Clinical Engagement: from theory to practice

A qualitative case study on the use of the Medical Engagement Scale to improve the work environment at Oslo University Hospital

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Thesis submitted as a part of the Master of Philosophy Degree in Health Economics, Policy and Management

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Abstract

Purpose
The relevance of the clinical engagement approach for Oslo University Hospital is evaluated through the case study on the experiences of the pilot-project “Strengthen Employeeship”. Particularly, the issue of interest for this master’s thesis is whether the Medical Engagement Scale and the Healthcare Engagement Scale could be used to improve the work environment and achieve enhanced employeeship in a Norwegian context. The case study has followed the experiences of the project group from September 2015 to April 2016 and included the preparation phase, the measurement phase and the initiation of an improvement plan based on the survey results.

Design & methodology
This is an exploratory case study. The methodology used is qualitative and the source of data is multiple, consisting of field observations, semistructured interviews with key actors in the project, several informal conversations with the head of the project and relevant documents.

Findings
Theoretically, the clinical engagement approach offers a systematic framework to the specific issue of employeeship in the hospital context, as it considers the themes of “collaboration” “commitment” and “satisfaction”. Nevertheless, there are structural and contextual variables that challenged the practical implementation of the Medical Engagement Scale and of the Healthcare Engagement Scale in a Norwegian context, pointing to the conclusion that these tools are just partially applicable to the workplace improvement processes of Oslo University Hospital.

Value
These findings contribute to raise knowledge on the relevance of the clinical engagement approach in a Norwegian context, identifying the additional value and the limitations that this approach can have in relation to the established MU employee survey.
Acknowledgements

The key to every great recipe is great core ingredients, say the Italians. In fact, this research would not have succeeded without the precious help and availability of the participants of the project “Strengthen Employeeship” at Oslo University Hospital. I would like to thank the head of the project, Morten Ørbæk, and each one of you for sharing your time, your passion and experiences with me. It was a pleasure to be part of this process and to follow you in your journey towards a better workplace.

My supervisor for this master’s thesis was Professor Lars Erik Kjekshus. Thank you, Professor, first of all for introducing me to this project, giving me the opportunity for a unique insight in the world of Oslo University Hospital and its dynamics. Moreover, thank you for sharing your expertise, for wise pieces of advice and for reassuring words in times of stress. Much appreciated!

This master’s thesis does not just conclude my involvement in the case study at Oslo University Hospital. It also signifies the end of my life as a student after five years of education at the University of Oslo. Many people have helped me getting through these university years and each of them, in their own way, have encouraged and inspired me. I would like to thank my mother, Alessandra, for teaching me to be curious, to be passionate and to be joyful, showing me that single women can move mountains. Thanks to my sisters back in Italy, Sarah, Francesca and Letizia for being the best cheerleaders ever. Also, thanks to my Norwegian family, particularly to Svigermor Rita, Svigerfar Agnar and Mormor Wera for welcoming me to this beautiful country and supporting me with your encouraging words and positive attitude.

Finally, the greatest acknowledgment goes to my husband, Pål Agnar. Dear Pål, thank you for putting up with me, for making it all easier, for believing that this is all worth it and telling you are proud. Thank you, for being the best partner to ride with, on the roller coaster of life!

Gloria
“Knowledge is the true organ of sight, not the eyes”

Panchatantra
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<table>
<thead>
<tr>
<th>Acronym</th>
<th>Norwegian</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUS</td>
<td>Oslo Universitetssykehus</td>
<td>Oslo University Hospital</td>
</tr>
<tr>
<td>MES</td>
<td>-</td>
<td>Medical Engagement Scale</td>
</tr>
<tr>
<td>HES</td>
<td>-</td>
<td>Healthcare Engagement Scale</td>
</tr>
<tr>
<td>MU</td>
<td>Medarbeiderundersøkelsen</td>
<td>MU employee survey</td>
</tr>
<tr>
<td>NSD</td>
<td>Norsk senter for forskningsdata</td>
<td>Norwegian Center for Research Data</td>
</tr>
<tr>
<td>HMS</td>
<td>Helse, miljø, sikkerhet</td>
<td>Health, Safety and Environment</td>
</tr>
<tr>
<td>RHF</td>
<td>Regional Helseforetak</td>
<td>Regional Health Authority</td>
</tr>
</tbody>
</table>
1 Introduction

The field of the Human Resource has gradually expanded its scope of action and its strategic role within the management of organizations (Thompson, 2012, p. 250). This evolution reflects the growing acknowledgement that employees are key assets for organizational success, and decades of research have proven the importance of employee behavior for organizational performance, to the extent that one may say “healthcare organizations are only as good as their employees” (Thompson, 2012, p. 254). For this reason, activities such as talent management, skill development, employee retention and wellbeing are to be seen as high priorities for healthcare managers at every step of the ladder. Specifically, an important aspect of employee behavior that has been gaining managers’ attention is the role of motivation and engagement for organizational performance. The increasing interest on this subject matter results in a series of policy implementations, at several organizational levels, that aim at increasing clinical engagement: for example by involving clinicians in strategic decision-making, enhancing their role in change processes and shaping a culture of shared responsibility (Clark, 2012, p. 439).

A starting point for any improvement policy and intervention though, is the assessment of the level of clinical engagement and the identification of trends and patterns that may bring into light the critical factors affecting the work environment. The use of surveys to this purpose is increasing, as these psychometric tools provide the possibility to map employees’ attitudes and opinions time-effectively, at low costs and on large scale.

This master’s thesis is a case study on the pilot-project “Strengthen Employeeeship” at Oslo University Hospital. This pilot consists in the measurement of the levels of clinical engagement through the English-born Medical Engagement Scale (MES) and the Healthcare Engagement Scale (HES), which operationalize the phenomenon of clinical engagement. By gaining a better understanding of the factors affecting employeeeship, the pilot-project aims at creating a work environment that fosters engaged, motivated and inspired employees. This project is specific in the way it focuses on one particular aspect of clinicians’ behavior, engagement. Still, working on engagement embraces a much broader discussion on the organizational culture – “the collective programming of the minds” - that has consequences for a variety of features, including the managerial values, the working environment and the approach to leadership in the organization. In other words, by starting from engagement, there
is a potential to address a range of issues that affect the present situation as well as future developments in the organization. For this reasons, the clinical engagement framework, consisting in the measurement through the surveys MES and HES and in the suggestion of improvement interventions, seems to be an interesting way of approaching the issue of “strengthen employeeship” at Oslo University Hospital.

This case study, through the experiences of the pilot-project at Oslo University Hospital, aims at exploring whether, in practice, these tools can be useful to improve the work environment in a Norwegian context.

1.1 Study objectives and structure

This case study will investigate the experiences with the improvement of the work environment through the MES and HES surveys at Oslo University Hospital. The research question investigated is:

What is the relevance of the clinical engagement approach, in its conceptual and empirical framework, for the improvement of the work environment and employeeship at Oslo University hospital?

In the context of the pilot-project “Strengthen Employeeship”, a specific goal is to get a better understanding of the factors affecting the motivation and the participation of employees in a work situation, and the starting point for this work was the measurement of this phenomenon through the two surveys MES and HES. To understand the relevance of these tools for the Norwegian context of Oslo University Hospital, this case study focuses on two main issues: a) the conceptual framework underpinning the term medical engagement and how this is significant for enhancing employeeship; b) the practical implementation of this approach through the MES and HES surveys and the initiation of an improvement framework based on the survey results.

For the first issue, the master’s thesis will start by looking into the concept of employeeship in a theoretical perspective, presenting the contributions from the literature that can be relevant to understand and define the term. Moreover, the theoretical foundations of the concept of clinical engagement are presented, illustrating how this framework can be of interest for the improvement work on employeeship in a Norwegian context. Also, the matter is actualized by
presenting the potential positive effects that engaged employees have on increasing the quality of treatment, enhancing openness and multidisciplinary cooperation.

Secondly, the master’s thesis will address the practical implementation of the pilot-project through the MES and HES surveys, taking into consideration the experiences of the managers of the project group in understanding and carrying out these surveys. Moreover, a point of interest is the use of the survey results as background for initiating the improvement work in the clinics. These experiences will be used to identify the strengths and weaknesses of the Medical Engagement Scale and of the Healthcare Engagement Scale when implemented in a Norwegian context.

Finally, the master’s thesis discusses how the clinical engagement approach, from theory to practice, is relevant for Oslo University Hospital in the effort of improving employeeship and the work environment.

<table>
<thead>
<tr>
<th>Level of analysis</th>
<th>Theoretical</th>
<th>Empirical</th>
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<tbody>
<tr>
<td>Issue of interest:</td>
<td>The conceptual framework of clinical engagement</td>
<td>The practical implementation through the MES and HES surveys</td>
</tr>
<tr>
<td>Sub-question</td>
<td>The definition of employeeship and its relation to the theoretical framework of clinical engagement.</td>
<td>The experiences with the measurement of clinical engagement through the MES and HES surveys.</td>
</tr>
<tr>
<td></td>
<td>How does the conceptual framework suggested by the clinical engagement approach relate to the issue of improving employeeship and leadership?</td>
<td>What are the strengths and weaknesses of the MES and HES surveys for initiating the improvement of employeeship?</td>
</tr>
</tbody>
</table>

*Table 1: Issues of interests and sub-questions of the master’s thesis*

The data used in the case study will be qualitative, consisting in the information gathered through semistructured interviews, the numerous field observations collected from the autumn of 2015, and the analysis of different documents concerning the project.

It is the first time that the concept of clinical engagement is introduced in Norway. The findings of the study will contribute to raise knowledge on the significance of the clinical engagement approach in a Norwegian context, identifying the additional value and the limitations that this approach can have in relation to the established MU employee survey.
1.2 Study Background

1.2.1 Engaging doctors in England

The well-known charity foundation “The Kings Fund”, which works for research, learning and policy advising in England, has recently concluded:

“One of the biggest weaknesses of the NHS has been its failure to engage clinicians – particularly, but not only doctors – in management and leadership” (Ham et al., 2011, p. ix)

The clinical professions in the NHS have been reluctant to the incorporation of the clinical practice into the management of the services and to a consequent subordination of their autonomy and judgement to organizational and financial logics. A result of this fear has been the averseness to enter leadership positions at the organizational level and an unfortunate relation between clinical practice and management (Martin, Beech, MacIntosh, & Bushfield, 2015, p. 18).

Particularly, this deficit in engagement and good leadership, and the subsequent proliferation of negative behavior among employees, has come to the attention of the public after the discovery, around 2005, of a series of severe failures in patient safety and quality of care. These discoveries led to public inquiry and commissioning of the trusts, like in the case of the Mid Staff Hospital scandal (Francis, 2013, p. 4; Pope & Burnes, 2013).

Since then, the NHS has launched a series of policies and reforms that aimed at improving the leadership capabilities from the board to the ward, enhancing a culture of collaboration, commitment and openness to reduce the risk for selective moral disengagement among health care professionals (Clark, 2012, p. 437).

Among these programs, the joint project “Enhancing Engagement in Medical Leadership” undertaken by the National Institute for Innovation and Improvement and the Academy of Medical Royal Colleges between 2006 and 2010, aimed at measuring and improving medical and clinical engagement in the NHS trusts, creating a framework for improvement of clinical leadership. The project resulted in two key products, the Medical Engagement Scale (MES) and the Medical Leadership Competency Framework (Spurgeon, Mazelan, & Barwell, 2011, p. 115). The survey tool MES was designed by the external company Applied Research Ltd,
who conducted all data analysis, prepared summary reports for each trust and maintained a national database. An assessment of the levels of medical engagement across numerous trusts and several years gave a substantial normative database of 10,500 medical staff for the MES scale.

The result of the assessment of the level of medical engagement was then compared to the performance assessment done by the independent regulatory body “Care Quality Commission”. The comparison of the levels of medical engagement to this range of externally assessed performance and quality indicators found the two to be strongly correlated (Spurgeon et al., 2011), thus renewing the interest in clinical engagement as a factor of performance and as a useful managerial tool.

1.2.2 The pilot-project “Strengthen Employeeship” at OUS

“We should start looking at the workplace in a holistic employeeship-perspective and avoid using old narratives characterized by dualisms like employee-employer, leader-follower, doctor-nurse, which highlight contraposition rather than unity” (Unit manager)

The idea of exploring new ways of analyzing the work environment at Oslo University Hospital came originally from a collaboration between a clinic’s Work Environment Committee (KAMU) and the CEO’s HR Staff. Particularly, a desired outcome was to address the factors affecting employeeship in the clinic, in order to create a workplace that facilitates collaboration, learning, values sharing and commitment at all organizational levels.

To study and measure these factors, two clinics at Oslo University Hospital decided to start up a pilot-project called “Strengthen Employeeship” and established a cooperation with Professor Peter Spurgeon¹ and Applied Research Ltd. to carry out a survey on medical engagement with the Medical Engagement Scale (MES). In order to address the issue of work engagement also among other clinical staff groups, the Healthcare Engagement Scale (HES) was introduced, thus including all types of clinical professionals in the study. This was an important choice taken by the steering group of the pilot-project, showing the acknowledgement of the essential role that nurses, therapists, psychologists and other clinical

¹ Professor Peter Spurgeon BSc PhD is the Project Director of «Enhancing Engagement in Medical Leadership» and Director of the Institute of Clinical Leadership at the University of Warwick.
professions play in caregiving. Moreover, it also gave the right signals when it comes to enhancing a culture of shared responsibility that goes beyond professional titles.

The background for participating in the project varied across clinics and leaders. One unit for instance, aimed at strengthening the component of employeeship in the workplace, defined as a feeling of a “shared we”, including all clinical workers in the development of the unit, being it managers, doctors, psychologist or allied personnel. One division expressed the wish for finding an alternative framework for work improvement at the hospital, as their experiences with the national MU (Medarbeiderundersøkelsen – Employee Survey) had been repeatedly disappointing. Another division participated to investigate the issue of absenteeism, and reckoned that working on motivational factors and employee engagement would help them address relevant issues affecting work satisfaction. Others joined the project because invited to do so by managers at the clinic level and were initially skeptical about the purposes of the framework. Still, they thought it could be interesting to become part of a project that focused on the relationship with and among employees.

The one of employeeship appears to be a recent theme for discussion and, to my knowledge, this is the first time that a survey study of this type, specifically focusing on clinical engagement, was carried out in a hospital trust in Norway. The MES and HES surveys were conducted in the two clinics at Oslo University Hospital in October 2015. The survey data was collected and elaborated by Applied Research Ltd., who also created a report of the results. On the base of these results, the working group of the pilot-project identified the priority areas that will be the starting point for the interventions planned throughout the summer of 2016.

The MES and HES scales are only one of many approaches to the measurement of work engagement. In an international perspective, the Utrecht Work Engagement Scale and the Gallup Work Audit have also investigated the measurement of work engagement, taking into consideration other theories on the factors affecting the individual in an employment situation (Simpson, 2009). Moreover, the QPS Nordic questionnaire is broadly used in Scandinavia in the field of occupational psychology, and is for example at the base of the “Medarbeiderundersøkelsen” (MU), the annual employee survey carried out in all Norwegian health trusts. The national employee survey MU, is a tailored version of the QPS Nordic questionnaire and is an integrated part of the work with Health, Safety and Environment (HMS) in all Norwegian Health Trusts. This tool measures a variety of psychological and
social factors in the workplace, and among others, also motivation and engagement. Even though the aim of this thesis will not be the evaluation of the MES and HES scales as psychometric tools vis-à-vis other instruments, it will look into the different frameworks for improvement that the MES and HES surveys suggest, in comparison to the MU survey. Specifically, I will discuss the use of these tools at Oslo University Hospital to improve the work environment, enhance job satisfaction and strengthen organizational commitment.

