Leading processes of patient care and treatment in hierarchical healthcare organizations in Sweden – process managers' experiences

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Abstract

Purpose – The purpose of this study is to gain better understanding of the roles and functions of process managers by describing Swedish process managers' experiences of leading processes involving patient care and treatment when working in a hierarchical health-care organization.

Design/methodology/approach – This study is based on an explorative design. The data were gathered from interviews with 12 process managers at three Swedish hospitals. These data underwent qualitative and interpretative analysis with a modified editing style.

Findings – The process managers' experiences of leading processes in a hierarchical health-care organization are described under three themes: having or not having a mandate, exposure to conflict situations and leading process development. The results indicate a need for clarity regarding process manager's responsibility and work content, which need to be communicated to all managers and staff involved in the patient care and treatment process, irrespective of department. There also needs to be an emphasis on realistic expectations and orientation of the goals that are an intrinsic part of the task of being a process manager.

Research limitations/implications – Generalizations from the results of the qualitative interview studies are limited, but a deeper understanding of the phenomenon was reached, which, in turn, can be transferred to similar settings.

Originality/value – This study contributes qualitative descriptions of leading care and treatment processes in a functional, hierarchical health-care organization from process managers' experiences, a subject that has not been investigated earlier.

Keywords Qualitative study, Leadership, Conflict, Mandate, Process managers

Paper type Research paper

Introduction

The complexity of modern day care and treatment requires interdepartmental cooperation, and the skill to achieve this cannot be provided by one party alone (Edgren, 2008). There has been a gradual but belated shift in Swedish health-care organizations in recent decades toward process orientation, where the focus is on interdepartmental

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processes at hospitals (Faltholm and Jansson, 2008), but it is still relatively limited (Hellström and Eriksson, 2007). This is partly a response to the need to find ways to deal with the complexity of the care that is required (Vera and Kuntz, 2007).

Process orientation generally has a positive impact on hospital efficiency (Vera and Kuntz, 2007) and organizational performance. Processes that are carried out more effectively and quickly might result in improvements such as time reductions, increased customer satisfaction, better quality and financial performance and reduced costs (Kohlbacher, 2010). Further positive effects have been identified in different care contexts, such as improved outcomes for patients with joint replacements (Vanhaecht *et al.*, 2010), better care performance at hospital stroke units, reduced length of stay and readmission (Vos *et al.*, 2009) and shorter throughput times at emergency departments (Asplund *et al.*, 2010).

Difficulty in improving process orientation has been highlighted. It is easier to talk about implementing process orientation than actually to do it (Hellström *et al.*, 2010). Hellström *et al.* (2010) discuss a number of underlying reasons. The organization itself might be an obstacle to implementation. Furthermore, health-care staff identify conflicts regarding organizational principles and structures. These difficulties and the challenge of shifting focus toward processes in health-care organizations are seen as results of deeply institutionalized organizational routines and interdisciplinary boundaries (Faltholm and Jansson, 2008; Eriksson, 2005) as well as differing inter-professional and interdisciplinary cultures (Hall, 2005). There is thus a need to understand the processes in the health-care organization (Benyoucef *et al.*, 2011).

Process organization can be implemented in different ways, either by using coordination mechanisms in a functional structure, i.e. as a matrix, or by adopting a restructuring approach, i.e. restructuring the functional organization into an organization made up of multidisciplinary departments (Vos *et al.*, 2011). Regardless of the model, process orientation aims to bring activities together into a logical chain, where each activity produces value that increases with the number of activities carried out. Value is a measurement of the benefit of care in aiding recovery. In an ideal situation from a process point of view, the shift in focus is from the functional organization to the diagnosis, care and treatment of the patient, regardless of where in the hospital it is provided or by whom (Eriksson, 2005).

