now he's in the process of passing it on to me. So, from next year, I will conduct PDR conversations.
>
> Managing consultant, group interview

The excerpt above reflects a tendency among clinical directors and head nurses who are conscious that personnel management is a new and - for many – uncomfortable task for managing consultants. Accordingly, several departments use what one informant calls 'a sliding approach' to the delegation of personnel management, i.e., a form of vertical *connective work*, gradually relocating line-management ties from clinical directors to managing consultants. One clinical director explains how he invoked the classic medical teaching adage 'see one, do one, teach one' and asked newly appointed managing consultants to sit in on the annual PDR conversations this year, expecting they will conduct them independently next year.

4.1.1. Alone and in between

Taking on personnel management responsibilities for former colleagues can become a boundary-crossing affair for the managing consultants, particularly when it involves managing colleagues considered 'above' themselves in the professional hierarchy. Two newly appointed managing consultants, who are relatively early in their careers, explain this position:

> Managing consultant 1: I actually think it has been a wish, at least from our side as well, not to have PDRs with our much older colleagues. It would seem completely wrong.
>
> Managing consultant 2: I also think that right now it would seem completely wrong. It would be difficult to define who was managing whom. And right now, we are in a department where this whole reorganization has caused quite a stir.
>
> Managing consultant 1: Yes, if suddenly we had to be responsible for personnel management … [shakes her head]
>
> Managing consultant 2: It may be that in ten years, when it is us, who are the old ones, it will make more sense. But right now, I just think it's not feasible.
>
> Managing consultants, group interview

Particularly the comment 'it would be difficult to define who was managing whom' underlines the coexistence of an (informal) professional hierarchy and a (formal) organizational hierarchy where formally granted managerial authority does not - in practice - grant the managing consultants the legitimacy to act as managers of professional seniors (cf. Alvehus et al., 2021).

Below, a newly appointed managing consultant describes a legitimacy challenge, as colleagues use irony to challenge her role. On the question of whether her status has changed with the new role, she says:

> The others tease me a little, 'so what does the *manager* say?' So, in that way, of course, you get a different relationship. We still sit and talk together, as we did before. But if something comes up relating to a hospital change or something, they do look at me and say, 'What does this mean? What do we do?' It actually changes.
>
> Managing consultant, interview

The ambivalent recognition ('so what does the manager say?') illustrates the fragile legitimacy of *vertical connectivity* when formal authority clashes with the informal professional hierarchy. As this managing consultant expresses, on the one hand she is still part of the rank-and-file group and teased when she acts as a manager, on the other hand, she is also expected to be able to answer managerial questions as part of a management collective.

A consultant also describes this ambiguity as a lack of distance. She considers it 'a huge problem' that the person she has to refer to, i.e., the managing consultant, is someone she is working with side by side. 'It is too close to bring up things you don't like', she finds. On the other hand, a consultant from another hospital finds that 'it does not make sense to go to someone who is never around with staff-related matters'.

Summing up, managing consultants' discomfort with personnel management reveal how the new managerial structure disrupts existing informal hierarchies and creates new connections when managing consultants perform their tasks. Some managing consultants now oversee colleagues they consider superior in the traditional, informal hierarchy defined by professional expertise, which creates doubt and tension. Yet, this position may enhance vertical connective work that facilitates a flow of information and decisions between doctors in the clinic and upper administration (cf. Adams et al., 2020). Vertical connective work extends the clinical directors managerial reach, while also giving rank-and-file doctors a communication channel to the clinical directors. However, the following sections show that formal delegation of personnel management does not always afford the informal authority needed to manage.

4.2. Professional expertise: horizontal connections in negotiating managing consultants' jurisdiction

As described, the reform phased out the 'specialty lead' role, which oversaw specific medical areas without organizational duties. The reform aimed to establish a career path to organizational management positions for doctors, as recruitment to such positions had been difficult, while roles defined by professional expertise remained highly desirable. Departments could either transition existing specialty leads into managing consultant positions or recruit candidates explicitly interested in management. The following sections examine two strategies for defining the new role alongside professional, clinical expertise: parallelization and integration.

