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Perceptions of trust in physician-managers

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Abstract

Purpose – The purpose of this paper is to explore the dual role of physician-managers through an examination of perceptions of trust and distrust in physician-managers. The healthcare sector needs physicians to lead. Physicians in part-time managerial positions who continue their medical practice are called part-time physician-managers. This paper explores this dual role through an examination of perceptions of trust and distrust in physician-managers.

Design/methodology/approach – The study takes a qualitative research approach in which interviews and focus group discussions with physician-managers and nurse-managers provide the empirical data. An analytical model, with the three elements of ability, benevolence and integrity, was used in the analysis of trust and distrust in physician-managers.

Findings – The respondents (physician-managers and nurse-managers) perceived both an increase and a decrease in physicians' trust in the physician-managers. Because elements of distrust were more numerous and more severe than elements of trust, the physician-managers received negative perceptions of their role.

Research limitations/implications – This paper's findings are based on perceptions of perceptions. The physicians were not interviewed on their trust and distrust of physician-managers.

Practical implications – The healthcare sector must pay attention to the diverse expectations of the physician-manager role that is based on both managerial and medical logics. Hospital management should provide proper support to physician-managers in their dual role to ensure their willingness to continue to assume managerial responsibilities.

Originality/value – The paper takes an original approach in its research into the dual role of physician-managers who work under two conflicting logics: the medical logic and the managerial logic. The focus on perceived trust and distrust in physician-managers is a new perspective on this complicated role.

Keywords Healthcare, Managerial logic, Medical logic, Part-time manager, Perceived trust, Physician-manager

Paper type Research paper

Introduction

Many researchers have discussed the importance of medical leadership by physicians for improving healthcare (Angood and Shannon, 2014). The healthcare sector needs physicians to lead (Clark and Armit, 2010; Degeling *et al.*, 2003). Researchers have also addressed the potential benefits and detriments to healthcare when physicians take full-time or part-time management positions (Angood and Shannon, 2014; Clark and Armit, 2010; Degeling *et al.*, 2003). However, one issue that has not been fully addressed

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in the research on such policy and organizational changes is the trust and the trusting relations between physicians and managers (Calnan and Rowe, 2008).

Trust between people working in healthcare is essential for creating and maintaining supportive relationships and reliable systems (Gopichandran and Chetlapalli, 2013). Although much of the research on trust in healthcare emphasizes the trust relations between the patient and the physician, rather than the trust relations between healthcare professionals (Calnan *et al.*, 2006), trust relations are particularly salient when physicians take on managerial responsibilities. According to Groenewegen (2006, p. 3), the trust research on the professions has failed "to account for the changes due to increased managerial control in the professions".

Interpersonal trust cannot be assumed in the current governance trend in healthcare that requires, among other things, the increased interdependency of physicians and managers. As Calnan and Rowe (2008, p. 101) write, trust "is conditional and has to be earned". Thus, physician-managers earn trust by demonstrating both managerial competence (ability) and medical competence. Andersson (2015) describes this situation as an identity challenge for physicians who take on managerial responsibilities in addition to their medical responsibilities. As managers, physicians are required to have multiple and complex leadership competences that, typically, have not been acquired through previous education and experience (Angood and Shannon, 2014; MacCarrick, 2014; Sebastian *et al.*, 2014). These competences, intended to facilitate workplace effectiveness, include relationship management, communication, leadership and professionalism and other business skills in addition to comprehensive knowledge of the medical and healthcare system (Stefl, 2008).

This paper explores the perceived trust in part-time physician-managers in their dual role as both managers and physicians. The focus is on the physician-managers' perceptions of the received trust from their physician colleagues. We think, regardless of whether the physician-managers' perceptions reflect the actual trust in them, their perceptions of received trust will affect their actions as both managers and as physicians. Moreover, these perceptions may influence their willingness to assume managerial responsibilities.