1.2.3 The context of leadership at Oslo University Hospital

“Together with the patient, we develop tomorrow’s caregiving”

(The vision of Oslo University Hospital)

The context of Oslo University Hospital is the one of a growing organization that just in the last two decades has undergone numerous mergers, ownership shifts, dislocations and several financial and institutional reforms. The hospital trust is owned by the South-Eastern Norway Regional Health Authority (Helse Sør-Øst RHF), as the Health Authorities and Health Trusts Act of 2001 transferred the ownership of all public hospitals from the 19 county governments to the central government, organizing them into five (then four) Regional Health Authorities (RHF) (Hagen & Kaarbøe, 2006). The health enterprise is constituted by the fusion of the previous Aker University Hospital, Rikshospitalet University Hospital and Ullevål University Hospital, which since 2011 have had a joint management. Oslo University Hospital (OUS) is the workplace of approximately 20,000 employees, providing a vast range of health services from about 40 different locations in the city (Universitetssykehus, 2015).

Today, the trust is divided into 15 clinics ramifying into several departments, divisions and units. At each organizational level we find one manager in charge, creating a five-level leadership structure. We talk about level 1 (top leadership), level 2 (chief of clinic), level 3 (head of department), level 4 (division manager) and level 5 (unit manager), as illustrated in figure 1.
This structure, where one manager at each organizational level has the overall responsibility for its organizational unit, is called unitary management. The introduction of unitary management in the hospitals in 2001 had two main purposes: a) to create a profession-neutral leadership model, where the manager does not represent a specific professional group, and b) to emphasize that one manager has the total responsibility for the unit’s results: this includes responsibility for caregiving, budget and staff (Universitetssykehus, 2015).

This person can either be a clinician that has taken on a managerial position, and usually combines it with the clinical practice, or a general manager without direct engagement in patient care.

The model of unitary management differentiates Norway from other countries, like the UK and Denmark, where a “troika” structure (consisting of a consultant, a nurse and a general manager) or a joint management structure (consisting of a physician and a nurse) have been used (Kirkpatrick, Jespersen, Dent, & Neogy, 2009).

The practice of leadership at Oslo University Hospital can be portrayed as a continuous effort in striking a balance between holistic and local perspectives, between clinical and financial goals, between professional autonomy and organizational loyalty. Leaders at each organizational level have a vast range of responsibilities, spacing from staff responsibility, to budgeting and patient care. However, the concretization of the managerial roles varies across organizational levels. While leaders at level 2 and 3 focus on the management and coordination of services from a macro-level, managers at level 4 and 5 are closer to the patient and to the operative core of the organization.
Also the combination of clinical and managerial roles varies across disciplines and organizational levels: while unit and division managers may still practice medicine, from level three and upwards managers are usually 100% devoted to their leadership roles. However, several Norwegian studies have pointed out that showing a clinical affiliation still plays an important role for maintaining authority and legitimacy (Mo, 2008, p. 411) (Spehar, Frich, & Kjekshus, 2012). In fact, some symbols of association and proximity to the clinical practice remain evident also for managers at higher levels, like wearing a white coat even when not practicing on a daily base.

The range of professional backgrounds of the managers has been expanding since the introduction of unitary management in 2001, with the establishment of a profession-neutral managerial role, which opened the doors of management also to other professions than the medical one (Spehar & Kjekshus, 2012, p. 49). On the aggregate level, the percentage of doctors in managerial positions has been decreasing, while other professions have been marching in. For instance, descriptive statistics from a longitudinal study done in Norway between 2005 and 2009 point out that doctors hold less than a half of the managerial positions at level 3, and that the percentage of managers with a non-clinical background has been increasing in the same period (Kjekshus & Bernstrøm, 2010, pp. 25-26).

However, the medical profession is still significantly represented at the highest organizational levels, which may signify that the days of iatrocracy\(^2\) are yet not over. To illustrate this, table 2 shows the division of professional backgrounds in leadership positions at Oslo University Hospital:

<table>
<thead>
<tr>
<th>Professional background of managers at OUS</th>
<th>% of Physicians</th>
<th>% of Nurses</th>
<th>% of Other Professions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional background of managers in higher leadership positions</td>
<td>19</td>
<td>25</td>
<td>56</td>
</tr>
<tr>
<td>Professional background of managers in lower leadership positions</td>
<td>41</td>
<td>12</td>
<td>47</td>
</tr>
</tbody>
</table>

Table 2: Professional backgrounds in leadership positions at OUS (L. E. Kjekshus, personal communication, March 6, 2016)

\(^2\)The term “iatrocracy”, from the Greek *iatros* (physician) and *kratein* (to rule), was coined by Professor Emeritus Ole Trond Berg to describe the organization of the healthcare sector as physician-dominated systems.
All leaders at Oslo University Hospital must comply to a set of formalized standards, containing three main elements: 1) leaders must be capable of achieving results in accordance with the overall goals and strategies of the organization; 2) leaders must show integrity; 3) leaders must be motivating and unifying (Universitetssykehus, 2016). Particularly, the requirements states that leaders shall “think strategically, set clear and ambitious goals and be capable of developing a culture that motivates the organization toward necessary changes and restructuring, also across clinics and levels”. Moreover, managers shall be “visible and inspiring leaders, who create wellbeing in the organization and motivate towards engagement” (Universitetssykehus, 2016, p. 33).

The context of the practice of leadership, and subsequently the relationship between managers and employees, is nevertheless challenged by a series of elements that regard particularly the size of the organization. We can define these challenges as problems related to the vertical and horizontal span of control. Because of the distance between the operative core and the top leadership, and the numerous managerial levels in within, the large vertical span of control makes the structure more bureaucratic, with slow decision-making processes and complex information flow. Moreover, horizontally, there is great variation in regard to the number of employees that managers relate to (which just at the unit level ranges from 10 to 200 employees), and in regard to the geographical distribution of the units on different locations (Universitetssykehus, 2015, pp. 75-80).

This organizational context is relevant to the issue of enhancing employeeship, as the possibilities for participation, inclusiveness, cohesiveness and collaboration may be hindered (or enabled) by these structural elements. Moreover, the size and the culture of the organization should be taken into consideration when addressing the factors affecting the work environment. In an organization as Oslo University Hospital, characterized by large variation in regard to the size and the composition of its organizational units, the practice of leadership and the experience of employeeship might be particularly challenging to address.
1.2.4 The MU - survey and improvement framework

As introduced above, the MU survey is the national employee survey carried out annually in all Norwegian health trusts, and is an integrated part of the hospitals’ work on Health, Environment and Safety (HMS). The MU survey and improvement framework serve different purposes: a) it is a practical tool for leaders to initiate local improvement in their units; b) it produces a basis for development and intervention at the organizational level; c) it gathers information mapping workers attitudes and opinions on a series of dimensions; d) consisting of a national database, it keeps track of trends and shifts and makes inter- and intra-trust comparison possible.

The MU questionnaire is based on the QPS Nordic survey and consists of 66 questions divided into 23 themes that cover a variety of important psychological and social factors affecting the individual and its work environment. In the MU survey, employees are asked to answer the questionnaire “hierarchically”, in regard to the leader and to the organizational unit closest to them. In other words, employees of unit X will answer on the matters that regard unit X and on the manager of unit X (level 5). At the same time, the manager of unit X (level 5) will answer the survey on the matters regarding its division Y (level 4). The division manager Y will answer the survey concerning its department Z (level 3), and so on. In this sense, the mapping of data on the psychosocial factors is collected on a unit base and not for the whole organization (even though aggregate data is used to illustrate organizational trends and performance). Similarly, the improvement work that follows the survey results is mainly conducted locally, where each unit or division manager, together with the employees, identifies two improvement areas and one maintenance area that the interventions will focus on. Later on, the managers are required to hand in specific action plans that describe how the unit is planning on working on the improvement and maintenance areas.

One of the reasons that was advocated for trying out another employee survey in the pilot-project “Strengthen Employeeship”, i.e. the MES and HES surveys, was the discontent with some of the aspects of the framework established around the MU survey and with the different practices related to it.

In the interviews, I had the possibility to understand more about the practical use of the MU survey and about the challenges and the positive experiences that characterized the leaders’ relationship to this survey.
One of the first aspects of the MU that employees and leaders reacted to is the length of the survey, which some described as “exhausting”. Some understood the fact that the survey covers a range of factors of interest and thus needs to be extensive, but at the same time, many employees perceived some parts of the questionnaire as a succession of similar questions.

Another aspect of the MU that received criticism, is the fact that the categories reported in the survey were perceived as “rigid” and “ambiguous”. In fact, employees may understand concepts differently when they respond to the survey and when they have to pick the categories to work on in the improvement work - “[…] like, what do they mean with the term “safety3”? I mean, that I am confident that the work I do is correct? Or that I feel physically safe? Or that I am in a safe environment with my colleagues?” (Employee, joint meeting).

However, the main criticism concerning the MU survey regarded mostly the post-survey improvement work, rather than the questionnaire itself. Here, many leaders described this process of “improvement” as dominated by reactive rather than proactive activities, a chance to complain without truly committing to find joint solutions to the unit’s challenges. An interesting point in this regard, was to understand why managers and employees felt that the framework established through the MU did not bring about the desired results. Some, expressed frustration and skepticism toward the use of this tool, mostly because they hardly saw results.

Managers agreed that autonomy in the creation and implementation of interventions and improvement activities was a key element to succeed with the use of employee surveys as managerial tools. In fact, the development of local solutions, that supplemented (or even substituted) the standardized framework of the MU survey was received positively by employees and managers. Moreover, through the interviews, I could understand that having a systematic framework for improvement (often coming from the top leadership), is a double-edged sword. On the one hand, it gives guidelines for the creation and implementation of working plans guarantying compliance; on the other hand, this systematic framework might be perceived as artificial, as an imposed task, which results in the passive development of plans that are rarely evaluated. When managers expressed their experiences with the improvement work post MU survey for example, they told to have received positive results

3 The English term “safety” is chosen here by the author to translate the Norwegian term “trygghet”.

12
and feedbacks from the employees when they managed to “make [the improvement work] their own”. For example, managers would find creative and alternative solutions to present the survey results, by bringing the employees in off-site cozy environments that would incentivize participation and open conversation. Moreover, when the MU-survey was not carried out in 2014, the development of local surveys and feedback loops were successful activities to engage employees in the process of improvement. This can illustrate that top-down activities and specific frameworks for improvement might reduce employees’ ownership of and commitment to the processes, as the survey becomes for the employees an occasion to focus on negative aspects, and for the managers a dull task to be finished with.

How can we balance the use of systematic frameworks with the need for local solutions? This dilemma does not just regard employee surveys, but also other frameworks initiated in the hospital at higher levels, that however might be characterized by halfhearted compliance rather than enthusiastic commitment.

Given the mixed-feelings regarding the MU survey, the project-group decided to try out an alternative approach to improving the work environment, the clinical engagement approach. In this thesis, I will evaluate how this framework can be of interest when addressing the issue of employeeship and engagement among the clinical staff.

In the next chapter, I will give an overview of the method and structure of the case study and describe the data gathering and analysis processes. Chapter 3 introduces the concept of employeeship and determines its place in the literature on leadership. Also, it presents the clinical engagement approach, with the definition and operationalization of the term clinical engagement. This theoretical part lays the ground for making two main assumptions on the expectations of findings concerning the relevance of this approach for the work improvement at Oslo University Hospital. Subsequently, in chapter 4, these assumptions are investigated through the empirical implementation of the clinical engagement approach, in the context of the pilot-project “Strengthen Employeeship”. These findings will be discussed in chapter 5 where the relevance of the clinical engagement approach for the work on employeeship will be determined.
2 Data and methodology

2.1 The case study

A case study, also known as “the study of the particular”, focuses on a singular phenomenon of interest, a real-life situation bounded to a specific context (Rosenberg & Yates, 2007, p. 447). Robert Yin defines the case study research method “as an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used” (Yin, 2003b, pp. 13-14).

Classification

The literature suggests several criteria for the classification of a case study research, taking into consideration different aspects of the study, like the purpose, the number of units analyzed and the way the student considers each unit. Firstly, Yin (2003b) distinguishes between single and multiple case study designs (depending on the number of situational contexts that are analyzed) and between holistic or embedded case study designs. A holistic case study research is constituted by one integral unit of analysis forming the context of the study, while the embedded case study design includes sub-units of analysis within the same context. Considering this theoretical classification, the case study design considered in this master’s thesis is a single holistic case study, as the context is the one of the implementation of the project Strengthen Employeeship at Oslo University Hospital.

Another fundamental categorization of case study designs, also suggested by Yin, focuses on the purpose of the analysis of the case and on how the data collected in the study is used to achieve this purpose, which might be of a descriptive, exploratory or explanatory nature. An exploratory case study collects preliminary data asking general questions on a specific phenomenon that opens up for the analysis of a specific research question. A descriptive case study illustrates a series of events or a contextual situation as it occurs, mostly in a narrative form. Finally, explanatory case studies aim at understanding and explaining casual relations in the phenomenon, often on the bases of theoretical assumptions that lay the grounds for hypothesis-formulation (Yin, 2003a).
This particular case study is exploratory, as it aims at giving a first assessment of the relevance of the survey tools MES and HES for improving employeeship at Oslo University Hospital. Since the context of the pilot-project is a work in progress, and a series of interventions will be carried out and evaluated throughout the summer and autumn of 2016, it is too early to say something regarding the casual relationship between the interventions and their actual effect on engagement. Thus, further research and assessments are necessary to conclude on the causal effect of the project on engagement and employeeship.

Research question

The case study opens for an initial evaluation of the relevance of the framework of clinical engagement for enhancing employeeship, which is the main goal of the pilot-project at Oslo University Hospital.

The framework for clinical engagement has been implemented in many hospital trusts in the NHS, achieving good results in improving clinical engagement and the overall organizational performance. The main objective of this master’s thesis is to give an evaluation of the relevance of this tool for a Norwegian hospital setting. My assumption, in fact, is that the success of such frameworks depends upon the contextual situation they are implemented in.
The following research question will be investigated:

What is the relevance of the clinical engagement approach, in its conceptual and empirical framework, for the improvement of the work environment and employeeship at Oslo University hospital?

To understand the term “relevance”, this master’s thesis borrows a definition from the field of information science, considering that “something (A) is relevant to a task (T) if it increases the likelihood of accomplishing the goal (G), which is implied by T.” (Hjørland & Christensen, 2002). In this sense, the relevance of the clinical engagement approach (A) to improve the work environment at Oslo University Hospital (T) is determined by the likelihood of accomplishing enhanced employeeship (G) through the implementation of the framework.

The clinical engagement approach consists of a theoretical conceptualization and of an empirical implementation. The overall relevance of the approach for Oslo University Hospital will be evaluated by considering the following elements in the process: a) the concept of clinical engagement; b) the MES and HES surveys; c) the survey report; d) the framework for improvement.

<table>
<thead>
<tr>
<th>The theoretical conceptualization of employeeship and clinical engagement</th>
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<td>1st assumption on the relevance</td>
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<table>
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<tr>
<th>The empirical implementation of the clinical engagement approach</th>
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<tr>
<td>The concept of clinical engagement</td>
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*Figure 3: The analytical framework to assess the relevance of the clinical engagement approach*

**Specification**

The context of the case study is the implementation of the pilot-project “Strengthen Employeeship” in two clinics at Oslo University Hospital, from September 2015 to April 2016. The contextual situation that has been investigated is the measurement of the levels of clinical and medical engagement with the Medical Engagement Scale (MES) and the
Healthcare Engagement Scale (HES) and the development of interventions that target areas with potential for improvement based on the survey results.