4.2.1. The parallel structure

Some managing consultants articulate their role as being an organizational parallel to the clinical experts. In departments with such a parallel management strategy, the managing consultants take on a role as facilitators of a professional direction rather than definers of the direction, as explained in this citation:

> So, just because we're managing consultants, it doesn't mean we're the ones with the greatest expertise in our field. For example, we have a professor who serves as our expert in [a subspecialty, anonymized.] […] Each team has its own expertise and knowledge base, but as managing consultants, our role is to support them in having the best conditions at all times to carry out their work.
>
> Managing consultant, interview

This strategy is particularly prominent at one of the hospitals. In a group interview, three clinical directors outline their departments' organizational structure on paper, as one of them shares a reflection:

> I could almost sketch out a matrix model in my head. Because the clinical manager needs to be involved in everything. What's new in the [one disease] area, what's new in [other disease area]? It kind of falls between the cracks here. There's more to it than what we're outlining here. We're outlining an operational organization, we're not … We're not outlining the clinical expertise, where there are other spearheads than those who are good at this [operations] now. So, we must remember to consider that as we look ahead. So that there isn't an over-focus on operations in the coming years. Because right now, we're so fascinated by this [points to her sketch of the organizational management structure].
>
> Clinical director, group interview

The clinical director's reaction to the sketches reflects that the professional hierarchy in terms of clinical expertise is excluded from the formal structure and becomes invisible when the formal structure is outlined. She believes the new management structure and the promotion of organizational management within the hospitals may marginalize and devalue clinical or professional leadership.

Interviews with managing consultants and consultants reflect the division of labor described by the clinical directors. Managing consultants primarily describe their responsibilities as operational tasks, such as shift scheduling, while specialty leads are attributed to clinical leadership: updating guidelines, ensuring quality, and advancing research and development. One managing consultant describes the specialty leads as experts generating 'ideas about development and visions: Where is the department going, what is our pipeline, what are our ambitions?'. Thus, these departments feature two career tracks: an organizational track for managing consultants and a professional track based on clinical expertise, which may lack formal positions but still exists.

Managing consultants in a parallel-structured department are challenged by the power struggles between the formal, organizational hierarchy and the more informal hierarchy of clinical expertise. An interview with a consultant without managerial responsibilities illustrates this struggle. While her line manager is the managing consultant, she sometimes goes straight to the clinical director:

> Sometimes I've written directly to my clinical director if I felt 'this is too relevant - It needs to move forward. I can't live with having discussed it [only] in our own team […] I can't accept not having in writing that I've brought this to the attention of the boss [i.e. the clinical director]'. I've had a couple of incidents like this. And then I've gone directly to the clinical director.
>
> Interview, consultant

In departments with this parallel structure, managing consultants are often considered unfit to act as line managers for their colleagues, reflecting the strong informal hierarchy defined by professional expertise.

4.2.2. The integrated structure

In other departments, the formal organizational hierarchy matches the hierarchy of clinical expertise, meaning that the managing consultant is both considered among the most prominent clinical experts and has an organizational responsibility. A clinical director explains that he strategically delegates clinical leadership to the managing consultants, as his role outside the clinic prevents him from making certain decisions. For instance, he recruited Dr. M based on her clinical expertise to develop a specific section of the department. Initially hesitant, Dr. M accepted the role, explaining:

> I actually thought that I could do many things better [than the status quo] in terms of driving development in the department, and I wanted to initiate new things. I'm not sure how good I am at personnel management and such. I'll leave that to others to judge. But in terms of doing the best possible for the patients and relatives we are here for: Well, honestly, I think I would be a better leader. […] As a newcomer to the section, I said: 'Where are our guidelines?'. And then I was told, 'Guidelines? You can do whatever you want with these patients. That was the attitude. But the task [of this specialty] is just completely different today. And I find that incredibly exciting.
>
> Managing consultant, group interview

Today, Dr. M has not regretted her decision for one moment. She says: 'In fact, if someone asked if I wanted a full-time management position with no clinic, I think I would say yes. Actually'.

As several of the managing consultants explain, it is difficult to draw the line between organizational and clinical leadership. One of Dr. M's colleagues explains his role by saying: 'I do lead the clinical direction to a wide extent, albeit in a somewhat overarching way. Questions like "should we cut here or a little bit further over here?" That's not where I am involved. I am involved in questions like "who should we collaborate with and why?", and such matters', illuminating the different horizons of management.

Another integration strategy is appointing doctors with a strict professional focus as managing consultants. This is the strategy of a clinical director, concerned with the department's international esteem and critical of managerial rhetoric: 'Relax all that managerial stuff; don't prioritize it so much', he says, during an interview. Accordingly, he explains, he has employed Dr. E as managing consultant, as she will support his emphasis on international, professional recognition rather than 'managerial stuff'. Another managing consultant highlights a similar approach: 'It's important to be visionary and know management language. You have to speak Excel with management to secure funding for the specialty' (interview, managing consultant). Characterized by formal integration, this approach reiterates a binary between (valuable) clinical work and (less valued) managerial work.