Theoretical framework

Trust in physicians

Physicians follow a professional logic, described by Freidson (2001) as "a third logic", in which they take responsibility for the control and development of their work. According to Frowe (2005), this possession of "discretionary powers", a key element of professionalism, requires establishing trust because such powers are essentially "tacit and individual". Physicians trust that their fellow physicians are competent, embrace altruistic norms and act ethically. Trust in organizations, as Kramer (1999) writes, and in professions, as Larsson (2007) writes, is essential and creates behavioural expectations about collective goals (Gilson, 2003). However, trust in professionals, like all trust, inevitably involves risk when people must rely on others' judgements. Medical professionalism involves the recognition of "some important descriptive characteristics of professional knowledge (extensive and complex), training (lifelong) and practice (difficult to assess)" (Wynia *et al.*, 2014, p. 712).

Much of the trust in physicians is owing to their education and experience and to the fact that their profession has been institutionalized by a code of ethics, examinations,

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qualification standards, regulations, etc. (Tarrant *et al.*, 2010). However, trust in a profession also requires proof that such trust has been earned and is deserved. If a profession (or some of its members) fails to prove its trustworthiness, then it is unsurprising that its right of autonomy will be challenged (Frowe, 2005; Groundwater-Smith and Sachs, 2002).

In healthcare, a lack of trust in a profession will call into question its members' ideas on how best to manage the healthcare system (Wynia *et al.*, 2014). According to Hall *et al.* (2001, p. 613), the relationship between trust and medical ethics is so fundamental that "(p)reserving, enhancing, and justifying trust are the fundamental goals of much medical ethics". In addressing the decrease in trust in healthcare systems, Collier (2012) raises concerns about problems of patient care and the reduction of physician influence in governmental healthcare policy.

The physician-manager's dual role

The creation of, and support for, the physician-manager's dual role suggests that hospitals and clinics are confident that physicians' medical competence can compensate for any weak administrative competence (Mulec, 2006). Because physician-managers are trained and skilled in healthcare practices and use a medical language, the assumption is that other healthcare professionals will be reluctant to criticize or even question their administrative decisions. In other words, the physician-manager's medical competence is expected to translate to more effective clinical governance (Day, 2007).

From a governance point of view, researchers identify both benefits and detriments arising from the dual role of the physician-manager (Clark, 2012; Degeling *et al.*, 2003; Sorensen *et al.*, 2013). Researchers point to the positive benefits of "organizational transformational change" (McAlearney *et al.*, 2005, p. 13), more informed decisions (Fitzgerald, 1994) and more effective financial decisions at the strategic level (Veronesi *et al.*, 2014). However, other researchers report negative effects, such as the increase in managerial-medical conflicts (Correia, 2013; Viitanen *et al.*, 2006), greater tension between professional values and management objectives (Kippist and Fitzgerald, 2009) and poorer healthcare results (Fitzgerald and Dadich, 2010). Despite these concerns, current practice shows that healthcare organizations continue to give physicians managerial responsibilities in the expectation that physician-managers can contribute to overall improvements in medical care and management efficiency (Angood and Shannon, 2014; Clark and Armit, 2010).

However, few researchers have specifically examined the physician-manager dual role and how it influences fundamental aspects of physicians' professionalism, including trust from other healthcare professionals. In her study of clinicians with management assignments, Fitzgerald (1994) found that while physician-managers placed a high value on their subordinates' and other colleagues' support, they recognized this support was at risk once they assumed managerial responsibilities. She writes that isolation and loss of trust ranged from a lack of appreciation of management to "downright hostility". More recently, in a study on interprofessional practice, McNeil *et al.* (2013) found that perceived threats to professional identity influenced the success of organizational reforms, including occupational cooperation. Both studies conclude that physician-managers risk losing other physicians' trust in their medical competence.

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Multiple logics in healthcare

In addition to the "third logic" of professionalism that Freidson (2001) describes, healthcare systems are said to operate under multiple, complex logics that exist simultaneously (Glouberman and Mintzberg, 2001; Wikström and Dellve, 2009). Scott (2004) describes these logics as opposing and competing. One logic, the managerial logic, is mainly concerned with the cost-efficient use of limited resources. Another logic, the medical logic, emphasizes medical decisions based on expert knowledge and ethical values.

Some healthcare management researchers argue that the managerial logic, in combination with certain bureaucratic changes, has both strengthened management and weakened the medical profession (Eriksson, 2005; Kurunmäki, 2004). Arman *et al.* (2014) claim the managerial logic has gained favour because of its focus on patient throughput. Yet there is an argument that the medical logic retains a powerful position in healthcare. According to Scott (2008), the medical logic can turn professionals into "institutional agents" who are able to make positive transformations in institutions.