I have followed the implementation of the project from the preparation and measurement phases in the autumn of 2015 through the presentation of the results and the identification of the core improvement areas in the spring of 2016. I have been observing the work group and the project group meetings and I have helped in the presentation of the survey results to the group of managers. These meetings have been a precious source of information regarding the perceived limitations of the current work with employee surveys in the hospital, the challenges that managers have in understanding the purpose of these activities, and the barriers to success in the measurement and improvement phases of the pilot-project.

Moreover, the experiences of the leaders in the clinics involved in the pilot-project “Strengthen Employeeship” were investigated in a series of individual semistructured interviews with the key actors of the project. The interview subjects have been chosen strategically based on their position in the organization and to ensure the illustration of a plurality of perspectives in the study.

Finally, these experiences point to the identification of the strengths and weaknesses of the clinical engagement approach in the context of Oslo University Hospital. These findings create the foundation for answering the research question on the relevance of the framework for clinical engagement to improve employeeship and work environment at Oslo University Hospital.

2.2 Data collection and analysis

The case study will present the qualitative data gathered in the period going from the autumn of 2015 to the spring of 2016, based on the experiences of the clinics with the pilot-project “Strengthen Employeeship” and the use of the MES and HES surveys as managerial tools.

In order to increase the internal validity, multiple sources of information have been used. Firstly, the observation of the meetings of the project group and of the work group in the preparation, measurement and in the initiation of the improvement; secondly, the semistructured interviews carried out with a selection of managers at different organizational levels; thirdly, the analysis of different documents related to the project.
The sampling of the participants for the interviews was based on the quite limited population of managers participating to the pilot-project. It depended both on the leaders’ availability to get involved and on the degree of knowledge that they felt they could contribute with, given the relatively short experience with the project. Not every manager in fact, had the possibility to attend every meeting and to really get an in-depth understanding of the aims and means of the pilot-project, something that put restrictions to the range of possible interviewees. Nevertheless, the fact that the number of informants was limited to seven individuals may be less problematic for this particular case study, because of the low need for external validity, as the study does not aim at generalizing these findings to describe larger populations. Moreover, by annotating field observations throughout the autumn of 2015 in the joint meetings and in a long series of in-depth conversations with the head of the pilot-project, I was able to collect enough material to answer my research question. Mostly, the aim of the interviews was to confirm the information already gathered through the meetings and establish the different patterns of thinking of the participants in regards to the pilot-project and in the use of these survey methods to improve the work environment.

Seven interviews, lasting from 45 to 50 minutes, were conducted in March and April 2016. Managers from different organizational levels and different professional backgrounds in the two clinics were invited to sit in individual semistructured interviews. The seven interviewees had different professional backgrounds, they were managers from different levels or covered other key positions in the clinics; some had been working in the healthcare sector for decades, others were new to the system. Moreover, through the observation of their contribution and participation in the meetings, I understood that they also had different perspectives regarding the use of employee surveys for improvement work.

As the participants had already received information about my project during the meetings of the work group, and as I had also helped the project manager in the presentation of the report of the survey results, the majority of the managers I contacted showed great availability and interest in helping me collecting more information through the interviews. The participants were contacted by email and received the research information sheet approximately one week before the interviews took place, so that they would have time to read it ahead.
The setting of the conversations was the office of the interviewee. The participants were briefed on the confidentiality and anonymity of the information provided before the interviews. Moreover, each participant was presented with the approval of the Norwegian Centre for Research Data (NSD), the agency in charge of giving authorization to researchers for the collection of personal data. Each interviewee signed a written consent to participate to the study.

I used an interview guide to lead the interviews, but the participants were free to bring up other topics than the one I had listed. After explaining the subject and the aims of the study to each respondent and after asking them some personal descriptive information, the interviews were recorded with two devices. At the same time, I took written notes on the interview guide with the key words that summarized the respondent’s answer to each question.

The standard interview guide covered a range of issues of interest, spacing from the participant understanding of the topic, to their negative and positive considerations regarding the use of these frameworks and to their thoughts on the culture of the organization. The interview included both open-ended questions as “what type of experiences do you have with the use of employee surveys to improve the work environment?”, ending questions like “have you experienced obstacles to your autonomy as a manager to initiate improvement measures?”, and follow-up questions when needed.

**Comparison to the MU survey**

Moreover, two divisions that were not involved in the pilot-project were selected for comparison. Here, I have had informal conversations with two division managers, interviewed one unit manager and observed the joint meeting of the unit in the presentation of the MU survey results. The purpose of these conversations was to get an overall understanding of the way leaders at different levels are involved in the organizational development through the MU survey and their consideration of the value of the survey as a starting point for workplace improvement. To get a better insight in the practical activities related to the MU survey, I have been observing one unit in their joint meeting. Here, the results of the MU survey were

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4 The «Norsk senter for forskningsdata – NSD» is the Norwegian Center for Research Data, a Limited Company owned by the Ministry of Education and Research. It is the partner for implementation of the statutory data privacy requirements in the research community, giving research projects the necessary legal approvals for data collection and elaboration.
communicated and discussed in groups, with the purpose of developing action plans for improvement. The meeting lasted four hours and the working style was a combination of three joint sessions of the unit with the manager and two group sessions where four or five employees could discuss the results and the perceived challenges, without the manager, in separate rooms. I sat in a corner in order not to intrude the confidential conversations of the employees and to reduce their discomfort in being observed. I took detailed field notes for the whole session since the conversations were not recorded. Approximately a month after the joint meeting, I carried out a semistructured interview with the unit manager and investigated the experiences of the leader and of its group in tackling the issues brought up in the survey and in the meeting. This interview was recorded, transcribed verbatim and analyzed through thematic content analysis.

**Analysis**

The themes investigated in the interviews with the managers of the pilot-project “Strengthen employeeship” where inspired both by the theoretical background on work engagement and employeeship, and by the observations done at the meetings since September 2015. In this sense the identification of themes for the data analysis was of a mixed nature, being both inductive (based on the mentioned theories) and deductive (extrapolated from the interpretation of the interviews).

I personally transcribed all the interviews verbatim and analyzed them through thematic content analysis. The analysis of the text followed the guidelines of Saldana’s “The coding manual of qualitative researchers” (2015), which suggests an initial open-coding and a subsequent selective-focused coding. Moreover, frequent codes where grouped under cathegories, which represent important factors for evaluating the relevance of the clinical engagement approach at Oslo University Hospital. Illustrated in figure 3, the main cathegories I indetified as relevant for the assessment were: a) the concept of clinical engagement; b) the MES and HES surveys; c) the survey report; d) the framework for improvement.

The results of the MES and HES surveys were the starting point for the improvement work. The quantitative data of the survey was collected and analyzed by Applied Research Ltd. and a report of the survey results was made available at the beginning of January 2016. I will
present and discuss these results later on in the study, to illustrate the experiences with the measurement phase of the pilot-project.

2.3 Methodological considerations

Validity and reliability are essential criteria in determining the quality of a case study. Validity is traditionally defined as the extent to which the study findings are relevant to address and answer the research question. Reliability on the other hand, consists in the clarity of the methodology used in the study design, in the sense that by repeating the same study another researcher would draw the same conclusions (Justesen & Mik-Meyer, 2012). In order to strengthen the reliability of my study I followed a research design and the conceptualizations of case studies given by the relevant literature, as explained in the above sections. Also, the frequent use of tables and schematizations in this master’s thesis was intended to highlight the logics of the author in the use of the theories and in the transition from theory to practice.

Moreover, in qualitative case studies, we can distinguish between external and internal validity. External validity, also called transferability, is the extent to which the study findings are generalizable outside the boundaries of the specific context studied. Internal validity on the other hand, asks whether the case study investigates what it is supposed to (Malterud, 2001). Concerning the transferability of the findings, the fact that the two clinics volunteered to participate in the pilot-project might raise suspicions, pointing to the fact that they are somehow different from other clinics at Oslo University Hospital. For example, they could have experienced challenges with the MU survey at a greater extent than other clinics, which influenced them to take part to the project. Alternatively, it might signify that these clinics are more engaged in improving the work environment than the rest of the hospital. This is considered as a limitation to the degree of representativeness of the clinics. Still, the main objective of the case study is limited to explore the relevance of the clinical engagement approach by describing the experiences of the pilot-project “Strengthen Employeeship”, and the author’s mantra throughout the analysis has been to “not exaggerate the extent of the material” (Malterud, 2001).

To specify the methodological limitations of this study concerning the internal validity I will briefly point out my reflections in regard to the number of informants and to the role of any observer bias.
The rationale for including a limited number of interviewees to the study is twofold. Firstly, given the small scale of the pilot-project “Strengthen Employeeeship”, these respondents were evaluated as the ones with enough knowledge to respond on questions regarding the clinical engagement approach. Secondly, given a certain degree of data saturation, I decided that the seven interviews, combined with the field observations, the document analysis and the other informal conversations in the project group, would give me enough variation and depth in the material to answer the research question. In this sense, I decided to sample the informants in a way that would ensure polyphony in the study (Justesen & Mik-Meyer, 2012).

In regard to the role of the observer, the literature points out that even “contemporary theory of knowledge acknowledges the effect of a researcher's position and perspectives, and disputes the belief of a neutral observer” (Malterud, 2001). In fact, being included in the various processes of measurement and implementation through the pilot-project may have influenced my perception of the events. In order to diminish the risk for bias, I have adopted a reflexivity approach, by acknowledging the partiality and the contingency of the information gathered and by consistently considering alternative explanations to my own conclusions. Also, I have respected the principle of recording and transcribing data faithfully and followed the guidelines suggested in the methodology literature for analyzing the results.

In the following chapter, I will present the theoretical foundation for this master’s thesis. A starting point to frame the topic of employeeeship and clinical engagement is the introduction of the concept of Professional Bureaucracy by Henry Mintzberg. This archetypal organizational configuration is relevant to this master’s thesis as it offers a useful characterization of the hospital as a work environment. Understanding the situational factors, the type of workers and the coordinating mechanisms characterizing this environment is an essential premise to comprehend why enhancing participation and inclusion is so fundamental in healthcare organizations with strong operative cores. Moreover, later in the chapter, I will present the concept of employeeeship. Here I will suggest a theoretical framework, shared leadership, which in my opinion is conceptually close to the one of employeeeship. The shared leadership approach offers a useful portrait of how inclusive and distributed leadership is particularly appropriate for strengthening employeeeship in the hospital sector. Finally, the chapter presents the topic of clinical engagement, its operationalization and its instrumental value for achieving positive outcomes in a hospital setting. These theoretical frameworks lay
down the foundations for making two assumptions on the relevance of the clinical engagement approach, which will be investigated in the transition from theory to practice.

## 3 Theory

### 3.1 Leadership in Professional Bureaucracies

«In the complex world of healthcare the belief that a single person is the leader or manager is far from reality. Leadership is a competency-based behaviour that has to come from everyone involved in healthcare» (NHS Institute for Innovation and Improvement & Academy of Medical Royal Colleges, 2009, p. 2)

Hospitals are peculiar types of organizations to lead, because of the way in which work is horizontally specialized and vertically divided, and because of the population of individuals working in it. Mintzberg (1993), defines healthcare organizations as Professional Bureaucracies. The Professional Bureaucracy is a configuration characterized by the fact that skills are standardized and that work activities are mostly horizontally specialized. The first aspect illustrates the fact that workers in Professional Bureaucracies are highly skilled individuals, ergo professionals, that received a set of standardized skills and competences through years of training and education. Moreover, in the hospitals the horizontal specialization of the work activities is preferred to the vertical, since professionals are experts in their own discipline, and hence need (and appreciate) a certain degree of autonomy, which would not be possible in a vertically specialized system (Mintzberg, 1993, pp. 28-33).

<table>
<thead>
<tr>
<th>Prime coordinating mechanism</th>
<th>Professional Bureaucracy</th>
<th>Machine Bureaucracy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key part of the organization</td>
<td>Standardization of skills</td>
<td>Standardization of work processes</td>
</tr>
<tr>
<td>Main design parameters</td>
<td>Operative core</td>
<td>Technostructure</td>
</tr>
<tr>
<td></td>
<td>Training, horizontal job specialization, vertical and horizontal decentralization</td>
<td>Behavior formalization, vertical and horizontal job specialization, limited horizontal decentralization and action planning</td>
</tr>
<tr>
<td>Type of employees</td>
<td>High-skilled professionals</td>
<td>Low-skilled professionals</td>
</tr>
</tbody>
</table>

*Table 3: Professional vs. Machine Bureaucracy (Mintzberg, 1993)*
The opposite of a Professional Bureaucracy would be the configuration of the Machine Bureaucracy, which is based on the standardization of processes, rather than skills. In the Machine Bureaucracy, horizontal decentralization and action planning are limited.

“so whereas the Machine Bureaucracy relies on authority of a hierarchical nature – the power of office – the Professional Bureaucracy emphasizes authority of a professional nature – the power of expertise” (Mintzberg, 1993, p. 192).

In this regard, hospitals and health care organizations can be considered Professional Bureaucracies, with a highly skilled operative core and a horizontal specialization of labor into a number of different disciplines. Nevertheless, as we have seen earlier, Oslo University Hospital shows some hierarchical features, as decision-making and patterns of delegation follow a clear managerial line that forms a five-level hierarchy of office. This illustrates that the actual hospital setting deviates in some aspects from the archetype of the Professional Bureaucracy suggested by Mintzberg. In fact, recent scholars have challenged this approach to healthcare institutions, pointing to the increase of managerial roles and to a shift towards a more Machine Bureaucracy structure, with higher levels of standardization of work processes and monitoring. The main argument here is the reduction in autonomy of doctors with the introduction of systems of control that aim at enhancing quality of care (Flynn, 2002, p. 168).

Still, it is unconfutable that the operative core of healthcare organizations, the clinical personnel, remains the heart of the activities, the beating organ of this complex body, the conditio sine qua non of caregiving. Also, as seen above, the individuals working in these organizations remain strongly tied to their professional associations, which in turn play a central role in setting the standards of their education, their training and their behavior (Mintzberg, 1993, p. 192).

What type of leadership is then needed in a Professional Bureaucracy? This view of the hospital’s ecosystem constitutes a premise for understanding why the classical Weberian bureaucracy, based on hierarchical leadership, does not fit into a context of highly specialized professionals. Leader-centered perspectives in fact, have been challenged in the Norwegian health care sector, because of a reluctance from the professional groups to be systematically subjected to management and control from external sources, often perceived as an attack to professional autonomy (Wikström & Dellve, 2009, p. 412).
Furthermore, other traits in the development of the health care system can explain the disillusion for the leader-centric approaches and call for a higher degree of involvement of professionals. For instance, the growing use of cross-functional teams, the increasing speed of delivery, new patterns of availability of information and job complexity are important factors in the changing work-design of the hospitals (Bolden, 2011, p. 253).

Even though the Professional Bureaucracy is fashionable and seems to be the most suitable configuration for an environment characterized by highly skilled individuals, this structure incorporates some dysfunctional aspects as well. Firstly, it poses a challenge in creating and following overall organizational strategies, as the strategies are often those formulated by the individual professionals as well as the professional associations from the outside (Mintzberg, 1993, p. 201). Secondly, this structure does not consist of integrated entities, creating problems of coordination among the professionals and their disciplines. Thirdly, with great autonomy comes also great discretion. If discretion goes too far, it can create a condition where the needs of the client and of the organization are neglected. Finally, the Professional Bureaucracy suffers from problems of innovation, as old standards are difficult to adapt to new programs, especially when they rely on interdisciplinary efforts (Mintzberg, 1993, pp. 208-209).