As the integration structure concentrates *horizontal connectivity* in a single role, a key disadvantage is the heavy workload placed on managing consultants. Several interviewees reported significant strain. One canceled an interview due to stress-related sick leave. A managing consultant from an integrated department explains:

> I'm not particularly available as a manager because I'm constantly rushing around. I have one administrative day per week. […] I'm nowhere near a 37-hour workweek[1] right now. It's much more. […] So on the four days a week when I'm in the clinic and listed in the work schedule, I squeeze in all these administrative tasks and meetings while also trying to do roughly the same as the others in terms of patient care […] I know I'm doing enough, but you can quickly be looked at with disapproval. When you're listed as a full-time person in the work schedule, like 'I'm with [name of speaking doctor] in the morning shift today'. Then I have to do at least 50 %, right? So, it's no use if I only do 20 %. But at the same time, I also have three hours of meetings. So that's why … that's why I am here with my sandwich at 2:30 p.m.

Summing up, articulations of the new managing consultant role vary between integration of clinical expertise, and parallelization, where early-career consultants take on organizational management, while senior colleagues – for example the former specialty leads - hold a more or less defined clinical leadership role. Integration and parallelization represent different strategies for *horizontal connective work* (cf. Adams et al., 2020). Integration grants mandates and legitimacy for the managing consultants, but creates heavy workloads. Informants note that younger doctors who value work-life balance are reluctant to commit to the extensive hours needed to excel as both experts and managers.

[1] 37 h is the standard work week in Denmark.

4.3. Financial responsibility: connecting financial accountability and medical work

For clinical managers, the mandate to make financial decisions is central to real managerial power. However, many informants argue that this task should remain distant from the clinic, since doctors may favor their own area at the expense of others. As managing consultants operate on the boundary of the clinic and management, are they to be trusted to make financial decisions? This section explores how their financial responsibility ranges from extensive section oversight to limited control focused on operations.

4.3.1. From financial consciousness to extensive responsibility

Most managing consultants are expected to be 'financially conscious', monitoring expenses under their remit. In some departments, they are expected to execute the financial direction issued by the clinical director. One managing consultant notes how she is waiting for her clinical director to go through financial priorities with her, just so she can 'sit with [her] colleagues and say, "listen, we have to change how we do things; we have to consider the budget"'. A similar dynamic exists in another hospital, where a consultant sympathizes with the managing consultant's role: 'They just become the enforcer, having to tell us, "Well, that's not possible. That's just how it is. It's been decided." In some respects, I see it like that. And I think it can't be much fun for the managing consultants to be in that position'.

For other managing consultants, financial responsibility is more clearly associated with authority to lead, as we see in the following exchange during a group interview, where the participants compare their financial jurisdiction:

> Managing consultant 1: Can you 'find resources?' […] I mean if you think, 'I would actually prefer to have an additional nurse from the main team come in, could you decide that?'
>
> Managing consultant 2: Yes […] It's not a problem. It's coming up shortly, actually, when we discuss how our budget cuts should be implemented, like 'We will move nursing resources from external functions to the ward'.
>
> Managing consultant 1: And for that, you don't need to come up here [points to the clinical director on the sketch]? You talk to them about it?
>
> Managing consultant 2: We, my nurse co-leader and I, have cleared and secured it. And we have secured support for that.
>
> Managing consultants, group interview

Evidently, managing consultant 2 has more financial autonomy than most. Yet, as her quote indicates, this autonomy is exercised jointly with her nursing co-leader, reflecting how financial and staffing decisions are typically shared across medical and nursing management. For her, financial responsibility resembles what a clinical director from another hospital calls 'old-fashioned management responsibility in a small department within the department.' Still, managing consultant 2 underlines that her jurisdiction is often hard to delineate:

> It's hard to find the right balance, isn't it […] The first time I thought, 'I'll decide this myself, no need to inform [the clinical director]', he later said, 'I would have liked to be cc'd on that'. So, he wants to be kept informed about what I'm doing, which is fine, but sometimes I think, 'There must be something he doesn't want to be involved in'.
>
> Managing consultant, group interview

This is also reflected in other interviews, where informants underline their ambiguous position regarding department finances: 'the playing field is not clearly drawn […] I have to keep staff costs neutral, but actually it is the clinical director who oversees the budget and tells people to take some time off … and so it becomes a bit messy'.