Physicians and healthcare managers, according to the multiple logics concept, have different characteristics, goals and even values. In some cases, physicians in hospitals and clinics not only question but also ignore managers' decisions (Choi *et al.*, 2011). Physicians may even doubt healthcare managers' skills (Burnes and Pope, 2007). In this context, trust and trust relations are of fundamental importance.

Clearly, healthcare managers require the trust of physicians if the two groups are to cooperate in clinical governance. Gaining such trust requires that managers recognize that physicians must follow their code of ethics and that they require autonomy as well as respect for their expertise (Bergin, 2009). Möller and Kuntz (2013) argue that physicians as part-time managers support the collaborative management perspective without diminishing the underlying values of the physicians.

Interpersonal trust

Mayer *et al.* (1995, p. 712) define trust as follows:

> […] the willingness of a party to be vulnerable to the actions of another party based on the expectation that the other will perform a particular action important to the trustor, irrespective of the ability to monitor or control that other party.

When professionals trust each other, then it is possible to focus on tasks instead of controls (Mayer and Gavin, 2005). Mutual trust between professionals also supports the exchange of knowledge (Dirks and Ferrin, 2001; Schoorman *et al.*, 2007). Trusting others, however, increases one's vulnerability to others' actions and behaviour, neither of which can be controlled (Hall *et al.*, 2001).

Many researchers have identified and described various elements and influences of interpersonal trust. Das and Teng (2004) conclude trust derives from people's competence, reliability, character and predictability. Schoorman *et al.* (2007) state that trust, which develops between people in the present moment, shapes future behaviour. According to Mullarkey *et al.* (2011), trust derives from an organizational design. In a study on nurses, Hsu *et al.* (2013) describe trust as a combination of ability and benevolence. Connell and Mannion (2006) associate trust with a commitment to institutional structures. Andersson *et al.* (2011) conclude that trust derives from people's willingness to act based on their confidence in others' words, actions and decisions.

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Analytical model

We synthesize these interpretations of trust in the development of an analytical model for use in this research. According to the model, the trustor's trust in the trustee derives from confidence in the ability, benevolence and integrity of the trustee. In particular, research by Colquitt *et al.* (2011), Mayer and Davis (1999), Schoorman *et al.* (2007) and Söderström *et al.* (2009) inspires this model. These three elements are defined next:

(1) *Ability*: A perceived set of skills and/or characteristics that enable one to handle a specific domain of expertise (Arman *et al.*, 2014; Hall *et al.*, 2001).

(2) *Benevolence*: A perceived willingness to act without self-interest and to be a role model for ethical values and good behaviour (i.e. to act as a "good" person) (Burnes and Pope, 2007; Hall *et al.*, 2001).

(3) *Integrity*: A perceived commitment to mutually accepted principles and devotion to work (Bergin, 2009; Hall *et al.*, 2001).

This analytical model, with its three elements of trust, is the framework used to collect and analyse the study's empirical data on perceived trust and distrust in part-time physician-managers. Trust in physicians derives from their competence (i.e. ability) in performing medical procedures, their benevolence in treating patients and their integrity in supporting institutionalized professional structures. Trust in healthcare managers derives from their leadership skills, financial intelligence and experience and responsibility for, and loyalty to, organizational governance. The part-time physician-manager has the complex challenge of earning and maintaining both kinds of trust.

Methodology

This paper focuses on the physician-managers' perceptions of the received trust from their physician colleagues. We focused on the physician-managers' perceptions of the trust they receive from other physicians because we believe that these perceptions influence their actions in their dual role and ultimately their desire to assume managerial duties. Scheier and Carver (2014) report that people's perceptions of others' opinions are highly influential as far as behaviour and self-regulation. Quinn and Rosenthal (2012) state this influence is especially observable when such opinions are negative and/or stereotypical. Therefore, the physician-managers' perceptions of how they are viewed are worth investigating.