With this background, we understand why the pilot-project at Oslo University Hospital was initiated by a call for enhancing the phenomenon of “employeeship”, described by the participants as the “reciprocal commitment, responsibility, coactivity, and good work environment” in the hospital. Most interestingly, employeeship was understood as “the significance of the single individual, for the whole unit”. In fact, it is comprehensible that in an environment where a multitude of different professional need to work collectively to achieve organizational goals, the element of employeeship is fundamental.

But what is the theoretical foundation of the term employeeship? In the next sections, I will give a review of this interesting concept, of its place in the literature, and its relationship to engagement.
3.2 Employeeship

3.2.1 Employeeship: a “new” concept?

Relational approaches to leadership have commonly stressed the importance of “the human factor” for organizations. In the 60s and 70s, with the ideas of brilliant psychologists and organization theorists as Maslow, McGregor and Herzberg, the research on motivational factors of workers behavior reached its apex (Eriksson-Zetterquist, Kalling, Styhre, & Woll, 2014, p. 114). With a higher focus on the role of employee behavior and of motivation, we observe also an incremental amount of concepts and theories on how leadership could use these theories to improve employee performance.

The term “employee empowerment”, for example, became part of the everyday language of the manager since the 80s, focusing on behavioral change through task-based involvement. In this perspective, empowerment is characterized by information sharing, upward problem solving, task autonomy and self-management (Wilkinson, 1998). Moreover, the term “employee involvement” has been used to describe managerial activities that aim at improving the channels of communication among employees, to generate commitment to the organization and create greater initiative (Marchington, Goodman, Wilkinson, & Ackers, 1991, p. 1).

In other words, they idea that employee behavior is a factor of performance and a strength that organizations should be able to exploit, is not new. However, previous research has normally produced theories on how good leadership could include employees, rather than what it meant to be a good employee. The term “employeeship” (medarbeiderskap), in fact, is a new and uncommon concept, one of the last evolutions in the literature of organizational theory on the approach to management and on the dynamics between leaders and employees.

Furthermore, a review of the literature shows that in the recent years the issue of employeeship has been in the spotlight in the Nordic countries, especially in Sweden, where a “medarbetarskap” model was developed in the Volvo car industry and then expanded to other types of organizations. This model emphasizes the elements of responsibility, loyalty and initiative (Møller, 1994). Employeeship here, is identified as the counterpart to leadership, a
concept that gives a more complete perspective on the participative work relationships between leaders and followers (Bertlett, Johansson, Arvidsson, & Jern, 2012, p. 429)

Moreover, an interesting approach that has been gaining the attention of managers and researchers of the healthcare sector in the UK and in the US is the one of shared (or distributed) leadership (SL). In my opinion, this approach is a useful conceptualization of a new understanding of leadership that fits particularly well with the issue of employeeship and engagement in Professional Bureaucracies. The rationale for selecting this specific theory is that it does not neglect the need for leadership. Nor does it create a contraposition out of the concepts of leadership and followership. In this approach, leadership is a competency-based phenomenon and thus, in Professional Bureaucracies, is shared. By looking at this theoretical framework, the master’s thesis aims at gaining a better understanding of the concept of employeeship and thus identify how, in theory, the framework of clinical engagement is relevant for the work improvement at Oslo University Hospital.

### 3.2.2 Employeeship as shared leadership

Shared leadership and distributed leadership principles have been introduced to several healthcare organizations in the US and in the UK, showing a new approach to leadership, different from the previous visions of the heroic-leader and of the “the great man” (Hartley & Benington, 2011, p. 15) (Kocolowski, 2010) (Martin et al., 2015, p. 14) (Craig L Pearce & Sims Jr, 2002, p. 172).

Since the turn of the millennium, we can observe an increasing amount of theoretical contributions to the topic of shared leadership, and the subsequent ramification of this concept into several different variants (distributed, democratic, collaborative, collective leadership, to name a few) (Bolden, 2011, p. 252). Notwithstanding this proliferation of concepts on the topic, it is still possible to identify some key components, common to most perspectives, which help to define the concept of shared leadership and how conceptually close it is to the one of employeeship.

In this perspective, leadership is not viewed as the responsibility of one person, but as social process and a group activity. This concept acknowledges that leadership goes beyond formal titles of appointment, and includes all the professionals that have a hand in leadership outcomes (Bolden, 2011, p. 252).
In fact, to distinguish this leadership approach from the previous leader-centered perspectives, Pearce and Conger define shared leadership as:

“A dynamic, interactive influence process among individuals in groups for which the objective is to lead one another to the achievement of group or organizational goals, or both. This influence process often involves peer, or lateral, influence and at other times involves upward or downward hierarchical influence” (Craig L. Pearce & Conger, 2003, p. 1)

Peter Gronn (2002) defines distributed leadership as the “concertive action” of a team, a symphony of instruments playing in tune with each other. A synergy, resulting from something more than just the “numerical” sum of individual actions (Gronn, 2002, pp. 425-429). The shared leadership approach promotes a framework that cherishes the strategic role of employees in the achievement of organizational goals, creating a culture of “employee-ship”, rather than one of “leader-followership” (Wikström & Dellve, 2009, p. 420).

Moreover, considering the hospitals as Professional Bureaucracies, this democratic approach to leadership seems to fit well into a culture of collegiality, rather than a culture of line management and subordination.

Leadership is shared when it is understood as an emergent property of a group of interacting individuals or units, when its boundaries are opened, and when the diversity of competences is distributed across the many, and not concentrated on one single individual (Bolden, 2011).

Hooker and Csikszentmihalyi (2003) make some interesting remarks regarding how the introduction of shared leadership principles affects the group psyche, suggesting that this type of work-environment will likely promote flow and creativity, because of the balance between freedom and control offered by such a framework (Hooker & Csikszentmihalyi, 2003, pp. 228-231). By institutionalizing patterns of collaboration and channels of communication, we create optimal conditions for the expression of preferences and ideas, which in turn fosters innovation and commitment (Woods & Gronn, 2009, p. 433).
relationship is also confirmed in the Nembhard and Edmondson (2006) study on the effects of leader inclusiveness on psychological safety and engagement in improvement of healthcare teams. Here, collaborative learning in cross-disciplinary teams also helped overcome controversies related to professional status.

This perspective is particularly interesting in regard to the issue of clinical engagement, as it is oriented towards the study of employeeship, participation and collaboration.

In the next section, I will present the theoretical conceptualization of the concept of clinical engagement and of its operationalization through the Medical Engagement Scale and the Healthcare Engagement Scale. These scales were used by the pilot-project “Strengthen Employeeship” to understand and improve the phenomenon of employeeship.

### 3.3 Clinical Engagement

#### 3.3.1 Definition

In order to understand what has been measured through the MES and HES scales at Oslo University Hospital, a first step is to define the abstract concept of engagement.

The topic of “engagement at work” in fact, is a construct that has been defined in different ways in the literature. Scholars of this field have looked into different faces of the same phenomenon, studying and defining personal engagement, work engagement and employee engagement (Simpson, 2009, p. 1018). Engagement is often seen as the difference between competencies (the can do) and willingness (the will do).

A general definition of the term is found in Schaufeli & Bakker’s Utrecht Work Engagement Scale:

*Engagement is “a persistent, positive, affective motivational state of fulfilment in employees that is characterized by vigor, dedication and absorption”*

(Bakker, Schaufeli, Leiter, & Taris, 2008)

The Medical Engagement Scale, however, is specifically developed to measure work engagement in the hospitals. In fact, it targets and investigates the concept of medical
engagement: doctors are the main subjects of the study. Thus, the following definition is used to understand medical engagement:

“Medical engagement is the active and positive contribution of doctors within their normal working roles to maintaining and enhancing the performance of the organization which itself recognizes this commitment in supporting and encouraging high quality care” (Spurgeon et al., 2011, p. 115)

Following the definition by Spurgeon et al, it is possible to identify the two main dimensions that underpin engagement: the level of organizational opportunities and the level of individual capacities:

![Figure 4: The definition of clinical engagement as a multidimensional variable](image)

An important thing to notice however, is that both the pilot-project at OUS and this master’s thesis aim at studying the phenomenon of clinical engagement, including all clinical workers in the analysis and thus trying to understand the mechanisms that nurture a work environment characterized by inclusion, collaboration and work satisfaction that will maximize the individual capacities of all clinicians.

Engaged employees are characterized by the fact that they share belief and pride in the organization they work in. They show commitment to improve the outcome of their work and comprehension for the wider organizational context beyond their own job role (Atkinson, Spurgeon, Clark, & Armit, 2011).

Moreover, the organization plays a central role in enhancing clinical engagement. From previous experiences in the health trusts, the NHS Institute for Innovation and Improvement identified a list of organizational elements that foster engaged clinicians: a) a stable top-level leadership that leads by example; b) a future-focused and outward-
looking culture; c) the provision of support and development at all levels; d) setting expectations, and firm decision-making; e) effective communication; f) clarity of roles and responsibilities and empowerment; g) promotion of understanding, trust and respect between doctors and management (Atkinson et al., 2011).

Considering the definition of the concept, and the way it interconnects the organization and the individual, clinical engagement offers an interesting and multidimensional way of understanding the relationship between the employees and the workplace. Later in this chapter, I will present how this concept is operationalized through the MES and HES scales.

3.3.2 Clinical Engagement: input and output variable?

In the previous section, I gave a short illustration of the main elements that have an impact on engagement, in the sense that clinical engagement is considered the desired outcome, the output variable of the equation. In this section however, I will turn the question around and ask: why is engagement important? In other words, what impact does engagement have on other essential variables defining successful healthcare organizations?

If the humanitarian argument advocating that the employees’ wellbeing is an objective *per se* is not sufficient to justify the work on employee satisfaction and inclusion, there is plenty of research showing the instrumental value of engagement. In fact, it is established through several studies that work engagement and employee satisfaction are important factors for the overall performance of organizations. Bakker, Demerouti, and Verbeke (2004), Schaufeli, Taris, and Bakker (2006), Salanova, Agut, and Peiró (2005) analyze work engagement in different sectors of the service industries and support the link between employee engagement and performance. They all point out that engaged employees perform better and are willing to go the extra mile, from which we can assume that work engagement influences customer satisfaction and, eventually, financial results (Bakker et al., 2008, p. 194). Also, Gruman and Saks (2011) suggest that when addressing performance management, a bigger focus should be placed on employee engagement.

The same can be observed in the context of health care organizations, where clinical engagement seems to be correlated to different performance measures, as patient mortality, quality and safety of care (Spurgeon et al., 2011, p. 115).
A particularly interesting observation is the instrumental value of clinical engagement for quality and safety improvement (Gosfield & Reinertsen, 2008). To achieve results in the implementation of programs for the improvement of safety and quality in fact, a significant factor is the organization’s ability to expand the focus of the policy from the patient-clinician interface, to the underlying issues affecting employee behavior that are embedded in the organizational culture (Parand et al., 2010).

By addressing the issue of clinical engagement, the management is able to target and include a range of healthcare professionals, from doctors to nurses and allied personnel, in the improvement of caregiving. Enhancing a culture of participative and multidisciplinary collaboration, clinical engagement strengthen the actual possibilities of speaking out in front of negative behaviors and negligence, diminishing the risk for selective moral disengagement characteristic of cultures of silence (Nembhard & Edmondson, 2006, p. 945; Pope & Burns, 2013). Moreover, the introduction of patient pathways from the top of the organization has given many the impression that caregiving is increasingly a standardized and result-oriented process (Flynn, 2002, p. 168): thus, a front-line leadership approach that increases employee engagement by inclusiveness and ownership may play an essential role in policy implementation and compliance.

Clinical engagement suggests a framework that focuses on the role of the single employee in decision-making and the shared responsibility for the achievement of organizational goals. For this reason, it fits particularly well in the process of finding new ways to enhancing employeship:

"Transforming health care organizations to improve performance requires effective strategies for engaging doctors and developing medical leadership. Most efforts in the US and in the UK to develop medical leadership have focused on structural changes that integrate doctors into administrative structures, but these have limited impact. Recognizing the distributed and collective nature of effective leadership, some health care organizations are attempting to create greater alignment between clinical and managerial goals, focusing on improving quality of care” (Baker & Denis, 2011, p. 335)
3.3.3 Clinical engagement: operationalization

The measurement of medical and clinical engagement done through the MES and HES surveys relies on the premise that employee engagement is the product of an interaction between the individual motivation to participate and the cultural context of the organization that enables and facilitates this commitment (Spurgeon et al., 2011, p. 115).

The multidimensionality characteristic of engagement is the key premise for the development of a psychometric tool to measure the phenomenon: like motivation, engagement is an invisible hypothetical construct, an assumed physical process that is unobservable directly. Thus, a definition of engagement needs to acknowledge a set of energetic forces, a multiplicity of needs, drives and external factors affecting the human behavior, without necessarily considering one single source as primarily important (Pinder, 2008, pp. 11-13).

This multidimensionality and plurality of factors is expressed in the MES index by the definition of three component meta-scales that cover the main factors of “giving” (commitment), “receiving” (satisfaction) and “reciprocating” (collaboration), each including two subscales that address organizational and individual traits (Spurgeon et al., 2011, p. 115).

The literature stresses the fact that engagement is not a one-way road, a state of mind and willingness intrinsic to the health personnel. On the contrary, engagement is a synergy brought about by the combination of the active contribution of the clinical personnel at the individual level, and the cultural and environmental context of the organization, which should support and encourage high quality of care (Gruman & Saks, 2011, p. 127). In this regard, the role of leadership is...
central: particularly, transformational leadership is advocated as a good managerial approach as it increases employee’s perception of social support and provides the employees with the necessary resources (Gruman & Saks, 2011, p. 131).