Some managing consultants deliberately avoid financial responsibility. Asked about budgets, two managing consultants from the same hospital respond, 'Not at all' and add that they 'prefer it that way'. For clinical directors, retaining financial control can be seen as the most fruitful strategy, ensuring accountability as final decision-makers. A few clinical directors, however, argue that financial discussions distract from hospital leadership's core purpose:

> I see a decoupling of medical work and management […] I don't remember one medical topic or research topic being discussed in the management group […] It is too much about playing with Lego and being subjected to a business school mindset. Management should be about medical stuff.
>
> Clinical director, group interview

Across interviews, we see how the financial jurisdiction within the departments emerges relationally between the managing consultant and the clinical director. Within this relation, multiple factors shape the demarcation, notably the clinical director's willingness to delegate (parts of) this responsibility to the managing consultants and the managing consultant's willingness or ability to assume responsibility.

5. Discussion: navigating the double nexus of hospital management

This article has examined the micropolitical dynamics of establishing the managing consultant role in Danish hospitals, following the 2021 reform of the hospital management structure initiated by the DMA and DaRe. Although formally defined in the collective agreement, it remains open to multiple interpretations and understandings. Across the three studied domains of personnel management, professional expertise, and financial responsibility, the jurisdictions of the managing consultants are being negotiated over two coexisting nexuses: First, between the area of responsibility, defined as either a clinical responsibility or an organizational responsibility, and, second, between the leadership horizon, i.e., either the daily clinical operations or a long-term strategic orientation. To conceptualize this dual tension, we propose the Double Nexus Model, outlining four ideal-typical articulations of the managing consultant roles, with potential relevance to other hybrid doctor-manager roles (see Fig. 2).

The **Organizational Strategist** describes managing consultants who align departmental priorities with broader hospital strategies. These hybrid managers collaborate closely with senior leadership, i.e., clinical directors or other managing consultants, to connect clinical and organizational goals, negotiating resources and initiatives that serve both. Dr. M exemplifies this role through her efforts to initiate a cross-specialty quality improvement initiative that demonstrated gains in patient outcomes and resource efficiency. The Organizational Strategist's key advantage lies in their access to strategic forums and influence over hospital-wide priorities, but it comes at a cost. Dr. M, for example, was seen as detached from frontline work, highlighting the emotional demands of balancing administrative expectations with clinical values. Organizational Strategists are pivotal in integrating clinical and organizational goals but face dual accountability to clinical teams and hospital administration, shifting their orientation from clinical practice towards a managerial professional role.

The **Clinical Strategist** describes managing consultants who prioritize clinical values and clinical standards while negotiating with senior management. Focused on safeguarding care quality and clinical autonomy, they often find themselves at odds with organizational priorities. This role, resembling the phased-out clinical specialty lead, is exemplified by Dr. E, who acts as a strategic spokesperson for her specialty. Its strength lies in clinical credibility, trust from teams and the ability to challenge managerial decisions. However, Clinical Strategists face limits, particularly in broader strategic discussions, where administrators may consider them inflexible or lacking organizational overview. They defend clinical priorities effectively, but, due to their professional

orientation and resistance to managerial imperatives, risk isolation from department decision-making.

The **Clinical Lead** represents managing consultants oriented towards day-to-day clinical operations. Closely connected to the frontline, they ensure smooth, high-quality patient care. Their primary allegiance lies with clinical teams, often leaving strategic concerns to higher management. One managing consultant from the analysis describes the tension of being both part of the team and expected to take the lead. The role's advantage is trust and alignment with clinical colleagues, but its limitations include reduced influence on hospital-wide strategies and difficulty addressing resource constraints from senior leadership. While supportive of the quality of operations, this role's horizon is the daily rhythm, rather than long-haul direction setting.

The **Organizational Executor** describes managing consultants who focus on coordinating clinical activities and enforce administrative policies by translating high-level decisions into actionable steps within their departments. This role is common in departments where relatively junior consultants serve as managing consultants while others hold roles as clinical experts. Organizational Executors are distanced from strategic leadership, focusing on daily operations and supporting higher-ranked professionals or organizational leaders. In the analysis, a managing consultant tasked with cost-saving measures noted the emotional toll of peer resistance, as these changes were seen to undermine patient care. This role underscores the trade-offs between operational efficiency and clinical priorities. While Organizational Executors ensure alignment with organizational goals, colleagues may dismiss them as 'just the enforcer.' Balancing clinical credibility with managerial obligations is difficult, making the role less appealing.