Health-care processes have been scrutinized to achieve workflow efficiency in areas such as radiography (Teichgraber *et al.*, 2003) and critical care (Besunder and Super, 2012) and in changing patient transportation systems (Danny Segev, 2012). Implementing The Geisinger Health System's innovation strategy for care model redesign focusing on creating value emphasizes the importance of committed professional staff with an entrepreneurial bent and experience (Paulus *et al.*, 2008). Different process implementation methods have also been described, such as the Six Sigma (Chand, 2011), 3-blackboard (Vanhaecht *et al.*, 2011) and lean methods, all of which focus on essential processes (Vats *et al.*, 2012; Asplund *et al.*, 2010; Huggins, 2010) as well as quality-based savings through measuring, understanding and managing variation among clinicians in providing care (James and Savitz, 2011).

Previous studies have drawn attention to process organization in itself, with less attention paid to those who direct the care and treatment processes. Studies that focus on the experiences of process managers are conspicuous by their absence, a gap this study seeks to fill. The purpose of this study is to gain better understanding of the roles and

functions of process managers by describing Swedish process managers' experiences of leading processes involving patient care and treatment when working in a hierarchical health-care organization.

Method

Design

An explorative approach (Patton, 2002) was used in the study since the aim was to understand process managers' roles and functions. Qualitative research interviews were used. Qualitative methods are recommended obtain knowledge and understanding about the meaning people invest in specific situations or phenomena, such as process managers' experiences of managing health-care processes (Patton, 2002).

Setting

The interviewees were recruited from three hospitals. One of these was a 2,000-bed university hospital and the other two were general hospitals with 525 and 741 beds, respectively. The process perspective had been in place for more than 10 years as they all used the Balanced Scorecard (Kaplan and Norton, 1996) model to compile strategies and budgets from different perspectives. However, one of the general hospitals had worked more systematically with implementing process orientation, although the functional, hierarchical organization still remained the base. All three hospitals had identified and begun working on a number of processes related to the care and treatment of patients in diagnostic groups in the past five years and had appointed managers for these processes. The number of processes at the hospitals varied from 5 to 18, but all of them involved more than two different departments and often several. In summary, the role of the process managers was to coordinate activities within the process with the aim of developing the process. Furthermore, they were responsible for leading analysis of risks and incidents, for initiating and leading improvements and safety work, and also for evaluating improvements in the process.

Participants

In this study, the process managers are regarded as individuals with the potential to influence care and treatment processes. The job title varied among the participants. Some were called process managers, some simply "the person responsible for the process". In this study, they are all given the title process managers. The participants (12 of the 31 process managers at the three hospitals) were recruited voluntarily for the study and they all split their time between being a clinician and a process manager. To ensure variation in experience of leading processes, both male and female process managers for different processes and hospitals were selected. Five of the process managers were male and seven were female. All were physicians except two, who had another professional affiliation within health care. The mean length of professional experience was 31 years with a range of 16-39 years. The mean age was 56 years with a range of 44-66 years. Experience as a process manager varied from less than one year to four years. Only three of the process managers had received training in leading processes in a health-care organization and this took the form of a short in-service course.

Data collection

Data collection was carried out by interviewing 12 process managers at three hospitals in western Sweden. Before the interview commenced, the process managers were asked if they still agreed to be interviewed and they gave their written, informed consent. The interviews took the form of a conversation but were guided by a semi-structured interview guide with open-ended questions (Patton, 2002) to cover the research questions. Each interview took place at the respective process manager's office and lasted approximately 1 hour. A typical opening question was: "Could you tell me how you came to be working as a process manager?" Another question example was: "Can you tell me what you are doing to develop the process?" The questions were followed by further questions to probe for precision, clarity and greater detail.