The Healthcare Engagement Scale is a younger survey tool, developed more recently to investigate the levels of clinical engagement among other professional groups. The index is built on a structure of three process-scales and three outcomes-scales, representing three engagement processes and three engagement outcomes. Each of the nine cells in the intersection between process and outcome constitutes a component of engagement (Applied Research Ltd., 2016):

<table>
<thead>
<tr>
<th>Process-Scale 1) KNOWLEDGE TRANSFER</th>
<th>Outcome Scale a (OSa) PRODUCTIVE COLLABORATION</th>
<th>Outcome Scale b (OSb) PERSONAL COMMITMENT</th>
<th>Outcome Scale c (OSc) JOB SATISFACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a) Exchanging Facts and Explanations (INFORMATION)</td>
<td>1b) Applying Experience or Skills (EXPERTISE)</td>
<td>1c) Receiving Informative Feedback (DIRECTION)</td>
<td></td>
</tr>
<tr>
<td>‘Discussing data, evidence, and explanations about performance’</td>
<td>‘Using relevant knowledge to improve own or others’ performance’</td>
<td>‘Listening to constructive criticism about the way you work’</td>
<td></td>
</tr>
<tr>
<td>Process-Scale 2) EMOTIONAL CONNECTION</td>
<td>2a) Relating Authentically with Others (RAPPORT)</td>
<td>2b) Giving Enthusiastic Support (ALLEGIANCE)</td>
<td>2c) Feeling Appreciated or Valued (RECOGNITION)</td>
</tr>
<tr>
<td>2a) Relating Authentically with Others (RAPPORT)</td>
<td>2b) Giving Enthusiastic Support (ALLEGIANCE)</td>
<td>2c) Feeling Appreciated or Valued (RECOGNITION)</td>
<td></td>
</tr>
<tr>
<td>‘Relating in an open and genuine manner with colleagues or co-workers’</td>
<td>‘Being enthusiastically committed to or supportive of a new initiative’</td>
<td>‘Experiencing a sense of recognition as a valued member of the organisation’</td>
<td></td>
</tr>
<tr>
<td>Process-Scale 3) ACTIVITY FOCUS</td>
<td>3a) Working in Cooperation (RECIPROCATION)</td>
<td>3b) Undertaking Discretionary Activity (EFFORT)</td>
<td>3c) Obtaining Practical Help (ASSISTANCE)</td>
</tr>
<tr>
<td>3a) Working in Cooperation (RECIPROCATION)</td>
<td>3b) Undertaking Discretionary Activity (EFFORT)</td>
<td>3c) Obtaining Practical Help (ASSISTANCE)</td>
<td></td>
</tr>
<tr>
<td>‘Working co-operatively to tackle shared tasks or meet a joint objective’</td>
<td>‘Giving extra time or effort to facilitate own or others’ progress’</td>
<td>‘Being practically helped in meeting ongoing work demands and goals’</td>
<td></td>
</tr>
</tbody>
</table>

Figure 6: The structure of the Healthcare Engagement Scale (Applied Research Ltd., 2016)

An interesting observation regarding these two indexes is that, when comparing the Healthcare Engagement Scale to the Medical Engagement Scale, the components of “participation in decision-making and change” and of “development orientation” are missing. The first component can be interpreted as the inclusion of the employee in setting the route of the organization, while the latter can be seeing as the possibilities for professional development and for career progression in the organization. Why are these elements missing from the Healthcare Engagement Scale while they stand out as key factors for the Medical
Engagement Scale? Does this illustrate an assumption that doctors are better fit to make strategic decisions and climb up the ladder to leading positions?

Being developed specifically for the measurement of engagement in England, these instruments may reflect a different understanding of the division of roles and responsibilities between the medical profession and other clinical staff groups.

The rationale for focusing on medical engagement in the UK may stem from the fact that doctors have been engaged in the management of the hospitals at different extents in the history of the NHS. Initially in the role of medical superintendents, then substituted in the 1950s by professional administrators, it was just after the 80’s and the Griffiths Report that general management posts at district and unit levels were introduced and held by doctors (Buchanan, Addicott, Fitzgerald, Ferlie, & Baeza, 2007, p. 132). And even then, commentators argue that managerial positions were assumed out of defensiveness and fear for being subjected to professional managers, rather than out of an understanding of the role of good leadership in complex organizations (Bohmer, 2012; Buchanan et al., 2007; Kirkpatrick et al., 2009; Martin et al., 2015). Currently, many health trusts are run on a model called clinical directorate, which, differently from the Norwegian unitary management model, divides power in a triumvirate structure consisting of a clinical director (doctor or consultant), a senior nurse manager and a business manager (Clark, 2012, p. 439).

Thus, we already see that the background for the creation of these instruments may differ from the contextual situation they are implemented in. These elements will be taken into consideration later in the study, with a discussion of the relevance of the MES and HES scale in a Norwegian leadership structure. However, it is important to notice that a different contextual background creates the premises for the understanding of clinical engagement at Oslo University Hospital: not casually, the Norwegian pilot-project was called “Strengthen Employeeship” and not “Medical Leadership”. This indicates that, in the strategical process of developing the organization to achieve common goals, the Norwegian context expressed the intention of including all clinical professions, emphasizing the component of employeeship, rather than the one of leadership.
This brings us to the next assumption on the relevance of the clinical engagement approach for Oslo University Hospital:

**2nd assumption:** Given the different contextual backgrounds, the operationalization and the improvement of clinical engagement through the MES and HES surveys may meet challenges concerning the different leadership structures and the division of roles among the clinical staff in Norway and in the UK.

This chapter has presented two main concepts: the one of employeeship and the one of engagement in the healthcare sector. These theoretical frameworks share common grounds, in the sense that both are interested in understanding the factors affecting employees’ participation, commitment and wellbeing, which in turn bring about positive organizational outcomes.

In the next chapter, I will present the case, i.e. the pilot-project “Strengthen Employeeship”. The analysis of the case study will move from the theoretical level to the empirical one, thus considering the practical implementation of the framework of clinical engagement in a Norwegian context. To illustrate the experiences of the managers and the dynamics of the group, I used both memos from my field notes and data gathered through the interviews and other numerous informal conversations. The main question that will be answered is: what were the strengths and weaknesses of the MES and HES surveys in the initiation of the improvement work at Oslo University Hospital? This question, together with the previous overview of the relevant literature, will be discussed and systematized in chapter 5, where the overall relevance of the clinical engagement approach is evaluated.
4 Practice

4.1 Measurement Phase

4.1.1 Introducing the engagement approach

Motivations to participate

On September 1st 2015 the project group of “Strengthen Employeeship” met for the first time. This group consisted of a combination of division and unit managers, HR managers and employee representatives from the two clinics. Moreover, the project consisted also of a work group, which included a selection of employees (some nurses, surgeons, psychologists and therapists) and other representatives of different committees at Oslo University Hospital. It was visible already from the first meetings that the groups were heterogeneous in regard to their a priori knowledge on the subject of engagement, motivation and organizational development. Some of the participants had clear expectations from the project and had given thought to the value of employee surveys for the exercise of their role as leaders; some understood that this had something to do with the world of HR but awaited more information; some others had no clue of what the project was about – “I was just sent here by my boss to represent my unit, actually” (nurse, work group meeting).

The first discussions in the project group regarded two main subjects. On the one hand considerations regarding the culture of the organization, the challenges in engaging employees towards participation and collaboration and a willingness to enhancing commitment to the organization. On the other hand, the use of employee surveys as tools for the managers was debated. Particularly, some managers pointed out that mapping employee attitudes and perceptions had value only if it was followed by the actual possibility for improving the environment:

“We answer the employee survey, we communicate the results and then most of the times it goes directly in the drawer. Some of the things are easy to fix, but others are just out of our control” (unit manager).
As seen earlier, the complexity in decision-making and influence possibility at Oslo University Hospital can fairly be explained by looking at the five-level hierarchical structure of the organization that makes bottom-up influence rather limited and top-down policy-implementation diffused.

An important momentum for the initiation of this project, in fact, was the call for challenging the established structures of improvement, developing a comprehensive multi-level approach to strategy-development from the ward to the board.

Moreover, managers expressed a strong desire for finding new efficient ways of motivating their employees in being participative and committed to the organization and its goals. Also, they pointed out the fact that in the recruitment process of leaders a much higher focus should be placed on the managerial capacities of bringing the team together, rather than appointing managers out of their clinical achievements or seniority.

**Understanding the concept**

By being an observer at the meetings that took place throughout the autumn of 2015 and the spring of 2016, I had the chance to understand more about the dynamics connecting employees, managers and the organization. One of the first barriers to the commitment of managers to the project was the ambiguity of the English word “clinical engagement” and the apparent lack of a valid Norwegian translation of the term that could carry the meanings of commitment, motivation and inclusion characteristic of engagement. Moreover, the extent to which managers understood what the surveys were about and how they could be used to bring about results in the clinics seemed to variate in relation to professional backgrounds. Psychologists, HR managers and therapists were mostly comfortable with the topic; however, other participants with a medical background struggled with grasping the core of the issue of clinical engagement (and clinical leadership). This challenge was fueled by a general skepticism towards “yet another project”, as the evidence of efficacy of the clinical engagement approach (and generally of the surveys) was questioned, thus putting constraints to the willingness of the managers to allocate time-resources to the project.

Managers also expressed difficulties in communicating the substance of the project to their employees. To serve this purpose an adviser from the communication department was included to the project group as a counselling member. In this regard, the creation of an ad hoc communication plan, containing measures to make the project’s means and purposes
visible and to involve the employees through social media, was an efficient way of helping the managers in spreading important information and raise awareness on the issue of employeeship.

The conceptualizations of the MES and HES scales

One of the main issues in the introduction to the clinical engagement approach, however, was the division of a medical and a healthcare engagement scale. The steering and project group in fact, could not understand the peculiarity of dividing medical engagement from clinical engagement. Their understanding was that doctors, nurses, psychologists, therapists, and other specialized clinicians had equal premises for engagement, and that a conceptual division between two sets of employees – physicians and allied personnel – was in principle against the aim of the project: enhancing employeeship. This was a particularly difficult issue for one of the clinics, which specialized in multidisciplinary treatment that consisted in teamwork and cross-professional collaboration.

4.1.2 The MES and HES surveys

The questionnaires

After a long time of preparation and anticipation, in November 2015, the MES and HES questionnaires were available online, and the medical and clinical staff of the two clinics were invited to submit their answers within a period of four weeks. At the end of this period, 81 respondents out of 131 had completed the survey, giving a turnout of approximately 62%.

As this number was lower than expected, some of the managers involved expressed their concerns about the challenge of involving employees in yet another survey:

“Honestly, I find this difficult. I don’t know how to motivate them, because I don’t know what’s in it for them…and they have just answered the (MU) employee survey, and don’t quite understand the difference, what is what?! ” (Division manager)

Moreover, another issue was a concern regarding the validity of the questionnaires, as many employees had pointed out that some of the questions in the survey were difficult to understand. This can point to a practical challenge in translating a questionnaire from its original language and making it comprehensible for another audience, while keeping intact the meanings and the connotations embedded in the original language.
Apparently, one of the strengths of the MES and HES surveys was the fact that the questionnaires are meant to investigate issues regarding the whole organization, and not just the single unit. Some of the managers of the group meant that this was a positive aspect, as it symbolized the fact that the whole organization has a joint responsibility for engaging clinicians, and that the factors affecting the individual in her working situation can have roots outside the borders of each organizational units, and thus must be addressed with overreaching strategies.

The survey results

A total of 26 doctors and 55 clinicians scored respectively the MES and HES survey. The engagement report was received with much enthusiasm at the beginning of January 2016.

The results of the scores on the engagement index were reported both in numerical form and in a pedagogic-colored-version (given below) for each meta and subscale. Results above 57.5 were colored green and stood for “monitor and maintain effectiveness”; results between 47.5 and 57.5 were colored yellow and illustrated a “scope for improvement”; results under 47.5 were colored red and reflected a “priority for development”.

Moreover, the survey results for the Healthcare Engagement Scale were divided into professional groups, and reflected the structure of the HES scale, consisting of three outcomes scales (OS) and three process scales (PS):
As illustrated in figure 8, different staff groups experience different challenges. A recurrent barrier for engagement for most groups was connected to the components of “knowledge transfer” and “productive collaboration”. This underlines the importance of establishing patterns of interdisciplinary collaboration and communication that facilitates and ensures the exchange of information.

The main trends in the findings presented in the report were the following:

a) the relative level of medical and clinical engagement at Oslo University Hospital were significantly higher than the previous assessments done in the NHS;

b) the relative level of medical engagement was somewhat higher than the level of clinical engagement scored on the sample of mixed professions;

c) even though both clinics achieved engagement results above the average, the clinic with the larger plurality of professional groups scored slightly lower than the other clinic, characterized by homogeneity in professional backgrounds.

In the next section I will shortly present these results and elaborate on them in light of the contextual challenges of Oslo University Hospital.
4.1.3 Explaining the results

High levels of medical engagement

The medical engagement report shows that the clinics involved where characterized by highly engaged doctors in most matters. As shown in the figure, one of the clinics achieved relatively low results in the subscale 5 – development orientation. This subscale represents the organizational dimension of the meta-scale “being valued and empowered”. In the medical engagement perspective, the organization plays a central role in fostering engaged employees, by ensuring them the possibility for professional growth and continuous skill development. This aspect of medical engagement, when neglected, can have serious consequences, in primis, on the quality of patient care, but also on the level of employee commitment to the organization, on absenteeism and retention.

In the theoretical conceptualization of medical engagement, we saw how the interaction of organizational possibilities and individual capacities is essential in fostering engaged employees. In the case of metascale 3 “being valued and empowered”, a low score on development orientation means limited organizational possibilities for the medical staff to update and keep abreast of professional developments, resulting in a situation where the individual is not given the necessary instruments to progress and feel confident with her skills. In other words, the individual is not empowered - given the power of expertise and competences that brings about commitment and satisfaction with the job.

An interesting observation is the fact that the audience of managers and employee representatives did not perceive this result as very controversial, on the contrary, some quite agreed on the fact that there was a lack of an overall focus on development orientation:

“[…] in the MU survey, employees are asked whether they are ENCOURAGED toward professional development. Well, it’ not enough to be encouraged! They need to be GIVEN the
concrete possibility to develop their skills - and the organization lacks proper structures to this purpose” (Employee representative in one clinic)

However, an interesting finding is that when asked about the development possibilities for the employees in their own unit, most of the managers expressed moderate to full satisfaction with the offer they gave their staffs in terms of courses and day seminars. Many pointed out that they would use every penny of the budget allocated to professional development to satisfy the requests of the workers, and that one would rarely be denied seminars or courses.

Is there a discrepancy in the perception of the managers and the one of the employees in regard to the optimality of the learning offer? It might be the case. However, an alternative explanation could be that the MES survey was answered on the organizational level, not at the unit level. In fact, the medical personnel were asked about the role of the organization in suppling development possibilities. In this sense, the fact that the single units plan courses and seminars, does not imply the existence of an overall cross-level strategy for employees development in the whole clinic. What is the responsibility of the unit manager, of the division manager, of the department manager and of the HR manager in the provision of opportunities for employee development? How can the whole organization assure that its employees advance in their professional growth, when it lacks a consistent strategy that involves all organizational levels? This is a controversial topic, as it requires a critical evaluation of the current delegation of financial, clinical and staff responsibilities across the organization, touching sensitive issues of financial priorities and resources constraints. In addition, another factor causing the lack of this kind of institutionalized channels of development might be the variation of different professions and disciplines across the clinics. This variation makes the identification and the mapping of knowledge gaps and competency needs difficult from level three. A solution then, has been the creation of local solutions and practices, which however, variates largely across the organization.

Beside from development orientation, however, the results on the scoring of medical engagement were quite positive. Are doctors at Oslo University Hospital mostly engaged?

An important remark in this regard is the fact that the results are relative to the normative database that they are compared to. This means that, if the reality of medical engagement in England was consistently lower than the situation in the Norwegian context, then the results of an assessment of the Norwegian level of medical engagement relative to the English database would appear to be disproportionally high. To check the assumption of an inflation
of the scores caused by the normative database, I suggest a quick comparison of the medical engagement scores with the results of the MU survey on the common topics of collaboration, participation and satisfaction. The conclusion suggests that the MU survey seems to draw a different picture of the situation in the two clinics, with scores that, although mostly positive, identify some potential for local improvement in the sensitive areas of participation, interpersonal relationships and alignment with organizational goals. A more thorough evaluation of the MES survey vis-a-vis the MU-survey is required to arrive at any definitive conclusions on the validity of this tool for a Norwegian target group. However, the consistency of “green areas” in the scores of medical engagement raises some reservations.