5.1. The double nexus and restratification through a management reform

The Double Nexus Model advances the literature on hybrid doctor-manager roles by adding nuances to our understanding of the intersections between professional and organizational boundaries. The typology of four ideal-typical hybrid roles - the Organizational Strategist, the Clinical Strategist, the Clinical Lead, and the Organizational Executor - contributes to the ongoing debate on professional restratification (Freidson, 1985; Waring, 2014; Kirkpatrick et al., 2023; Alvehus et al., 2021) by showing how middle-management roles mediate broader changes to professional hierarchies and task jurisdictions. This resonates with Adams et al.'s (2020) argument that professionalism is increasingly characterized by connectivity, rather than protection of exclusive jurisdictions. However, while prior work emphasizes horizontal bridging between professional and organizational logics (Waring, 2014; Faulconbridge et al., 2021), our study suggests that hybridity also requires connective work across hierarchical levels. The double nexus thus extends the notion of connective professionalism by emphasizing hybrid doctor-managers as mediators not only between professions and organizations, but also between clinical frontlines and strategic leadership (cf. Currie and Procter, 2005; Burgess et al., 2015; Alvehus et al., 2021).

This study contributes empirically by analyzing hybrid roles in the non-Anglo-American context of Danish hospitals. Denmark has historically involved doctors extensively in management roles compared to Anglo-American contexts (Kirkpatrick et al., 2009), and the 2021 reform was initiated from within the profession itself rather than imposed externally. Advancement in the new formal hierarchy requires doctors to assume organizational management tasks. This aligns with Kirkpatrick et al.'s (2009) argument that consensus-based health systems, like Denmark's, enable the medical profession to take on a more innovative and entrepreneurial role in shaping hospital management policy, rather than merely responding to it (Brock et al., 2000; Kirkpatrick et al., 2009). Yet, as illustrated by the Organizational Executor, greater engagement in organizational management without corresponding professional/jurisdictional authority can weaken medical professionalism, as the connective work becomes somewhat one-directional.

Although our analysis focuses on the managing consultants, their responsibilities are closely intertwined with those of managing nurses. As illustrated by the example on financial responsibility, decisions are often taken jointly, meaning that what appears as financial autonomy is, in practice, co-produced. These collaborations shape how the managing consultants interpret and enact their role.

Lastly, the Double Nexus Model offers a framework for healthcare professionals and management teams to reflect on and define managerial roles within hospital departments. The model offers a shared language to support dialogue on the strengths and trade-offs of different managerial roles, and may serve as a productive tool to initiate dialogue within management teams about responsibility allocation, collaboration, alignment of professional and organizational values, and address the complexities of middle management. Such reflections can contribute to an informed and intentional ordering of clinical and managerial priorities while addressing the emotional and relational challenges often faced by hybrid managers.

5.2. Conclusion

This study has examined the micropolitical dynamics arising from a Danish hospital management reform, which established the managing consultant as a new hybrid doctor-manager role. Analyzing three key domains - personnel management, financial responsibility, and clinical expertise - we demonstrate how this reform reconfigured boundaries between clinical and managerial work and reshaped intra-professional stratification. The Double Nexus Model captures the horizontal (clinical vs. managerial) and vertical (operational vs. strategic) dynamics that managing consultants navigate, and offers a framework to interpret the multiple articulations of the role. In this sense, our model complements recent work on connective professionalism (Adams et al., 2020), showing how connectivity spans both horizontal and vertical hierarchies. Our findings further demonstrate that the hybrid role is not merely formally granted but continuously negotiated, reflecting broader shifts in professional governance, authority, and identity. By identifying four ideal-typical roles, we illuminate both the opportunities and challenges of hybridization in middle management. These insights extend beyond the Danish context, contributing to the global debates on professional restratification and the hybridization of doctor-manager roles.

Statement about gen-AI (requested by SSM)

During the preparation of this work the author(s) used ChatGPT and Grammarly in order to check language and get suggestions on how to shorten the manuscript. After using this tool/service, the author(s) reviewed and edited the content as needed and take(s) full responsibility for the content of the published article.

CRediT authorship contribution statement

Amalie M. Hauge: Writing – original draft, Methodology, Investigation, Formal analysis, Conceptualization. **Vibeke Kristine Scheller:** Writing – review & editing, Conceptualization. **Mickael Bech:** Methodology, Funding acquisition. **Marie Henriette Madsen:** Writing – review & editing, Conceptualization.