Data analysis

The interviews were transcribed verbatim and then analyzed using qualitative and interpretative analysis with a modified editing style (Crabtree and Miller, 1992). This means that the interview text was analyzed inductively, based on the aim and research issue, to understand the content of the interview text. To capture the meaning of the text, the first step in the analysis was to identify meaningful segments or units in the text. These units of meaning were either related to the purpose of the study or were freestanding. The NVIVO 10.0 program was used to organize these meaningful segments of text. Each unit of meaning was labeled with a code (called nodes in NVIVO). NVIVO was later used to organize the units of meaning into categories. The categories were then examined to identify patterns and relationships between the categories. This interpretative process of analysis resulted in three themes.

Ethics

Under the current legislation, this kind of research does not require ethical consent (The act, 2003:460 (Amended SFS 2008:192)). However, by law and under the Declaration of Helsinki (World Medical Association, 2002), participants are required to be informed. Consequently, the ethical considerations decided by the Swedish Research Council (The act, 2003:460 [Amended SFS 2008:192]) were observed. The participants were informed orally and in writing about the study and their voluntary participation and they were told that their information would be treated in confidence and that they could withdraw at any time. All participants gave their written consent.

Results

Based on the aim, the analyses resulted in three themes: *Having or not having a mandate, Exposure to conflict situations* and *Leading process development*. All three themes emphasize important aspects of process managers' experiences of leading processes related to care and treatment of patients in diagnostic groups in a hierarchical, linear organization. These important aspects are embodied as central concepts in each theme and are italicized in the text. The themes are illustrated by means of quotations from individual participants and are numbered.

Having or not having a mandate

Process managers do not have mandate *to make decisions* related to the content of the activity and financial issues, as these are matters for the heads of department. Nor do process managers have the financial resources at their disposal to develop the process or

to make any necessary changes. Care and treatment processes are initiated following a decision by the hospital management team. Process managers stated that their mandate was inadequate when they attempted to implement new ways of working in the process or when treating patients. They sometimes felt they were *trapped* between their own responsibility to develop the processes concerned and the decisions of the heads of department who manage the departments involved:

> Since I don't have the same authority as a head of department, any form of dissent can only result in me losing and that's not good. / […] / I need a little more authority from the hospital management. (1)

It is not just heads of department but also colleagues who make the work difficult. A process manager's work is sanctioned by the hospital management team and anything that comes "from the top" is inevitably treated with suspicion by the staff. Furthermore, there is at times a tendency among colleagues to be self-censuring so as not to stand out, which diminishes process managers' authority. A physician's traditional duty to provide care and treatment is strong and this could interfere with the proposed sequence in the process, which naturally makes a process manager's work more difficult. In these cases, process managers highlight the importance of support and an explicit mandate from the hospital management team.

As financial constraints in the health-care system necessitate prioritization, they feel they must accept actions taken within their specific process as always being assessed in relation to all actions taken in the departments involved. Process managers need to *coordinate* work between departments, *convince* heads of department as to what needs to be done and ensure that staff members are working in the right direction. Process managers need to be emphatic when drawing attention to the importance of *an explicit definition* of their assignment as process managers and what they are expected to achieve. If they are to exert influence and gain acceptance for the changes suggested in the process, they need to present very strong arguments:

> I have very little power. The only thing I can do is to explain to the managers involved. (9)

Some process managers do not regard the lack of decision-making power as being a problem. Instead, these managers feel they have a significant *impact on the work* being done within the process. Based on process mapping, they decide how the process team should work with the process and they develop action plans as the work progresses. They feel they have considerable freedom in their work. Process problems are discussed by the process teams to find solutions and the process managers often have meetings with the heads of department concerned. Process managers highlighted the need for *cooperation* to find solutions through consensus and to gain acceptance by colleagues:

> For me the mandate was to be allowed to cooperate with the others. I wasn't alone. Thankfully, I was able to work with the others to come up with solutions. They then took the solutions back to their departments to secure acceptance. I then made the decisions. (2)