As introduced earlier in this thesis, there is a substantial difference between Norway and the UK in the extent to which doctors have been engaged in the management of the healthcare sector. In Norway in fact, doctors have played a central role in the management of the hospitals from the 30s to the 70s, most notably under the Medical General Manager Karl Evang, who influenced significantly the development of the national healthcare system and of the Norwegian health policy of the twentieth century. Successively, the system underwent a series of reforms that challenged this central position in the 80s and in the 90s (Erichsen, 1995) and most recently with the introduction of the profession-neutral management in 2001. However, Spehar and Kjekshus (2012) have recently concluded that in the present situation doctors hold fewer leadership positions, but the ones that count the most (see table 2 in chapter 1.2.3). It is not to hide, however, that there has been criticism and opposition to the five-level leadership structure of the hospital, which is said to reduce professional autonomy and create a gap between the operative core at the bottom and the strategic apex at the top. This distance and complexity might have fueled narratives of contraposition between managers and professionals (in Norwegian, “ledelse” vs. “fagfolk”) and created a discontent towards the slowness and intricacy of bottom-up interaction processes from the ward to the board.

Thus, a plausible explanation for the consistency of top scores in the results might be the inappropriateness of comparing the Norwegian results to the English average. The medical engagement scale, basing the index on a normative database constituted by the previous results in the UK, might have inflated the results of the meta- and sub-scales.
Medical engagement vs. clinical engagement

Earlier in this thesis, I pointed out how the division between a Medical Engagement Scale and a Healthcare Engagement Scale received criticism in the Norwegian project-group, as it expressed the preconception that doctors are better equipped to engage in the hospital management than their clinical colleagues. In fact, the components of “participation in decision-making and change” – subscale 4 - and of “development orientation” – subscale 5 - are missing from the original version of the Healthcare Engagement Scale.

Even though the MES and HES indexes were built on different premises and thus measure engagement through different psychometric tools, the developers have added 16 items called “common marker items” to the HES survey, to allow the comparison of the medical and the clinical group.

By comparing these 16 items across the two surveys, the report points out some interesting facts about the differences in the level of medical and clinical engagement. The clinical staff were not as engaged as the medical staff, particularly for the engagement levels in regards to two elements: a) having purpose and direction (constituted by “appraisal and rewards effectively aligned” and “participation in decision-making and change”); b) work satisfaction.

These findings suggest that the doctors in the clinics involved still hold a front position in strategic decision-making and in perceiving that their goals and values are aligned to the ones of the organization. These elements are entangled, in the sense that being included in strategy development also means having a better chance at comprehending organizational goals and expressing individual values.

On the second point, work satisfaction, the definition of this phenomenon has been extensively discussed in the literature on work behavior in organizations. A useful understanding of this term is Locke’s conception of job satisfaction as an emotional reaction (rather than an attitude) that “results from the perception that one’s job fulfills or allows for the fulfillment of one’s important job values, providing and to the degree that those values are congruent with one’s needs” (Pinder, 2008, p. 271).
Why would doctors be more satisfied with their jobs than the group of nurses, psychologists, therapists and educators they share the workplace with? The nature and the factors of job satisfaction have been the subject of a long theoretical and empirical dispute, and a review of these standpoints is outside the purposes of this paper. However, the complex relationship between needs and values that defines satisfaction can fairly be related to the feeling of pride in one’s profession or position in the organization, and to the degree individual needs are met by the organization. A practical observation of the difference in job satisfaction between the two clinics, where one has a higher concentration of physicians and the other is populated by a multiplicity of different clinical professions, is seen in the way two division managers presented their workplace:

DM\(^1\): “This is our division xxxx... here we save lives, daily. We are not many here, but I had to learn how to lead Prima Donnas (laughing)...the sick leave is low, fortunately ... well, I guess the people working here know that they are irreplaceable, if they stayed home we would not have anyone able to take their place”.

DM\(^2\): “In our division I have, I don’t know, maybe one hundred employees, counting the substitutions, part-time and full-time workers; we have quite high absenteeism, unfortunately (...). This is where we work (showing a picture of a building under construction), it is a temporary solution, we hope the renovations will be done soon. It is peculiar to work in a construction site though, you know....”

These observations illustrate two important points: first, that differences in professional status may play a bigger role in clinical engagement than we expect; secondly, that the organizational failure in meeting one of the employees’ basic needs, as working in a proper infrastructure, can affect the overall performance and commitment to the organization.

The comparison of the Medical Engagement Survey and of the Healthcare Engagement Survey identifies thus a relatively small, but significant, difference in the levels of engagement between the group of 26 physicians and the group of 55 respondents working as clinical staff. Given the small size of the sample, and the questioned validity of the measurement, these results are hardly generalizable to the whole population of medical and clinical staff at Oslo University Hospital. Still, similar trends have been registered also by the MU survey of the same year, where doctors had higher scores for the categories of
“motivation” and “involvement”. However, this survey did not find any significant variation in the overall levels of “work satisfaction” between the two groups.

Comparing professional groups may appear as an unethical procedure, or at least controversial for the Norwegian context, as one runs the risk of stigmatizing staff groups that are not performing as well as their colleagues. This is an important ethical consideration to be discussed. However, if the purpose of the investigation is understanding the underlying negative patterns that affect employee satisfaction and allows the implementation of ad hoc policies to improve these areas, then the end may justify the means.

The comparison of the results across staff groups, like in the case of the MES an HES surveys, allows the identification of areas of improvement that the leadership can target in order to increase satisfaction and goals alignment.

**Professionalism and engagement**

In addition to comparing doctors to the clinical staff, also the comparison of clinical engagement levels within different clinical professions gave some interesting insights in workplace dynamics. The engagement report for the HES survey was presented with results divided in professional clusters (not by clinic or division), thus giving us the opportunity to make some interesting observations regarding the role of multiple professional backgrounds in engaging the clinical staff. A rationale for this comparison is that, in a working environment characterized by increasing job complexity and task specialization, optimal collaboration is enabled only if all clinical professions are included at the same extent. In particular, one of the clinics was characterized by a higher variety of different professional backgrounds working together, making the issue of good collaboration and teamwork even more essential and, at the same time, more complicated. The HES survey gave a useful overview of the key aspects that are affecting clinical engagement for each staff group. As expected, productive collaboration and knowledge transfer were the first sources of disengagement for most groups, with emotional connection and personal commitment being an issue for the group of social workers and social educators, who also reported a work environment lacking appreciation and feedback loops.
The issue of professional status and professional pride came up as a theme in the interviews, where the majority of the managers agreed on the fact that status differences were a present element in the hospital culture.

However, this issue was described from a plurality of perspectives by the managers, who gave different illustrations of how status was embedded in the hospital culture. Some stressed the fact that status differences were visible in regard to the allocation of resources, e.g. across medical disciplines (between mental health and somatic medicine for example). Some pointed out the evident differences in regard to employee retribution, e.g. between physicians and allied personnel. Two others explained that status differences where visible also within the same field, for instance within mental health, where significant differences in power and legitimacy existed between the world of psychiatrists, therapists and social workers. Moreover, status differences regarding prestige and esteem where perceived within the same profession, for example in the poor availability of doctors to recruit to new positions within psychiatry, compared to other medical fields – “[…]psychiatry has had bigger recruitment challenges (…) I mean, people would stand the line to get a surgeon position!” (Senior consultant).

Thus, status differences are defined and explained from different perspectives and it is outside the purpose of this master’s thesis to give a normative judgment on how things should be, on whether we should accept status differences or actively work to reduce them. Nevertheless, they are a present element of the culture of the hospital, and consequently influence the work environment, the practice of leadership, and the willingness to cooperate in teams. An important element is acknowledging that each profession is a necessary piece in the puzzle of caregiving:

“I mean, inter-disciplinarily working is something more than multi-disciplinarily working, right? [in the sense that] professions work BESIDE each other in multi-disciplinarity, while in inter-disciplinarity one SEEKS each other’s competencies to achieve the common good” (division manager).

Thus, the fact that the Healthcare Engagement Scale presented the survey results divided by profession, allowed for discussions on the different challenges that different staff groups meet in their everyday life.
4.2 Improvement Phase

After the presentation of the survey results, the project group initiated a discussion on how these results and the theoretical framework could be used in getting a better understanding of the factors affecting employeeship. A major downturn for the group was the fact that, in addition to receiving the survey results, there was an expectation of receiving concrete suggestions on how to improve the engagement levels. These suggestions, which at first did not come, were later supplied upon request of the head of the project. They contained a series of elements that could be taken into consideration when improving and monitoring engagement in the organization. In this section, I will shortly present the suggested measures and the way the project group proceeded in the delineation of a plan for improving employeeship. However, the case study followed the experiences of the pilot-project until April 2016, time at which the improvement phase had just begun. This implies that the assessment of the relevance of the clinical engagement approach is not based on the practical implementation of the measures and on their effects in the clinics, as this process will be continuing throughout the summer and autumn of 2016. However, I describe how the clinics have decided to proceed and to use these results, which helps assessing the utility of the measurement of clinical engagement through the MES and HES surveys for the work on improving employeeship.

4.2.1 Suggested measures

The survey results were accompanied by some guidelines that pointed out the managerial activities that could be the focus of the improvement work. These suggestions were divided accordingly to the six sub-scales reflecting the Medical Engagement Scale, i.e.: a) climate for positive learning; b) good interpersonal relationships; c) appraisal and rewards effectively aligned; d) participation in decision-making and change; e) development orientation; f) work satisfaction.

The guidelines offered a conceptual framework, rather than a concrete plan for improvement, something that created some discontent among the managers in the project, who expected a much more concrete approach to the improvement work.
These guidelines can be grouped in regards to the three main challenges that affect engagement: cooperation and openness, participation, development orientation and satisfaction.

In regard to cooperation and openness, Applied Research Ltd. suggested that management should focus on supporting multidisciplinary working and learning in teams, publicize positive results of successful collaboration, establish safe channels of communication and create an environment of trust characterized by coherent and consistent action.

For the issue of participation, the guidelines suggested an increased assessment of individual performance and commitment to organizational goals, particularly in pursuing change, through established systems of feedback, the enhancement of joint responsibility and commitment to organizational decisions, the development of structures and processes that facilitate participation and inclusion in decision-making.

Finally, for the last category, development and satisfaction, Applied Research Ltd. suggested focusing on the establishment of opportunities for professional development and individual progression, the promotion of a culture that values and supports the employees and the inclusion of the workers in setting the future direction of the organization.

The fact that the clinical engagement approach offered a clear conceptual framework for understanding the phenomenon of engagement, and that the improvement guidelines reflected the categories of the meta-scales, i.e. the elements of collaboration, commitment and satisfaction, gave the possibility to address these challenges in a more systematic way. So, notwithstanding the general disappointment for the lack of concreteness of the measures, these guidelines where used by the project-group to identify the focus areas to work on throughout the summer of 2016.
4.2.2 Strategy creation in the clinics

In a joint meeting at the end of February 2016, the project group discussed these guidelines and identified the elements that they considered useful for the improvement work in their clinics.

The group decided to split into focus groups, with the aim of addressing specific issues that the managers regarded as significant for enhancing employeeship and improving the work environment. They identified four main areas of improvement:

1. The practice of line management, multidisciplinary collaboration and the roles of the organization;
2. Learning and implementation structures, difference between capability and willingness to change;
3. Work environment factors, job satisfaction and the MU survey (purpose and function);
4. Communication

These categories incorporate and supplement the guidelines proposed by the clinical engagement approach, thus creating a framework for improvement that takes into consideration the issues that the managers of the clinics regarded as important for their improvement work. In this sense, the solution that the project group agreed to in order to set the route for the improvement phase is a costumed approach to engagement and employeeship that reflects local challenges as well as organizational.

In the next chapter, I will discuss the experiences of the project-group with the clinical engagement approach. This discussion will highlight the positive and negative aspects of the use of the Medical Engagement Survey and of the Healthcare Engagement Survey in the different phases of the project. By systematizing the information collected through the case study, this master’s thesis will finally give a total evaluation of this process and assess the relevance of these tools for the improvement of the workplace at Oslo University Hospital.
5 Discussion

5.1 Strengths and weaknesses of the clinical engagement approach

The concept of clinical engagement

Theoretically, the concept of clinical engagement offers a systematic approach to the specific issue of employeeship in the hospital context, as it considers the themes of “collaboration” “commitment” and “satisfaction”. In addition to suggesting a conceptual framework that helps managers understand how employees are affected by different factors, this framework also establishes a clear distinction between the organizational and the individual dimension, thus facilitating the identification of interventions at the organizational level that have potential for effect.

Still, the conceptualization is useful just if managers have the capability and the willingness to understand the topic of clinical engagement. In fact, when the issue was first introduced to the project group, some managers had difficulties in understanding the concept. This was connected to two main challenges: a) the apparent lack of a Norwegian translation for the word “engagement” that carries the same connotation as the English term; b) the different professional backgrounds of the managers that defined their perception of the value of the concept. Some for example, coming from more pragmatic and practice-oriented professions, were skeptical towards spending time and resources on such abstract issues as employeeship and engagement. When managers were familiar with the language and the tools of psychology and organizational development, on the other hand, the understanding of the thematic of engagement became less controversial and time demanding.

Nevertheless, the focus on clinical engagement shows to be relevant for addressing a variety of issues: a) safeguarding the psychological wellbeing of the employees; b) supporting the commitment to patient safety and service quality through the enhancement of a culture of openness and responsibilization; c) facilitating interdisciplinary teamwork and collaboration by highlighting the importance of inclusiveness and participation. Thus, the instrumental
value of clinical engagement in addressing these concrete challenges within the hospital helped in raising managers’ interest towards the subject.

The MES and HES surveys

Some aspects of the conceptualization of clinical engagement, however, do not fit in a Norwegian context. Firstly, the distinction between medical and clinical engagement turned out to be problematic, since managers are not necessarily physicians, and physicians are not necessarily managers. As pointed out in chapter 3.2.3, especially the absence of the meta-scales “development orientation” and “participation in decision-making” from the Healthcare Engagement Scale questioned whether these measurement instruments are pertinent to the division of roles and responsibilities at Oslo University Hospital. The project “Strengthen Employeeship” in fact, aimed at addressing the issue of engaging employees, coming from all clinical professions, in the commitment and achievement of organizational goals. The division between the medical profession and the allied personnel in a question of employeeship (understood as commitment, satisfaction and collaboration) appears as controversial and problematic in a country rooted in egalitarianism. In the English context, this may be appropriate, as doctors have been reluctant to participate in decision-making processes and organizational development, and thus, they are the prioritized target group for engagement. In Norway however, as the MU and MES survey results show, physicians are mostly engaged, included and well represented in the decision-making fora and in managerial processes.

One of the strengths of the Medical Engagement Scale and the Healthcare Engagement Scale, was that they aimed at addressing organizational issues: in fact, the employees were asked to answer on matters that regard the whole organization, not the specific unit they belong to. This aspect constitutes a significant difference between the MES and HES surveys and the MU survey, which is designed for initiating local improvement.

Managers mostly agreed on the fact that, in principle, it would be desirable to have coordinated and interconnected action plans and strategies that take into consideration all organizational levels. However, in practice, this is difficult to achieve for an organization of the dimensions of Oslo University Hospital. As a result, the action plans that regard work environment improvement are often limited to address the unit and the division level.
The survey report

One of the first issues raised after receiving the survey report was the validity of the results. In fact, the consistency of green results, with nearly top-scores for medical engagement, is most likely due to the fact that the normative database used to generate the results consisted of levels of clinical engagement generally lower than the Norwegian average.

Nevertheless, the report of results, divided by staff groups, enabled the identification of interesting trends. One of the strengths here was the fact that it initiated a discussion on how the management could use this type of information to better understand the factors affecting each profession in the workplace. This was especially useful to address the issues of collaboration and multidisciplinary work.