Ethics approval statement

This study involved interviews with healthcare professionals and administrators only and did not involve patients, vulnerable individuals, or the collection/use of human biological material. According to Danish national guidance, interview studies of this kind do not require approval from a Committee on Health Research Ethics. All participants received written and oral information and provided informed consent prior to participation. The study complied with applicable data protection regulations; personal data were handled confidentially, stored securely, and

anonymized/pseudonymized before analysis.

Declaration of competing interest

Amalie Martinus Hauge reports financial support was provided by Læge Sofus Carl Emil Friis og hustru Olga Doris Friis' Legat. Amalie Martinus Hauge reports a relationship with Danish Medical Association and Danish Regions that includes: consulting or advisory and speaking and lecture fees. Marie Henriette Madsen reports a relationship with Danish Medical Association and Danish Regions that includes: consulting or advisory and speaking and lecture fees. Mickael Bech reports a relationship with Danish Medical Association and Danish Regions that includes: consulting or advisory and speaking and lecture fees. The first author is employed at an institution that does commissioned research and analyses, including research and analyses funded by the Danish Regions and the Danish Medical Association. In 2022, Amalie Martinus Hauge and Mickael Bech published a report on a topic similar to this article's topic based on commissioned research funded by the Danish Medical Association and the Danish Regions. Amalie Martinus Hauge, Marie Henriette Madsen and Vibeke Kristine Scheller are involved in ongoing commissioned research funded by the Danish Regions and the Danish Medical Association. Mickael Bech is currently part of a research project funded by the Danish Regions and the Danish Medical Association. The funding parties have not been involved in the research leading to this article, neither in the design, choice of informants, analysis or writing process.

Acknowledgements

We, the authors, would like to express our gratitude to the organizations that participated in this study, including the hospitals, the Danish Regions, and the Danish Medical Association, for their time and willingness to contribute. Furthermore, we wish to thank Christian Bøtcher and Mathias Rask Østergaard Nielsen, for their valuable collaboration and insightful discussions. Finally, we are grateful to student assistant Oliver Harnung Scholten, for his dedicated efforts in coordinating group interviews, transcribing and coding many of the interviews. Lastly, we would like to thank the trustees of the research scholarship 'Læge Sofus Carl Emil Friis og hustru Olga Doris Friis' Legat', which has made this research possible.

Data availability

The data that has been used is confidential.