Exposure to conflict situations

Care and treatment processes are developed at the interface between the different interests and the different departments to which process managers need to relate. Working as a process manager means *de facto working within a kind of matrix organization*. Consequently, several process managers are uncertain about taking on the

assignment as they are highly conscious of the difficulties that might be encountered when working in a matrix. Being a process manager is a part-time assignment, and for the remainder of the time, they work in their professional capacity in one of the departments. Even if they attempt to strike a balance between different people representing different interests, there is still the risk of *conflict with heads of department*, who might consider process work provocative. Working in a hierarchical, top-down organization, process managers feel that heads of department are fully occupied with implementing other decisions taken by the hospital management team. Some process managers talk about a "thrifty" organization, which means that when a process manager suggests changes to promote improved collaboration between different departments, the initial reaction of heads of department is "What's in it for me?" (2) or "What will it cost?" (2). Process managers sometimes had difficulty in convincing heads of department to change indications for surgery, as seen in the example below:

> To make it easier for these women, I suggested that we perform a particular surgical procedure under local anaesthetic in the outpatients' ward instead of in the surgical ward. The head of department then said that in that case his department would not make any money as the surgical ward would not receive any payment. It would simply result in higher costs for them. (12)

Consequently, process managers always need to develop processes in collaboration with not just one but several heads of department. There is an obvious risk for conflict in this collaboration because the proposed changes in care and treatment would disrupt plans for achieving the targets laid down in decisions that have already been taken:

> When I meet the heads of department I find it difficult to get through to them as they are preoccupied with enforcing decisions made by the hospital management and they are not the least bit interested in the process. (1)

Some process managers talk about the *ambiguity* of their assignment, which implies risking conflict between different interests as well as difficulty in leading the process properly. This ambiguity was expressed in terms of the content of the assignment as well as the scope. Ensuring a constant flow in day-to-day work is always a priority at the departmental level, which is where process managers are employed. Process managers are often required to put their process work to one side if, for example, one of the physicians is on sick leave. Consequently, conflict may arise between the process managers' various commitments. Even for those who devote a great deal of time to their assignment, process work might conflict with other duties. It is always the work related to the process that is put to one side:

> There is a certain degree of uncertainty. When I had personal problems I had to reduce my working hours. The chief executive was very understanding but the first thing I was told was: 'Cut down on the process work.' (7)

Time also includes the aspect of tempo, related to differences in work rate. Process managers sometimes had a higher work rate and wanted to achieve better results than other co-workers in the organization who wanted to proceed more slowly.

Process managers sometimes found themselves *in a situation between parties* who were in conflict with each other where they might be required to act as intermediaries and provide reassurance. When, for example, people from different departments had conflicting opinions about how to work and cooperate in the process, or wanted to

pursue an initiative without communicating with the others, process managers were required to mediate, which involved firmness on the part of the process manager concerned:

> You can't be sensitive when you're faced with that kind of assignment. (6)

Process managers highlight the importance of explicit leadership in the organization along with a good climate of communication to avoid conflict situations or to deal with conflicts when they arise. Another area of conflict process managers are required to handle is allocating limited *resources* for new and expensive treatments. While medical research and development are continuously producing new treatments, health-care resources are finite. Process managers are fully aware of this reality and priorities need to be discussed and accepted by heads of department. Even so, process managers regard themselves as the patients' advocates and they feel obliged to support decisions that benefit the patients:

> There are expensive treatments available that might be beneficial but the benefits always need to be weighed up against something else. (10)

Leading process development

Despite difficulties, process managers constantly work to develop the processes involved. To succeed, they emphasize the importance of all staff members agreeing to work with processes. They all acknowledged anchoring as an important tool for successful development. The task of ensuring that an idea is firmly anchored can be undertaken in different ways. Process managers use formal meetings at the department such as weekly workplace meetings or patient conferences as a forum to speak about and promote their process. Regular patient conferences where colleagues at the department discuss different patients thus constitute one type of formal meeting. Process managers then make use of problems that have been identified as part of the development within the process team:

> When it emerges that we have a problem or there"s something that isn"t working very well, I examine the problem, work on it and then get back to my colleagues with suggestions. (10)

Process managers find it an advantage to establish a basic understanding of the process and then to work step by step to motivate their colleagues and other staff, urging them to get involved in developing the process. Talking to the staff and presenting ideas by asking questions and introducing different ways of addressing a problem help to promote anchoring. Process managers also use informal meetings with colleagues to motivate them and to develop the process. They endeavor to provide positive feedback on the patients' experiences of being treated by staff working in the process. By doing so, process managers feel they are helping to create a positive atmosphere. Guiding principles and instructions produced within the process team are part of the feedback system, the aim of which is to ensure anchoring. They also make use of the outcomes of process work, such as publishing statistics for treatments that use a commonly applied method. This arouses staff interest and encourages questions:

> I present the results. You could say it's about spreading the word, showing them "this is how it is […] we ought to be better." (8)

Working as a process manager is very much a matter of trust. It is important *to be open* at all stages in the process and to strive to achieve transparency. The hospital management team's expectations of the process and what they envisage that the process managers and the process team will achieve must be expressed with total clarity and precision. This openness includes the relevant activities and the ambition to involve everyone. It is important to involve the staff in data collection to identify problems, find solutions and analyze data:

> Nothing should take place behind closed doors or anywhere else for that matter. Everything should be open. (6)

The ways in which process managers *use their authority* in relation to the care and treatment process emerged from the analysis. Leading a care and treatment process requires process managers who have extensive experience in the medical profession. Process managers must have advanced medical knowledge to persuade people to listen when they want to ensure that changes in the process actually work. They must go beyond simply being interested. Their professional authority must include the ability to diagnose, care for and treat different groups of patients. It is important to have experience and authorities regarding the different aspects of the process, especially as the process managers do not have any formal right to make decisions influencing work in the individual departments:

> You must really know what you're talking about to ensure that you have authority in these matters and that you can assert yourself. You need to be a specialist in the field and you must have experience. (3)

Process managers' authority is not based solely on experience and knowledge but also on behavior. Process managers gain the confidence of the staff when it becomes obvious that instead of delegating responsibility and duties to colleagues and other staff, they themselves are actively the driving force.

The development of processes is based on *evidence*. The starting point in developmental work is having clearly identified patient needs. There is a continuous search for evidence on which to establish guidelines for clinical practice to help solve problems in the care and treatment process. The National Board of Health and Welfare is the first checkpoint but there are also European principles:

> We should not use artificial solutions decided in haste and not based on evidence. (7)

At the same time, the demand for evidence cannot be taken to extremes. In some situations, evidence or research results are not available. Process managers and the staff are thus compelled to rely on experienced-based knowledge.

Discussion

Based on interviews, the aim of this study is to gain a better understanding of the roles and functions of process managers by describing Swedish process managers' experiences of leading processes involving patient care and treatment when working in a hierarchical health-care organization.

This study shows that most process managers felt that their mandate was inadequate with regard to their responsibility for the development of processes. Those who were dissatisfied with their mandate were also dissatisfied with the scope given to influence the work undertaken within the process at each department. However, there

were a few process managers who were satisfied with their freedom to plan and carry out the work within the process team.

Both groups, however, reported a lack of explicitness regarding their assignment and mandate. Nevertheless, the need expressed by process managers for a formal and specified mandate might be interpreted as showing a rather naive attitude to leadership, attributable perhaps to the hierarchical tradition existing in health care (Axelsson, 2000, Asplund *et al.*, 2010). There is a difference between these two approaches. Those who are dissatisfied with their mandate talk about the need for a formal mandate (Nilsson, 2003) from the hospital management team, while those who are satisfied with their mandate talk about their informal mandate (Nilsson, 2003).