We also included the views of nurse-managers in our empirical investigation. The nurse-managers' perceptions of the trust that physicians have in the physician-managers provide data that could confirm, refute or simply add nuance to the physician-managers' comments. Nurse-managers have a particularly good understanding of the managerial role at the operational level of healthcare. Furthermore, nurse-managers understand the importance of the medical profession for all physicians, regardless of whether they have managerial responsibilities, as well as of the importance of healthcare developments as a whole. Nurse-managers can provide an informed, possibly different, interpretation of the perceptions of trust in physician-managers. Thus, as colleagues of physician-managers, nurse-managers are well-positioned to observe and comment on the trust between physicians and physician-managers.

We expected that our research on trust in healthcare would be a challenging area. As social sciences researchers who are outside the medical profession, we assumed it would

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be difficult to engage the physician-managers in open and frank discussions on their dual role. For this reason, we expanded our initial methodological design to include interviews with nurse-managers. These interviews provided an objective, third-party perspective on the physician-managers' dual role. Thus, the use of interviews with the nurse-managers not only facilitated our access to the physician-managers but also enriched our findings.

We view the physician-managers as the trustees and the other physicians as the trustors – and the nurse-managers as the third party. Thus, the physician-managers described how they viewed the physicians' trust in them as physicians and managers. The nurse-managers also described how they viewed the physicians' trust in the physician-managers as physicians and managers. In short, we investigated perceptions of perceptions. The following two questions guided the empirical investigation:

Q1. How do physician-managers perceive other physicians' trust in them?

Q2. How do nurse-managers perceive physicians' trust in physician-managers?

Although not addressed in this paper, the perceptions of other physicians (i.e. those physicians who do not have managerial responsibilities) would provide still more data on trust in physician-managers. We recommend this perspective for future research on the same topic.

The research was conducted in three hospitals in Sweden. We chose these hospitals based on differences among them in terms of size, organizational design and medical research focus. As each hospital uses the physician-manager model, the diversity among the hospitals allowed us to investigate the dual role model in different settings.

The study takes a qualitative research approach and an intra-organizational perspective. The empirical data were acquired in interviews (individual) and in focus group discussions. In the individual interviews, we interviewed eight physician-managers with a time commitment of 40-60 per cent to management and eight nurse-managers working full-time in management. These time commitments for physician-managers and nurse-managers are typical. We also took notes in six focus groups of two or three nurse-managers and three physician-managers. We focused on the three elements of trust in the analytical model: ability, benevolence and integrity. In particular, we asked the respondents to describe example situations related to trust in the physician-managers.

The processing of this data involved collecting, sorting, coding, categorizing and probing the data in an iterative manner – and then collecting new data – until no new patterns concerning perceptions of physicians' trust in physician-managers were found. After this process, we held another focus group interview with four physician-managers and four nurse-managers in which the main question was the following: "What does diminished trust mean and does it matter?"

We used theories on trust in the analysis of the empirical data. In the final stage of the analysis, we compared our research findings with these data to confirm their validity.

Findings

In this section, we present our research findings in terms of the three elements of our analytical model. Table I summarizes the reasons for the increase and decrease in trust in part-time physician managers.

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Table I.
Trust in the part-time physician-manager: increases and decreases

Elements of trust	Ability	Benevolence	Integrity
Increase	The physician-manager's medical competence is valuable when managerial healthcare decisions are required	The physician-manager is respected for the exercise of care with patients, colleagues and other healthcare professionals	The physician-manager can understand healthcare issues from various perspectives
Decrease	The physician-manager's responsibility for both managerial and medical issues can create conflicts Staff and financial issues require full-time work commitment by the physician-manager To maintain competence in day-to-day medical work, the physician-manager should have extensive involvement in medical practice	The physician-manager may subordinate principles related to equity and ethics The physician-manager may downplay collegiality among the medical staff	The physician-manager may be unable to prioritize both managerial and medical issues The physician-manager may not fulfil professional demands

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Ability

Ability in our model is a person's perceived set of skills and/or characteristics that enable one to handle a specific domain of expertise. Our respondents commented on both increased and decreased trust in the part-time physician-managers' abilities as managers and physicians.

The physician-managers and nurse-managers think that other physicians generally support the role of the physician-manager. One nurse-manager stated that the role "guarantees that medical issues are taken into account when decisions are made".