References

Adams, T.L., Kirkpatrick, I., Tolbert, P.S., Waring, J., 2020. From protective to connective professionalism: Quo vadis professional exclusivity? Journal of Professions and Organization 7 (2), 234–245.
Alvehus, J., Eklund, S., Kastberg, G., 2021. To strengthen or to shatter? On the effects of stratification on professions as systems. Public Adm. 99 (2), 371–386.
Bäker, A., Goodall, A.H., 2021. Do expert clinicians make the best managers? Evidence from hospitals in Denmark, Australia and Switzerland. BMJ Leader 5 (3), 161–166.
Bech, M., Jacobsen, C.B., Pedersen, L.D., 2021. Overlægeforeningens nye aftale kan sikre mere og bedre lægelig ledelse på sygehusene. Ugeskrift for Læger.
Brock, D.M., Powell, M.J., Hinings, C.R., 2000. Restructuring the Professional Organization: Accounting, Health Care and Law. Routledge, London.
Burgess, N., Strauss, K., Currie, G., Wood, G., 2015. Organizational ambidexterity and the hybrid middle manager: the case of patient safety in UK hospitals. Hum. Resour. Manag. 54, 87–109.
Cecchini, M., Pedersen, L.D., Bech, M., Jacobsen, C.B., Hansen, A.K.L., 2022. What makes a leader? Leadership identity and leadership behavior among highly professionalized public leaders. Int. J. Publ. Adm. 47 (7), 495–506.
Christensen, T., 2021. Jeg har fået nok: en beretning fra gulvet på Holbæk Sygehus. Dagens Medicin.
Clay-Williams, R., Ludlow, K., Testa, L., Li, Z., Braithwaite, J., 2017. Medical leadership: a systematic narrative review. BMJ Open 7 (9), e014474.
Currie, G., Lockett, A., Finn, R., Martin, G., Waring, J., 2012. Institutional work to maintain professional power: recreating the model of medical professionalism. Organ. Stud. 33 (7), 937–962.
Currie, G., Procter, S.J., 2005. The antecedents of middle managers' strategic contribution: the case of a professional bureaucracy. J. Manag. Stud. 42 (7), 1325–1356.
Dahl Pedersen, L., Thomsen, N., Bech, M., Cecchini, M., Jacobsen, C.B., 2019. Kortlægning af ledende overlæger i Danmark. Kronprins Frederiks Center for Offentlig Ledelse Institut for Statskundskab/Aarhus Universitet.
Danish Medical Association, 2024. Lægeforeningen I Tal - Fakta Om Medlemmerne.
Danish Regions, 2021. OK21: markant styrkelse af sygehusenes lægelige ledelse. https://www.regioner.dk/services/nyheder/2021/februar/ok21-markant-styrkelse-af-sygehusenes-laegelige-ledelse.
Dussauge, I., Helgesson, C.F., Lee, F. (Eds.), 2015. Value Practices in the Life Sciences and Medicine. Oxford University Press, Oxford.
Faulconbridge, J., Henriksen, L.F., Seabrooke, L., 2021. How professional actions connect and protect. Journal of Professions and Organization 8 (2), 214–227.
Freidson, E., 1985. The reorganization of the medical profession. Med. Care Res. Rev. 42 (1), 11–35.
Freidson, E., 2001. Professionalism, the Third Logic: on the Practice of Knowledge. Chicago. *University* of Chicago Press.
Fulop, L., 2012. Leadership, clinician managers and a thing called "hybridity". J. Health Organisat. Manag. 26 (5), 578–604.
Gibson, B.E., Terry, G., Setchell, J., Bright, F.A.S., Cummins, C., Kayes, N.M., 2020. The micro-politics of caring: tinkering with person-centered rehabilitation. Disabil. Rehabil. 42 (11), 1529–1538.
Goodall, A.H., 2011. Physician-leaders and hospital performance: is there an association? Soc. Sci. Med. 73 (4), 535–539.
Hargraves, E.K., Østergaard-Nielsen, M.R., Bech, M., Madsen, M.M.L.K., Hølchen, L.E., Jacobsen, C.B., 2024. Kortlægning af danske hospitalslægers oplevelse af organisering, ledelse og samarbejde. Kong Frederiks Center for Offentlig Ledelse/ Institut for Statskundskab, Aarhus Universitet.
Jakobsen, M.S., Ejersbo, N., Bech, M., 2015. Faglig, hybrid eller generalist – ledelse i sundhedsvæsenet – et studie af ledende overlæger i Danmark. Økonomistyring & Informatik 31 (2), 125–147.
Hauge, A.M., Bjørnholt, B., Bech, M., 2022. Lægelig ledelse – inspirationskatalog: Hvordan hospitalerne kan styrke deres lægelige ledelse med OK21. VIVE – Det Nationale Forsknings- og Analysecenter for Velfærd. https://www.vive.dk.
Jacobsen, C.B., Nørgaard, R.R., Østergaard-Nielsen, R., 2019. Sådan påvirker ledelse patientbehandling og dødelighed i sundhedsvæsenet. Tidsskrift for Dansk Sundhedsvæsen 95, 38–48.
Jones, L., Fulop, N., 2021. The role of professional elites in healthcare governance: exploring the work of the medical director. Soc. Sci. Med. 277, 113882.
Kirkpatrick, I., Jespersen, P.K., Dent, M., Neogy, I., 2009. Medicine and management in a comparative perspective: the case of Denmark and England. Sociol. Health Illness 31 (5), 642–658.
Kirkpatrick, I., Dent, M., Jespersen, P.K., 2011. The contested terrain of hospital management: professional projects and healthcare reforms in Denmark. Curr. Sociol. 59 (4), 489–506.
Kirkpatrick, I., Zardini, A., Veronesi, G., 2023. Management reforms, re-stratification and the adaptation of professional status hierarchies. Public Manag. Rev. 25 (11), 2231–2254.
Kjaer, E., Mathias, H., Østergaard-Nielsen, R., Bech, M., Mai, M., Koldby, L., Laurits, M., Hølchen, E., Jacobsen, C.B., 2024. Datarapport: Kortlægning Af Danske Hospitalslægers Oplevelse Af Organisering, Ledelse Og Samarbejde.
Kurunmäki, L., 2004. A hybrid profession: the acquisition of management accounting expertise by medical professionals. Account. Org. Soc. 29 (3–4), 327–347.
Ledelseskommissionen, 2018. Sæt Borgerne Først – Ledelse i Den Offentlige Sektor Med Fokus på Udvikling Af Driften.
Lepori, B., Montauti, M., 2020. Bringing the organization back in: flexing structural responses to competing logics in budgeting. Account. Org. Soc. 80, 101075.
Llewellyn, S., 2001. Two-way windows: clinicians as medical managers. Organ. Stud. 22 (4), 593–623.
McGivern, G., Currie, G., Ferlie, E., Fitzgerald, L., Waring, J., 2015. Hybrid manager-professionals' identity work: the maintenance and hybridization of medical professionalism in managerial contexts. Public Adm. 93 (2), 412–432.
Martin, G.P., Waring, J., 2012. Leading from the middle: constrained realities of clinical leadership in healthcare organizations. Health 17 (4), 358–374.
Miles, M.B., Huberman, A.M., 1994. Qualitative Data Analysis. Sage.
Ministry of the Interior and Health, 2023. Recommendations by the Danish Resilience Commission.
Moreira, T., 2011. Health care rationing in an age of uncertainty: a conceptual model. Soc. Sci. Med. 72 (8), 1333–1341.
Møller, A.M., Cecchini, M., 2023. Same position, different roles? How professional, organizational, and public policy logics shape frontline managers' role conceptions. Public Manag. Rev. 27 (8), 1868–1892.
Noordegraaf, M., Van der Meulen, M., 2008. Professional power play: organizing management in health care. Public Adm. 86 (4), 1055–1069.
Noordegraaf, M., 2020. Protective or connective professionalism? How connected professionals can (still) act as autonomous and authoritative experts. Journal of Professions and Organization 7 (2), 205–223.
Numerato, D., Salvatore, D., Fattore, G., 2012. The impact of management on medical professionalism: a review. Sociol. Health Illness 34 (4), 626–644.
Panagioti, M., Geraghty, K., Johnson, J., Zhou, A., Panagopoulou, E., Chew-Graham, C., et al., 2018. Association between physician burnout and patient safety, professionalism, and patient satisfaction: a systematic review and meta-analysis. JAMA Intern. Med. 178 (10), 1317–1331.
Patel, R.S., Bachu, R., Adikey, A., Malik, M., Shah, M., 2018. Factors related to physician burnout and its consequences. Behav. Sci. 8 (11), 98.