The formal mandate from the hospital management team appears to be very unspecific because process managers experience the need to interpret the responsibility embodied in their assignment in their own way. An unspecific formal mandate probably leads to uncertainty in process managers' leadership, limiting their freedom of action when undertaking development of the process. Process managers who thought their mandate was adequate had also made their own interpretations of their scope for making decisions.

The challenges in a matrix organization have been described earlier (Thomas and D'Annunzio, 2005). Challenges mentioned include unclearly defined roles and responsibility as well as ambiguous authority. The same challenges are found in this study. The call by process managers for explicitness concerning their responsibility reflects a need for clarity. This applies to the degree of freedom for process managers to develop their roles and functions as well as to expectations regarding what their roles and functions would enable them to achieve. Responsibility for designing the work and quickly finding out informative ways to develop the process and measure progress must rest with process managers (Huggins, 2010).

The need for explicitness concerning what is expected of process managers must be communicated to the heads of department and coordinated with their power and mandate. According to Walker and Carayon, communication is a key concept in process leadership and includes all the managers involved (Walker and Carayon, 2009). This is particularly important, as the position of head of department carries obvious and automatic authority (Hollander, 1992; Yukl, 2012), whereas the position of process managers does not. This study is accomplished in a hospital context unlike other contexts where implementation of process organization has been studied. This study context is distinguished by a strong professional authority and a culture characterized as conservative, mechanistic and increasingly standardized (Alharbi *et al.*, 2012). The hospital culture might influence how process managers think and act. Process managers need to rely on authority acquired through work experience and professional knowledge. Therefore, it is also important to emphasize the leadership function of process managers and not only to focus on their formal mandate and their right to make decisions. This shift of emphasis will empower them to inspire, motivate, stimulate and pay necessary attention to individuals, in this case, the staff involved in each respective process.

The process managers' training in process leadership was very limited. Only a few had received short periods of in-house training. To avoid any shortcomings among process managers in the way they lead the process, an extensive training scheme should be recommended to them before they take up the position of process manager.

According to Perjons *et al.* (2005), it is important to give process managers an introduction, especially with regard to security, ethics and legality. However, their research did not draw any attention to the challenges embedded in the leadership of processes in hierarchical organizations. The experiences of process managers in our study emphasize the importance of leadership qualities to be successful as a process leader in such an organization.

The importance of communication to succeed in organizing a process has been emphasized (Walker and Carayon, 2009), and this is a skill we also find that process managers require. Communication expertise has been found to be important in leadership (Nilsson *et al.*, 2005; Yukl, 2012), although Walker and Carayon do not relate communication expertise to leadership (Walker and Carayon, 2009). We feel it is important to do so and this is important in leadership training.

Process managers in our study gave several examples of their leadership which could be interpreted as transformational leadership strategies (Bass and Riggio, 2005). They mentioned their strivings to create a basic understanding of the process and motivate colleagues and other staff to participate in process development. This can be interpreted as the motivational element in transformational leadership (Bass, 1999). Furthermore, their clearly stated efforts to secure acceptance of development activities within the processes can also be interpreted as transformational.

Hellström and Eriksson (2007) state that the management concept must be created and interpreted in practice and that the need exists to bridge the gap between rhetoric and practice. Our results confirm the lack of leadership, which reveals the necessity for process managers with a mandate to interpret and translate the meaning of process leadership. Process managers do not talk explicitly about their leadership. Their mandate needs to be reinforced as they appear to be unaware of their potential power and the opportunity at their disposal to influence inbuilt leadership. Accordingly, implementing process orientation cannot focus purely on the structure and the process managers' decision-making latitude.

Aronsson *et al.* (2011) explore the complexity of process organizations and the need to combine different strategies to lead processes. However, they do not discuss the nature of the skills required to fulfill the assignment of leading this work. Our interpretation therefore is that this implies that process managers need to be highly educated. We recommend that health-care organizations train process managers before appointing them, not just in the process itself but also in leadership.