However, some respondents and focus group members said that the physicians think physician-managers lack the administrative ability that other healthcare managers have – primarily because they do not have enough time to deal with all their management responsibilities. Physician-managers must reserve time for patient care. One physician-manager said: "We maintain our medical legitimacy when we continue to have patients".

Another physician-manager said:

> They don't trust us because they know we don't have the education for administration, and we don't prioritize it – and even if we did prioritize administration, we are not expected to.

Some respondents were also concerned that some physicians perceive physician-managers engage too fully with their managerial tasks. One physician-manager concluded:

> If you are a too competent an administrator, your physician colleagues will probably suspect that your competence as a physician is going down the drain – and that is not good – then they really will distrust you.

More than half the respondents agreed that physicians' trust in physician-managers depends on how confident they are in the physician-managers' medical ability. One physician-manager said:

> There is a perception that not everyone can retain excellence in medical issues. This becomes a problem for physician-managers when they work only part-time as physicians.

Physician-managers who reduce their clinical practice risk are being perceived as not being current with up-to-date medical procedures. The so-called "knife time" is seen as essential for maintenance of skills. One nurse-manager said:

> The subordinates secretly direct complicated patient cases to surgeons without managerial responsibilities because other physicians lack trust in the physician-managers' competence.

More than half the nurse-managers and physician-managers agreed that trust in physician-managers depends on how the development of the physician-managers' medical competence is perceived.

However, some respondents thought physicians do not see this dual role as problematic so long as physician-managers perform only the simpler medical tasks. Nevertheless, one physician-manager stated: "I don't think I am perceived as a *real* doctor".

Benevolence

Benevolence in our model is a person's perceived willingness to act well without self-interest and to be a role model for ethical values and good behaviour. A

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nurse-manager's comment is representative of the respondents' views of the physicians' perception of benevolent behaviour in physician-managers: "A physician-manager should be a person who always protects the patients' right to the best care and who also cares about colleagues and other health professionals".

Swedish healthcare is largely based on the equity principle, which states that all patients will receive equal treatment and care, regardless of their background, diagnosis, gender, economic status or (in theory) constraints on the use of healthcare resources. However, the respondents worried how other physicians view the application of the equity principle in medical treatment and care when physicians are employed part-time as managers. The respondents said they were aware of physicians' doubts about the physician-managers' medical benevolence. For example, a physician-manager stated: "Medical staff worry that the equity principle will diminish when the treating physician has a managerial responsibility to stay within budget". Another physician-manager explained that the problem is "whether our colleagues trust the physician-managers' ethical intentions or think they just want to reduce costs. And it is really important to stay within the budget".

These budget constraints, and their supposed detrimental influence on the physician-managers' benevolent behaviour, were a recurring topic in the interviews. One physician-manager observed:

> When you begin to talk about money, you begin to act about money. But that doesn't mean I am acting unethically and not taking care of my patients. However, my [physician] colleagues sometimes distrust my good intentions.

She feared she was perceived "as a traitor who has abandoned her belief.".

The respondents were also concerned about perceptions of their benevolence in terms of their relationships with their colleagues. A physician-manager said she thought the physicians asked themselves if she could be trusted. The focus group members, who also stressed the importance of collegiality in medical settings, worried that the perception of the physician-manager's concern for colleagues could change if physicians suspect they prioritize budgets over medical treatment and care. One nurse-manager explained: "The doctor is important to the entire organization, and so is his concern for the other doctors and nurses – he is someone who cares. He is not an accountant".

Integrity

Integrity in our model is a person's perceived commitment to mutually accepted principles and devotion to work in healthcare. Most respondents and focus group members remarked on the tension that physicians sense between the physician-managers' medical responsibility to the patients and their administrative responsibility to the organization. One physician-manager said: "My colleagues and subordinates seem to understand that I must also consider financial and political decisions and what is best for the hospital – not just for the patient." Although the nurse-managers agreed with him, some physician-managers said they were aware that other physicians perceived a disturbing conflict between medical and administrative responsibilities. One physician-manager stated: "To subordinates, the medical and professional aspects must come first – but that is not always possible. This leads to the physician-manager's integrity being questioned".