Moreover, another strength of the MES and HES surveys was the fact that the managers had to relate to a limited number of factors affecting the engagement levels. The scores in fact, were presented for each meta and sub scale (see chapter 4.1.2), thus allowing the identification of factors that were connected to the organizational possibilities, and elements that regarded the individual dimension. For instance, the low score on the sub-scale 5 “development orientation” pointed to a lack of institutionalized patterns for continuous learning and professional development at the organizational level.

These aspects of the MES and HES surveys differentiates them from the MU survey, where the results are presented for each organizational level and managers tend to not investigate whether the results variate in regard to professional groups. Moreover, the MU report follows a different model for the presentation of the results. There, the list of scores is presented for each of the 23 themes and indicate also: 1) the number of respondents; 2) the score for the previous year; 3) the positive or negative difference from the last year score; 4) the OUS average; 5) the reference score. In addition, the report shows the score for each of the 66 questions, allowing managers to investigate and identify, which specific questions received low or high scores.

In this sense, there is a substantial difference between the survey reports in the clinical engagement approach and in the MU survey. The MU survey is more thorough in presenting the scores in a way that reflects the questionnaires, while the MES and HES reports present the scores in a way that reflects the organizational and individual factors affecting the
phenomenon of clinical engagement. Some managers have pointed out that a more in-depth presentation of the results, like in the MU survey, is preferable, as it allows managers to trace the results back to the related question in the survey. On the other hand, however, the presentation of the MES and HES surveys is much more easy-to-grasp, as it covers a limited number of interconnected factors. Moreover, these factors are particularly relevant for understanding the issue of employeeship as they allowed the project group to get a better understanding of the specific phenomenon of engagement.

The improvement framework

This case study has followed the experiences of the project “Strengthen Employeeship” up to the spring of 2016, when the improvement work entered its initiation phase. For this reason, the master’s thesis cannot give an in-depth description of the operationalization of the interventions, as these will take place in the clinics throughout the summer of 2016.

However, the guidelines for improvement delivered by Applied Research Ltd. were used to identify the core elements that could affect participation, commitment and satisfaction - the meta scales constituting clinical engagement. Thus, they were the starting point for the project group in the identification of areas of interest for further development.

The improvement framework listed a number of relevant aspects, but at the same time, it left enough flexibility to adapt the issues to the context of Oslo University Hospital. This work method is different from the MU improvement framework, where the units are specifically asked to identify two improvements and one maintenance area and send in action plans. The work with the MES and HES surveys has focused on understanding the phenomenon of engagement and on the suggestion of activities that the leadership could implement in order to enhance employeeship. These suggestions regarded the culture of the organization, which should aim at openness, participation and a greater focus on the individual development. In this sense, one may point out that the MES and HES framework give more autonomy to the groups in understanding the source of the challenge and creating overall strategies to address them.

Still, it is difficult to give a definitive assessment of the frameworks for improvement of the clinical engagement surveys vis-à-vis the MU survey. Through the interviews with the managers in fact, I understood that there are diverging opinions concerning the usefulness of
the framework prescribed by the MU. Some for example, meant that the improvement framework itself was not the issue, but that the follow-up and the evaluation of the interventions lacked structure and commitment:

“what is good with the MU is that it makes both the managers and the employees responsible for identifying the challenges we have in our unit, and how we want to work with that to change in those areas - straightforward improvement – (...) the challenge is that we haven’t committed ourselves enough to work with those interventions that we agreed upon, we are not good enough at following up” (HR Manager)

A general lack of focus on development strategies was identified both in the top leadership and among employees. Paradoxically, the improvement framework was said to lack a focus on precisely – improvement.

Subsequently, these activities became for many a tedious task to do once a year. It is not easy to understand to which extent these improvement activities should be prescribed, and to which extent the managers and the employees should independently create frameworks that are costumed to their unit. A general observation gathered from the interviews however, is that when guidelines and frameworks are specified to detail, the work on the employee survey becomes passive and lacks commitment. Managerial autonomy is positive for creating solutions suited to each working unit.

What is the role of the organization then, in the matter of workplace improvement? Managers meant that, even though local autonomy was important for increasing commitment and engagement in the process, the improvement work could not be confined to the units themselves. What the hospital lacked in this sense, was the presence of clear plans for intervention that included all organizational levels. Even though the MU survey is considered to be a tool for local improvement, many of the challenges identified in the units called for overarching and intersectorial strategies.

The project “Strengthen Employeeship” so far, can be seen as something more than a measurement and improvement process. This process was first of all a learning process. Managers learned about the phenomenon of employeeship and engagement and about the factors affecting this state of mind. Because of this learning activity, I would expect the improvement work to be characterized by higher commitment, as the managers have a better
understanding of the subject and of the instruments. Such an understanding is often missing in 
the improvement work of the MU survey, as managers point out to have received little or no 
training opportunities to comprehend the use of the survey instrument as tools for 

improvement.

This assumption however, goes beyond the aims of this master’s thesis as it implies the 
analysis of the leaders’ approach to the improvement interventions in the clinics. This process 
is planned to take place in the summer of 2016 and could not, unfortunately, be a part of the 
analysis of the case study.

In the following table, the core findings on the experiences with the improvement work of the 
MES and HES surveys are classified into strengths and weaknesses of the clinical 
engagement approach, when going from theory to practice:

<table>
<thead>
<tr>
<th>Weaknesses</th>
<th>The clinical engagement approach from theory to practice</th>
<th>Strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td>✗ Abstract concept, difficult to understand for some professional groups. Lacks a good translation in the Norwegian language.</td>
<td>The concept of clinical engagement</td>
<td>✓ The concept is closely related to the issue of employeeship and explains engagement through 3 variables on 2 dimensions.</td>
</tr>
<tr>
<td>✗ The preconception on different premises for engagement between doctors and other clinical groups does not fit into an egalitarian system as the Norwegian one.</td>
<td>The MES and HES surveys</td>
<td>✓ The surveys are meant to measure challenges from an organizational perspective and do not delegate the sole responsibility for improvement to the units.</td>
</tr>
<tr>
<td>✗ The results for medical engagement are inflated. The process of connecting the scores to the questionnaires is not straightforward as in the MU survey.</td>
<td>The survey report</td>
<td>✓ It presents the results for each profession. The scores are directly connected to the factors affecting engagement (the meta and subscales).</td>
</tr>
<tr>
<td>✗ The guidelines are not detailed, nor concrete, and must be adapted to a Norwegian context.</td>
<td>The framework for improvement</td>
<td>✓ It consists of guidelines with activities that can enhance engagement. It “teaches” what factors affect engagement, rather than prescribing working activities.</td>
</tr>
</tbody>
</table>

*Figure 11: Strengths and weaknesses of the clinical engagement approach, from theory to practice*
5.2 MES and HES: quantitative tools for qualitative improvement?

The research question that will be answered in this discussion part is:

*What is the relevance of the clinical engagement approach, in its conceptual and empirical framework, for the improvement of the work environment and employeeship at Oslo University hospital?*

The term “relevance” is understood through the following definition: “*something (A) is relevant to a task (T) if it increases the likelihood of accomplishing the goal (G), which is implied by T*,” where:

- (A) is the clinical engagement approach, consisting of its theoretical foundation and of the MES and HES surveys;
- (T), the task, are the multiple activities related to the improvement of the work environment in the organization;
- (G), the goal, is enhanced employeeship, one of the objectives of the interventions for improving the work environment.

To answer the research question, I start by reconsidering the two initial assumptions of findings. The first assumption was based on the theoretical review of the concept of employeeship and engagement. The term employeeship is a new concept in the field of management and organizational theory, and we have difficulties in finding a unique definition of this phenomenon. This concept carries many of the elements of employee involvement and empowerment. However, the term is also understood as a positive energy coming from the single employee that engages in participation, shares the responsibility for outcomes and is committed to the organization. In this sense, the shared leadership approach, focusing on the elements of conjoint agency and distributed leadership, is a close description of what employeeship means. In the theoretical part of this thesis, I have also pointed out how the concept of clinical engagement seems to be of interest for the study of employeeship in Professional Bureaucracies.
1st assumption: the concept of clinical engagement, understood as a multidimensional phenomenon fostered by the elements of commitment, collaboration and satisfaction at the organizational and individual level, offers an interesting and relevant approach to the issue of employeeship in Professional Bureaucracies.

Moreover, the second assumption identifies some possible challenges in regard to the empirical use of this approach in the Norwegian work environment context. These challenges can be related to the different structures of leadership in the hospital (unitary management vs. directorate model), and to a different distribution of roles and responsibilities across professions.

2nd assumption: given the different contextual backgrounds, the operationalization and the improvement of clinical engagement through the MES and HES surveys may meet challenges concerning the different leadership structures and the division of roles among the clinical staff in Norway and in the UK.

The experiences described in the case study consisted in the implementation of this approach in the context of the pilot-project “Strengthen Employeeship”. Particularly, the points of interest where the introduction of the concept of engagement, the measurement phase, and the use of the survey results to identify the intervention areas.

The clinical engagement approach gives a useful definition of the phenomenon of engagement in a hospital setting, particularly relevant to the issue of employeeship. This approach in fact, enhances the role of the single clinician for the whole organization and supports a structure oriented towards share leadership, understood as a competency-based joint activity. In this sense, it is particularly interesting for the hospital sector, characterized by the literature as a “Professional Bureaucracy”.

The experiences of the case study confirm that one of the strengths of the clinical engagement approach is that it gives a multidimensional understanding of the factors affecting engagement, thus pointing out that engagement, as employeeship, is a relation- based phenomenon. Moreover, this multidimensionality is reflected in the operationalization of the concept through the MES and HES surveys. The factors affecting engagement are also easy-to-grasp, as they can be identified in the spheres of “giving”, “receiving” and “reciprocating” that are essentials for the wellbeing of the workers. The same structure is also used in the survey reports, thus giving managers the possibility to identify the factors that received low or high score. Even though the issue of clinical engagement was unfamiliar at first, the
hierarchical representation of the Medical Engagement Scale makes the subject easy to understand.

Nevertheless, as expected, there were structural and contextual variables that challenged the implementation of the clinical engagement approach from theory to practice. First, the issue of applying two different standards of engagement to medical and clinical employees by creating a Medical Engagement Scale and a Healthcare Engagement Scale. This seemed to be in contrast with the structure of management practiced at Oslo University Hospital and with the aims of the pilot-project “Strengthen Employeeship”, which focuses on the inclusion and participation of all professions in the leadership processes. Moreover, the validity of the measurement of medical engagement through the MES survey is questioned as, in practice, the index gave suspiciously high results. In addition, the translation of the questionnaires to the Norwegian language may have affected the validity of the surveys.

Still, the process initiated by the clinical engagement approach gave some positive results. Firstly, it raised awareness on the subject of engagement as a new approach to improving the work environment, offering a systematic conceptualization of how the clinics can work on the issue of employeeship.

Secondly, by comparing these experiences to the previous work done with the MU survey, the project-group could identify the additional value of this approach. For example, the comparison of results across professional groups made clear that different staff groups meet different challenges, and thus need ad hoc strategies for improvement.

Thirdly, the clinical engagement approach focused on the role of the organization, rather than on the single working unit, in creating a culture that promotes collaboration, organizational commitment and job satisfaction. This was particularly interesting for the pilot-project “Strengthen Employeeship”, as it identified a lack of overarching and institutionalized structures for the implementation and the evaluation of interventions that entangled different organizational levels.

Thus, the relevance of this approach for the work improvement was just partial. Even though the MES and HES surveys may not be adopted as a tool for improvement at Oslo University Hospital, this learning process had positive outcomes that offer topics for discussion in the work groups.
6 Conclusions

The relevance of the clinical engagement approach for Oslo University Hospital was evaluated through the case study and the experiences of the pilot-project “Strengthen Employeeship”. The case study has followed the experiences of the project group from September 2015 to April 2016, and included the preparation phase, the measurement phase and the initiation of an improvement plan based on the survey results. Particularly, the issue of interest for this master’s thesis was whether the MES and HES surveys could be used to improve the work environment and achieve enhanced employeeship in a Norwegian context.

A review of the literature on employeeship showed that the concept of employeeship is relatively new and that a unique definition of the term is missing. However, I identified shared leadership (SL) as a close conceptual definition of employeeship, as it is a participative and collaborative perspective that focuses on including all professionals in shaping the present and future workplace of the hospital. The clinical engagement approach as a tool for improving employeeship was expected to be relevant from a theoretical point of view, as it gave a multidimensional definition of engagement that took into consideration the cardinal elements of commitment, satisfaction and collaboration on the organizational and on the individual level. Moreover, previous experiences with this type of approach show that a focus on clinical engagement, creating participative and collaborative working cultures, has a positive effect on a series of organizational outcomes, like patient safety and service quality, creativity and disposition to change and enhanced multidisciplinary collaboration.

However, when going from theory to practice, the operationalization of the Medical Engagement Scale and of the Healthcare Engagement Scale met challenges pointing to the conclusion that these tools are not suitable to the workplace improvement processes of Oslo University Hospital. The main challenges here were the division of a clinical and a medical engagement scale and the validity of the measurements.

Even though this process brought up some positive discussions and helped identify the areas of improvement that the project group will work on in the summer of 2016, the overall relevance of the tool for the work improvement was just partial. In fact, the process needs to be adapted to the organizational features of Oslo University Hospital and the measurement tools cannot be imported and applied as they are to a Norwegian context.
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Appendix

Appendix A - NSD Approval (Norwegian)

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Lars Erik Kjekshus
Institutt for helse og samfunn Universitetet i Oslo
Postboks 1130 Blindern
0316 OSLO

Var rkt: 47021 / 3 / HET
Dennes dat: Dettes rkt

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 25.01.2016. Meldingen gjelder prosjektet:

47021 Clinical engagement: From measurement to improvement. A case study on the use of the Medical Engagement Scale and the Healthcare Engagement Scale to improve work environment at Oslo University Hospital

Behandlingsansvarlig: Universitetet i Oslo, ved institusjonens øverste leders
Deglig ansvarlig: Lars Erik Kjekshus
Student: Gloria Traine

Personvernombudet har vurdert prosjektet og funnet at behandlingen av personopplysninger er meldepidlig i henhold til personopplyningsloven § 31. Behandlingen tilfredsstiller kravene i personopplyningsloven.

Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplyningsloven og helsetjenesterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.


Personvernombudet vil ved prosjektets avslutning, 13.05.2015, rette en henventelse angående status for behandlingen av personopplysninger.

Vennlig tilsetning

Ketrine Ullaaker Segdal
Hildur Thorarensen
Forespørsel om deltakelse i forskningsprosjektet

“Clinical engagement: from measurement to improvement”

Bakgrunn og formål
Denne studien er en integrert del av min masteroppgave ved Universitetet i Oslo og er dessuten knyttet til pilotprosjektet «Styrtet Medarbeiderekap» på OUS. Formålet med studien er å undersøke ledernes erfaringer og holdninger til medarbeidundersøkelsene MES og HES, og hvordan slike verktøy anvendes i organisasjonsutvikling og å forbedre arbeidsmiljøet på OUS.

Som leder i en av klinikene som deltar i pilotprosjektet «Styrtet Medarbeiderekap», inviteres du til intervju.

Hva innebærer deltakelse i studien?

Hva skjer med informasjonen om deg?
Alle personopplysninger vil bli behandlet konfidentsielt. Kun student og veileder har tilgang til opplysningene som samles inn, alle skriftlige notater er i papirversjon og navnelisten lagres adskilt fra øvrige data. Lydopptaket slettes etter transkribering og alle papirnotater makuleres etter prosjektslutt.