Pedersen, L.D., Thomsen, N., Elbæk, K.U., 2020. Kortlægning Af Ledende Overlæger i Danmark i 2019 Og 2020. Institut for Statskundskab, Aarhus Universitet.
Prætorius, T., Clausen, T., Dyreborg Larsen, A., Kirchheiner Rasmussen, J., Ricard, L.M., Hasle, P., 2024. Impact of decentralized management on sickness absence in hospitals: a two-wave cohort study of frontline managers in Danish hospital wards. BMC Health Serv. Res. 24 (1), 816.
Sartirana, M., Currie, G., Noordegraaf, M., 2018. Interactive identity work of professionals in management: a hospital case study. Public Manag. Rev. 21 (8), 1191–1212.
Sarto, F., Veronesi, G., 2016. Clinical leadership and hospital performance: assessing the evidence base. BMC Health Serv. Res. 16 (2), 169.
Schrøder, I., Cederberg, E., Hauge, A.M., 2022. What is good work in a hybrid organization? Account Audit. Account. J. 35 (3), 917–949.
Schuurmans, J., Stalenhoef, H., Bal, R., Wallenburg, I., 2023. Valuation and task differentiation in older person care. Sociol. Health Illness 45 (7), 1560–1577.
Simonen, O., Viitanen, E., Lehto, J., Koivisto, A.M., 2009. Knowledge sources affecting decision-making among social and health care managers. J. Health Organisat. Manag. 23 (2), 183–199.
Spehar, I., Frich, J.C., Kjekshus, L.E., 2015. Professional identity and role transitions in clinical managers. J. Health Organisat. Manag. 29 (3), 353–366.
Tavory, I., Timmermans, S., 2014. Abductive Analysis: Theorizing Qualitative Research. University of California Press, Berkeley.
Waring, J., 2014. Restratification, hybridity and professional elites. Sociology Compass 8 (6), 688–704.
Waring, J., Bishop, S., Black, G., Clarke, J.M., Exworthy, M., Fulop, N.J., Hartley, J., Ramsay, A., Roe, B., 2023. Navigating the micro-politics of major system change: the implementation of sustainability transformation partnerships in the English health and care system. J. Health Serv. Res. Policy 28 (4), 233–243.
Waring, J., Roe, B., Crompton, A., Bishop, S., 2020. The contingencies of medical restratification across inter-organisational care networks. Soc. Sci. Med. 263, 113277.