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A physician-manager, who had experienced substantial resource reductions, said:

> Physicians might perceive that the focus on financial matters may displace the focus on important values such as human empathy, treatment equity, and the duty of care. It is difficult to hold steadfastly to medical ethical codes – the very essence of healthcare – when medical practice must be weighed against cost.

Thus, physician-managers perceive that they are questioned in terms of where their integrity lies: in medical practice or in administrative matters. Especially in times of rapidly rising healthcare costs, this is a dilemma with serious implications for patients and for society – and for the perceptions of physician-managers' integrity. One physician-manager gave an example of this dilemma. He described the situation when patients are medically cleared to leave the hospital and are sent home – where they will receive community-based care – even when additional hospital care is needed. Such early hospital releases are often short-term cost-saving measures that eventually result in future costs when patients return to the hospital. Commenting on this situation, a physician-manager said:

> It is better to be sure the patients are well than to have them back in the hospital, sometimes even sicker than before – but as a manager it might be hard to argue for that. If you fail, the trust in you as a manager will decrease.

A nurse-manager also commented on this challenging situation:

> Even if our manager has a lot to do in his role as manager, we must see his devotion to his work with the patients – that is crucial. And if I can't see it, I can guarantee that the physicians won't see it, and if they don't, I don't think they will trust the physician-manager.

Does perceived trust matter?

Although the respondents could point to some instances where they thought the physicians' trust in the physician-managers had increased, overall their perception was that such trust had decreased. Some nurse-managers and physician-managers claimed that this decrease had influenced how physician-managers act and how others interacted with them. Several respondents stated it was necessary for physician-managers to prove to other physicians that they were "worthy of trust as a doctor". With reference to the physician-managers' self-perception, another respondent stated:

> It's an uncomfortable situation when I do clinical work. I am sometimes unsure if I can do it. Sometimes I even think I have to prove my competence to myself.

Because of this perceived decrease in trust, physician-managers stated they experienced a decrease in their status as physicians. The respondents agreed that this decrease in trust has implications for the physician-manager's hospital position. One physician-manager stated that his hospital colleagues referred less often to him on medical issues:

> They do not count as much on me. I have become a more peripheral person, especially for severe cases or for extraordinarily interesting operations or new methods.

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When the trust between physician-managers and other physicians is challenged or damaged by a loss of confidence, the physician-manager's leadership position is at risk. A physician-manager made this point:

> If they don't trust you, you can shout as much as you like, but nothing will happen because no one is listening.

Analysis and discussion

The dual logics

In healthcare organizations, the managerial logic and the medical logic reflect the different goals, values and responsibilities of the two domains of administration and service (Kouzes and Mico, 1979, on domain theory in human service organizations). The administrative domain, under the managerial logic, focuses on organization, productivity, cost control and evaluations. Its fundamental consideration is efficiency (Andersson and Tengblad, 2009; Cregård and Solli, 2012). The service domain, under the medical logic, focuses on good routines, scientific knowledge and patients (Degeling and Carr, 2004; Degeling *et al.*, 2003). Its fundamental consideration is the quality of patient care.

The healthcare sector must manage both domains in ways that all stakeholders accept. Unavoidably, both domains must make compromises. However, if one domain or both perceive the compromises are too severe, serious problems may arise (Chervenak and McCullough, 2003) and powerful representatives may take sides (Nash, 2003). In such instances, crises in administration and service are probable.

When physicians, who are far more comfortable with the care-based medical logic of the service domain, become managers, they are expected to assume the efficiency-based managerial logic of the administrative domain. Physician-managers, who must combine the two logics in an effort to earn and maintain trust from other physicians, risk losing the trust they have as physicians, especially when they are unsuccessful in combining the two logics (Clark, 2012; Kippist and Fitzgerald, 2009). As Iedema *et al.* (2004) conclude, a common result is that when physician-managers fear loss of trust, they are hesitant to enforce administrative routines even when such routines are required and/or beneficial.