Process managers stated that they were exposed to conflict situations, and at times, they were involved in conflicts directly. One source of conflict was control of financial resources. Heads of department had the formal power to make decisions involving financial resources. This means that the matrix organization was not true and strong (Thomas and D'Annunzio, 2005) because the power was unevenly distributed between the parties. The scope to make decisions is related to the functional, hierarchical organization and Hellström *et al.* (2010) emphasize the problems of functional organizations (Vos *et al.*, 2011). Process managers confirm that organizations in themselves to some extent constitute obstacles to process management. On the other hand, they do not state what their perceptions are regarding organizational principles and structures.

Process managers do not mention the influence of different interprofessional and interdisciplinary cultures either, although these were previously found to be an obstacle

to implementing process organization (Vos *et al.*, 2009). Instead, they state that there is good cooperation between different professions in the process team. Nevertheless, the difficulties and challenges reflect a need for holistic thinking instead of functional thinking and not simply assigning financial responsibility to the functional departments. An initial step in this direction is to give process managers and heads of department shared responsibility to develop the processes, taking into account financial factors and rectifying the existing power imbalance.

There is also the question of whether or not, it is possible to organize health care into interdepartmental processes. Some researchers state that process leadership is appropriate in situations where there is a structured flow with a sufficient volume of similar repetitions (Lillrank *et al.*, 2011) and even where the health-care flow is not always structured or repetitive because consideration must always be taken to the needs and situation of each unique patient. Process managers, therefore, need to be prepared for the challenges that process leadership in health care can present in terms of specific conditions. They also need to be involved in organizing the health-care process and to deal with the potential risk of being involved in conflicting situations.

Process managers' leadership implies the need to cooperate with different groups of staff as well as managers at different departments and levels. Process managers emphasized the difficulty of striking a balance between these different collaborative partners.

It is difficult to say whether or not our findings present a true picture of process managers' leadership function. The process managers' descriptions produced an interpretation that the difficulties encountered in their function were related mostly to obstacles in the organization or among staff and managers, but it is possible that the process managers did not want to focus on their own shortcomings. The difficulties might also be related to the function itself and the lack of familiarity among heads of department with thinking and working in a process-orientated manner. This lack of familiarity could be explained by the fact that the degree of process orientation in Swedish health-care organizations is still low (Hellström and Eriksson, 2007).

Process managers' descriptions might also be an expression of the underlying reasons for the difficulty in implementing process-orientated organizations (Hellström *et al.*, 2010). It is doubtful whether the organizations themselves and the managers in the organizations are sufficiently prepared to implement process organizations and handle the different logics (the functional organization and the care and treatment process) at the same time but where the functional organization is predominant.

Study limitations

The study results have been discussed with an awareness of their limitations. To reduce pitfalls for misunderstandings during the interview and the researcher's preconceptions of health care and leadership, we attempted during the research process to give the interviewees time to explain and reflect and to remain aware of our understanding of the health-care process organization and management. Another limitation is that only 12 process managers from three hospitals were included in this study although the interviewees' descriptions of their experiences of leading processes were extensive and provided an understanding of the phenomenon at a deeper level. The aim behind qualitative studies is not to make generalizations but to provide the opportunity to acquire a deeper understanding of the phenomenon (Crabtree and Miller, 1992). Despite

the limitations, the findings provide insight into the problems of being a process manager and they highlight the possibility of developing the role, including the conditions that led up to taking on the role initially. This additional knowledge can be transferred to other health-care organizations.

Conclusions

The results indicate a need for explicitness regarding the conditions under which a process manager works and the content of the assignment at hand. These conditions and the content need to be communicated to all managers and staff involved in the care and treatment of patients as part of the process, irrespective of the department. Emphasis also needs to be put on realistic expectations and orientation of the goals that are an intrinsic part of the task of being a process manager.

Notes

KN: Study design, data collection and analysis and manuscript preparation.

MS: Data analysis and manuscript preparation.

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