Deltakerne vil ikke kunne gjenkjennes i publikasjonen.


Frivillig deltakelse
Det er frivillig å delta i studien, og du kan når som helst trekke dit samtykke uten å oppgi noen grunn. Dersom du trekker deg, vil alle opplysninger om deg bli anonymisert.

Dersom du har spørsmål om prosjektet, ta kontakt med Gloria Traina – gloria.traina@studmed.uio.no eller veileder Lars Erik Kjekshus l.e.kjekshus@medisin.uio.no.

Studien er meldt til Personvernombudet for forskning, Norsk samfunnsvitenskapelig datatjeneste AS.

Samtykke til deltakelse i studien

Jeg har mottatt informasjon om studien, og er villig til å delta

--------------------------------------------------
(Signert av prosjekt deltaker, dato)
Appendix C - Sample of interview guide (Norwegian)

Intervjuguide
– individuelt, semistrukturert intervju

Varighet: 50 minutter – 1 time

Tema i masteroppgaven: Deltakernes erfaringen med prosjektet «Styrket Medarbeiderskap», spesiell, anvendelsen av spørreskjemaene Medical Engagement Scale og Healthcare Engagement Scale til å forbedre arbeidsmiljø og engasjement nivå ved Oslo Universitetssykehus.

Problemstilling: “What is the relevance of the framework for clinical engagement, from measurement to the implementation phase, for the improvement of work environment, employeeship and leadership at Oslo University Hospital?”

Fase 1: 1. Løst prat og informasjon (5 min)
Rammesetting
- Tema for samtalen, formål: undersøke ulike tilnærminger til lederskap og til anvendelsen av medarbeiderundersøkelsene, verktøy nytte.
- Bruk av intervjuet i masteroppgaven, lagring og behandling av data, anonymitet og tashetsplikt (intervjuet blir tatt opp med min telefon, med kodelås. Intervjuene blir transkriert og opptaket slettet. Intervyteksten blir da analysert gjennom tematsk koding, og dekonstruert. Jeg lagrer intervjuonotatene og navneliste separat. Intervjuene gir meg en bedre forståelse av hva du som leder tenker om tema, men dine meninger er anonyme og jeg har selvagt respekt for taheetsplikt)
- Informer om opptak og få samtykke.
- Er noe uklaart eller har du spørsmål?
- Jeg kommer til å stille deg noen bakgrunn spørsmål som ikke blir tatt opp, før vi starter.

> Hva er din utdanningsbakgrunn?
> I hvor mange år har du jobbet i et helsefotak?
> I hvor mange år har du jobbet som leder?
> Hvor lenge har du vært leder i denne avdelingen/sekjon/enhet?
> Jobber du 100% som leder eller i delt stilling?
- Start oppgave

**Fase 2:** Erfaringer

* 3. Overgangsspørsmål: (15 min)*

- Etter din mening, hvorfor velge tittelen «Styrket medarbeiderskap»?
- Hva er bakgrunnen for at din enhet, eller avdeling, deltar i prosjektet?
- Er det vært noen spesielle utfordringer som dere ønsket å undersøke?
- Hva slags erfaringer har du med medarbeiderundersøkelser som verktøy for forbedring?
  - MU undersøkelsen
  - MES-HES undersøkelsen
- Kan du gi eksempler på positive erfaringer med MU som verktøy for lokalt forbedringsarbeid?
- Sjekkliste eller oppfølgingspapir?:
  - Nyttet
  - Forståelse av metoden
  - Eksempler på positive erfaringer
  - Autonomi og medvirkning i prosessen

- Hva opplever du er dine viktigste funksjoner som leder? (Eks: faglig støtte, arrangere og delta i møter, personaloppfølgning, pasientbehandling, rapportering, liaison funksjoner, konflikt håndtering?)
- Hva bruker du tiden din på, som leder?
- Hva er viktigst for god pasientbehandling? (Rangere etter prioriteter)
  - Medarbeidernes motivasjon
  - Medarbeidernes faglige kompetanse
  - Bemanningsstørrelse
  - Tiltrengselhet av teknisk utstyr
  - Fysisk bygg
  - Tverrfaglig samarbeid
  - Teamarbeid og kommunikasjon
  - Koordinasjon av tjenester gjennom god ledelse

**Fase 3:** Fokusering

* 4. Nøkkelspørsmål: (20 min)*

- Hvordan forstår du ordet «engasjement»? Hva legger du i dette begrepet?
- Etter dine erfaringer som leder, hva tror du skaper høyt eller lavt engasjement hos medarbeiderne?
- Hvilke aspekter av rammeverket med ME og HES undersøkelsen synes du mangler i MU undersøkelsen? Omvendt?

- Sett oss i en scenario situasjon: hva er det første som kan skje hvis man ikke gjennomfører arbeidsmiljøkartelling hvert år, men f eks. hvert andre eller tredje år?
- Hvordan opplever du at ulike nivåer i organisasjonen blir involvert i forbedringsarbeid i etterkant av MU undersøkelsen?
- Har du noen gang opplevd at det er hindringer i din autonomi til å sette i gang forbedringsstiltak?
- Hvilken gruppe valgte du å være med i forbedringsfasen i prosjektet?
  - Hvorfor? Hva ønsker du å oppnå?
  - Oppfølgingsspørsmål eller sjekkliste
    - Handlingsplaner

**Fase 4:** Tilbakeblikk

* 5. Oppsummering (ca. 5-10 min)*

- Oppsummerere funn
- Har jeg forstått deg riktig?
- Er det noe du vil legge til?
### Appendix D - MES questionnaire (English)

1. I feel that my contribution is appreciated and valued properly  
2. I am able to personally initiate positive changes at work  
3. In this organization everybody learns by contributing and sharing their ideas  
4. I have a significant impact on all the important things that influence my job  
5. In this organization, the career prospects for employees like me are relatively good.  
6. I feel generally isolated from those taking decisions for the organization  
7. All in all, the employees receive appropriate award for the work they do  
8. The people I work with are rarely sympathetic or concerned toward my work pressure  
9. The employees are encouraged to discuss ways to improve the performance  
10. I feel that dedication to the job is misplaced in this organization  
11. I have few chances to develop my chosen career path  
12. There is no clear connection between the organization's goals and individual judgment  
13. There is no conflict between the decisions I have to make at work and my personal values  
14. This organization does not completely support my professional values  
15. The employees' good work is properly acknowledged and rewarded by this organization  
16. I am not actively encouraged to continue learning, either formally or informally  
17. To admit errors can put your career prospects at risk in this organization  
18. I have the chance to influence the future direction of the organization  
19. The career progression of the employees is not closely related to good performance  
20. I am generally disappointed with my work tasks and roles  
21. The organization supports employees like me in achieving their professional goals  
22. I think that the people I work with are generally speaking friendly and personally supportive  
23. The employees here experience that it is difficult to be completely honest and open about their concerns at work  
24. I have enough possibilities to update my knowledge and skills in this organization  
25. I have little commitment to the values and goals of this organization  
26. I am sure I can rely upon the people I work with  
27. The employees understand how their work contributes to the organization's goals  
28. I often meet resistance and reluctance among others towards getting involved  
29. Work-related issues are discussed freely among all kinds of employees  
30. I am not being encouraged to cooperate or collaborate with other employees
| 1. | Jeg føler at bidraget mitt blir satt pris på og verdsatt på riktig måte |
| 2. | Jeg er i stand til å personlig initiere positive endringer på jobb |
| 3. | I denne organisasjonen lærer alle gjennom å bidra og dele sine ideer |
| 4. | Jeg har en betydelig påvirkning på alle viktige ting som påvirker jobben min |
| 5. | I denne organisasjonen er karriereutsiktene for ansatte som meg relativt gode |
| 6. | Jeg føler meg generelt isolert fra de som tar beslutninger for organisasjonen |
| 7. | Alt i alt mottar de ansatte passende belønning for arbeidet de gjør |
| 8. | Folk jeg jobber med er sjelden sympatiske eller hensynsfulle overfor arbeidspresset mitt |
| 9. | Ansatte oppmuntres til å diskutere måter å forbedre ytelsen på |
| 10. | Jeg føler at dedikasjon til jobben er malplassert i denne organisasjonen |
| 11. | Jeg har lite rom til å utvikle min valgte karrierevei i denne organisasjonen |
| 12. | Det er ingen klar forbindelse mellom organisasjonens mål og individuell vurdering |
| 13. | Det er ingen konflikt mellom beslutninger som jeg må ta på jobb og mine personlige verdier |
| 14. | Denne organisasjonen støtter ikke fullt ut mine profesjonelle verdier |
| 15. | Ansattes gode arbeid blir ordentlig anerkjent og belønnet av denne organisasjonen |
| 16. | Jeg blir ikke aktivt oppmuntret til å fortsette å lære, hverken formelt eller uformelt |
| 17. | Å innrømme feil kan sette karriereutsiktene dine på spill i denne organisasjonen |
| 18. | Jeg har en mulighet til å påvirke den fremtidige retningen til organisasjonen |
| 19. | Karriereprogresjonen til ansatte er ikke nært knyttet til god prestasjon |
| 20. | Jeg er generelt misforstådd med mine egne arbeidsoppgaver og roller |
| 21. | Organisasjonen støtter ansatte som meg i å oppnå sine profesjonelle mål |
| 22. | Jeg synes folk jeg jobber med er generelt vennlige og personlig støttende |
| 23. | Ansatte her opplever at det er vanskelig å være fullstendig ærlig eller åpen om deres bekymringer på jobb |
| 24. | Jeg har tilstrekkelig med muligheter til å oppdatere min kunnskap og ferdigheter i denne organisasjonen |
| 25. | Jeg har liten forpliktelse til verdiene og målene til denne organisasjonen |
| 26. | Jeg er sikker på at jeg kan stole på menneskene jeg jobber sammen med |
| 27. | De ansatte forstår hvordan arbeidet deres bidrar til organisasjonens mål |
| 28. | Jeg møter ofte på motstand og motvilje blant andre for å involvere seg |
| 29. | Arbeidsrelaterte saker blir fritt diskutert blant alle typer ansatte |
| 30. | Jeg blir ikke oppmuntret til å samarbeide eller kollaborere med andre ansatte |
## Appendix F - HES survey (English)

1. All the people I work with learn by contributing and sharing their opinions
2. I receive enough information to keep my performance on track
3. My skills and talents are particularly well suited to the job requirements
4. My personal attempts to improve working routines are limited
5. My good work is well acknowledged and rewarded
6. I feel that I have few chances to develop my skills and the career path I have chosen
7. I appreciate when my abilities and judgment are treated with respect
8. From time to time I feel that I am not trained enough to handle the situations that I encounter on the job.
9. I feel I do not belong to and understand the people I work with
10. I'm usually reluctant to commit enthusiastically to new plans
11. I'm willing to readapt my working practice based on reasonable suggestions
12. I'm sure that I can rely upon the people I work with
13. The people I work with rarely concern about my work pressure
14. I have some degree of influence on several things that have an impact on my job
15. To go "the extra mile" is usually a good strategy to get things done
16. The support I get from the people I work with make me more efficient
17. To establish relationships based on mutual trust is essential to my own efficiency
18. I often meet resistance and reluctance among colleagues towards getting involved
19. I experience that I have an impact on new developments at work
20. I don't appreciate ignorant comments or opinions on the way I perform my job
21. I often dedicate extra time and effort to handle important job priorities
22. I am satisfied with the current extent of cooperation I have with others
23. I am not being actively encouraged to continue learning, either formally or informally
24. Showing personal commitment has often a positive impact on my colleagues
25. I often experience genuine gratitude for what I have done
26. Discussing evidence and argue a case is a good way to share concerns
27. It is sometimes difficult to work with my colleagues to facilitate progress
28. I feel that my knowledge and skills are not used in a proper way
29. My workload would be significantly reduced if the others were more helpful
30. I rarely encourage others to support and implement changes at work
31. I have nothing against useful feedbacks regarding my job performance
32. There are few opportunities to share opinions and ideas in a proper way
33. I am able to personally initiate positive change at work
34. I feel that my personal contribution is appreciated and valued properly
35. I feel that it is difficult to be completely honest and open about my concerns at work
36. I feel that sometimes my personal values are not supported at work
Appendix G - HES survey (Norwegian)

1. Alle jeg jobber med lærer gjennom å bidra og dele sine ideer
2. Jeg blir gitt tilstrekkelig informasjon til å holde prestasjonen min "på rett spor"
3. Mine evner og talent er spesialt godt tilpasset jobbkravene mine
4. Mine personlige forsøk på å forbedre arbeidspraksisen er begrenset
5. Mitt gode arbeid blir ordentlig anerkjent og belønnet
6. Jeg føler at jeg har liten mulighet til å utvikle mine evner eller min valgte karrierevei
7. Jeg føler meg fornøyd hvis mine ferdigheter og dømmekraft blir behandlet med respekt
8. Jeg føler iblant at jeg er utilstrekkelig trent til å håndtere situasjoner som jeg møter på jobb
9. Jeg føler at jeg har liten tilhørighet eller forståelse for de jeg jobber sammen med
10. Jeg er vanligvis motvillig til å forplikte meg entusiastisk til nye planer
11. Jeg er villig til å tilpasse min arbeidspraksis basert på fornuftige forslag
12. Jeg er sikker på at jeg kan stole på menneskene jeg jobber sammen med
13. Folk som jeg jobber sammen med tar sjelden tilstrekkelig hensyn til arbeidspresset mitt
14. Jeg har noe哪家好 på mange ting som påvirker jobben min
15. Å gå "den ekstra milen" er vanligvis en god strategi for å få ting gjort
16. Støtten som jeg får fra de som jeg jobber sammen med gjør meg mer effektiv
17. Å etablere relasjoner basert på gjensidig tillit er essensielt for min egen effektivitet
18. Jeg møter ofte på motstand og motvilje blant kollegaer til å involvere seg
19. Jeg opplever at jeg har innvirkning på nye utviklinger på jobben
20. Jeg misliker kunnskapsløse kommentarer eller meninger om hvordan jeg utfører jobben min
21. Jeg vier ofte ekstra tid og innsats til å håndtere viktige jobbprioriteringer
22. Jeg er tilfreds med det nåværende omfanget av samarbeid jeg har med andre
23. Jeg blir ikke aktivt oppmunert til å fortsette å lære, hverken formelt eller uformelt
24. Å vise personlig engasjement har ofte en positiv påvirkning på kollegaer
25. Jeg opplever ofte genuin takknemlighet for det jeg har gjort
26. Å diskutere bevis og å argumentere for en sak er en god måte å dele bekymringer på
27. Det er iblant vanskelig å jobbe med kollegaer for å fasilitere effektiv fremdrift
28. Jeg føler at kunnskapen og evnene mine ikke brukt på en hensiktsmessig måte
29. Min arbeidsmengde kunne blitt betydelig lettet hvis andre var mer hjelpsomme
30. Jeg oppmuntrer sjelden andre til å støtte eller implementere endringer på jobb
31. Jeg har ikke noe imot nyttig feedback angående mine jobbprestasjoner
32. Det er få muligheter til å dele meninger eller ideer på en skikkelig måte
33. Jeg er i stand til å personlig initiere positive endringer på jobb
34. Jeg føler at mitt personlige bidrag blir satt pris på og vertsatt på riktig måte
35. Jeg føler at det er vanskelig å være fullstendig ærlig eller åpen om mine bekymringer på jobben
36. Jeg føler at mine personlige verdier iblant ikke blir støttet på jobb