Increases/decreases of trust in part-time physician-managers

Trust in physician-managers is perceived to increase when physicians see their administrative decisions reflect their medical competence (Leggat and Balding, 2013, for a discussion on the importance of competent leadership in clinics). Because physician-managers have the special ability to explain medical practice, with its code of ethics, to hospital/clinic administrators, they can mediate between physicians and administrators so that both sides have a better understanding of each other's conditions and constraints (Degeling *et al.*, 2003; Sorensen *et al.*, 2013). However, according to our respondents, medical professionals hope and expect that healthcare administrators will acquire an increased understanding of medical practice and ethics rather than that medical staff will acquire an increased understanding of administrative work.

Trust in physician-managers is also perceived to increase when physicians think physician-managers make decisions that reflect benevolence and integrity according to the medical logic. This means that their colleagues must trust that physician-managers will deal with conflicting value systems, complex managerial and professional

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hierarchies and often-tense human relationships – respectfully and equitably. Physician-managers gain the trust of others when they make (and explain) difficult choices fairly, especially when unavoidable trade-offs between medical practice and the cost of this practice are necessary. They also gain the trust of others when they show concern for patients (Correia, 2013).

Trust in physician-managers is perceived to decrease when physicians think physician-managers are unable to balance the demands and duties of their dual role. If they focus too narrowly on the administrative role of cutting costs, maximizing patient throughput and communicating in specialized business language (Zapata and Rombach, 2010), they risk losing the trust of their medical colleagues. Physicians tend to resist cost comparisons and evaluations in patient treatment and are uncomfortable with the unscientific terminology of the marketplace. However, if physician-managers focus too narrowly on the medical goals of equitable, high-quality patient care, regardless of cost, they risk losing the support of hospital/clinic management.

The causes of decreases in perceived trust in physician-managers have one commonality: the difficulty in combining two roles in one position. The position requires others not only to trust in the physician-manager's ability but it also requires others to trust in the physician-manager's benevolence and integrity. Moreover, the physician-manager must deal with conflicting value systems, diverse groups of people and bureaucratic hierarchies. In short, the physician-manager's position requires managing two kinds of logics. In many organizations, different individuals manage the different logics.

Conclusions and practice implications

This research uses an analytical model – with its three elements of ability, benevolence and integrity – to investigate how physician-managers and nurse-managers perceive physicians' (the trustors) trust in physician-managers (the trustees). We examined the unique role of the physician-manager who works under the two, often conflicting, logics: the managerial logic and the medical logic. Our research confirms Kippist and Fitzgerald's (2009) finding of the tension between physicians' medical values/goals and healthcare administration's managerial values/goals. When the physician-manager combines the two logics, trust in the individual who has the dual role is at risk. The physician-managers in our study are aware of this problem and the nurse-managers confirm their perceptions. The challenge for the physician-manager is to gain the trust of other medical professionals by balancing cost efficiency with patient quality care.

Hospitals and clinics that use the physician-manager model would benefit by paying more attention to the diverse, and often conflicting, managerial and medical demands placed on physician-managers. When physician-managers must prioritize between medical needs and managerial mandates, they are placed in untenable positions. The trade-offs and conflicts inherent in the combined role require analysis at the strategic management level as well as at the interpersonal level of the medical professionals. In addition, it is important to give physician-managers training and support in this dual role (Angood and Shannon, 2014; MacCarrick, 2014; Sebastian *et al.*, 2014). Without such training and support, the physician-manager risks losing the trust of other medical professionals.

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Limitations and further research

Although our study was conducted in a Swedish hospital setting, the issue of dual healthcare roles has widespread applicability (Spehar *et al.*, 2012). Nevertheless, we recognize a limitation of our research. We investigated perceptions of physicians' trust in physician-managers from the perspective of physician-managers and nurse-managers. We did not interview other physicians (i.e. physicians who have no managerial responsibilities). Thus, our results are perceptions of perceptions. However, how we think others see us influences how we act and interact with them. Further analysis of physicians' trust in physician-managers, from the physicians' perspectives, could add another layer of interpretation to our findings.

We recommend interviewing non-managerial physicians on their ideas concerning the increase and decrease in trust in physician-managers. To add yet another perspective, we also recommend interviewing non-medical managers on the same topic. In such research, one goal could be the search for ways to mitigate or even resolve the conflict between the managerial logic and the medical logic such that both the quality and the efficiency of healthcare benefit.

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