The 'active struggle' of the hybrid middle manager: Exploring the notion of ethical resistance

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Abstract:

Purpose: This paper brings attention to the role of hybrid middle managers. In particular exploring the relationship of organisational purpose and role requirements.

Design/methodology/approach: The primary research question for the original research was: What does it mean to hybrid managers to lead and deal with imposed changes (restructuring) to services? A novel narrative approach based on a synthesis of Czarniawska, Gabriel and Boje was applied. Accounts from interviews were condensed into narratives by initially using the categories defined by Gabriel (2000) as epic, tragic, comic and romantic and then further categorised into stories, themes and a serial (Czarniawska 1997). The final stage of the three-way synthesised narrative approach incorporated Boje's (2001) notion of 'antenarrative' to include pre-emplotment elements.

Findings: Four narratives are provided that give insight to the nature of the struggles the hybrid middle managers were in the midst of. A struggle to address incongruent demands being placed on them that cause tension with their sense of purpose, organisational goals, and their hybrid clinical roles and management roles. In the midst of these struggles the narratives illustrate the dynamic of ethical resistance that seeks a way forward. However, this appears to come at a health and well-being cost to the middle managers.

Originality: The paper offers up the notion of an added third bind to the traditional double, that of 'ethical resistance', a struggle to align organisational purpose with clinical and management role requirements. Theorising this third bind provides a new insight into understanding the context and dynamics of the hybrid middle manager role and behaviour. Indeed, the idea of ethical resistance may cause a revision of how resistance is understood.

Keywords

virtue ethics, narrative, middle manager, ethical resistance, healthcare

Beyond the Double Bind of Middle Manager Work

This paper considers the role of hybrid middle managers (HMMs). The participants of this study are medical (clinical) professionals who were promoted to positions of middle management. The participants must act as traditional middle managers with administrative responsibilities (a duty of effectiveness or efficiency), but are also still firmly planted within past clinical professional networks, and medical identities (duty of care) (Burgess and Currie, 2013). Their promotions shifted their workload expectations and the HMMs' clinical activities were reduced. They spent less time and energy devoted to caring for and healing patients, and the bulk of their work practices and responsibilities now oriented towards resource management. With this shift in their workload the participants find themselves caught in a double bind; they feel the pull of their original allegiance to their duties of care and healing for their patients as well as responsibility towards their duty of effectiveness or efficiency as managers. Caught in this double bind, and in their roles as HMMs, they act as a bridge between their subordinate clinicians and senior managers.

This double bind is well documented in management-related research (Bateson, 1972; Watzlawick, Beavin, & Jackson, 1967), but unique to HMMs is a form of third bind. This third bind – an obligation to preserve the historically embedded sense of organisational purpose – facilitates the emergence of a form of resistance unique to this group and context: ethical resistance. Conroy (2010: 220) put forward the notion of 'ethical resistance' as a process to 'protect [institutional] practices from being corrupted.' Drawing on this notion of protection the HMMs allegiance to the organisational purpose, alongside the double bind tension between

caregivers and administrators creates a triple bind for which the HMMs must navigate. To study this third bind, we examine narratives of HMMs.

Our article is structured as follows. First, we explore antagonism in hybrid middle manager work that provides exploration of the double bind and the notion of ethical resistance. Second, MacIntyre's argument for virtue ethics connected to an institutional narrative unity – the organisational purpose – is explored in the context of health care. Third, we outline our research approach using narrative method derived from Czarniawska (1997). The narratives of ethical resistance in the work of these hybrid middle managers are outlined. Fourth, we highlight this manifestation of ethical resistance in hybrid middle manager work and the complexity of our notion of balancing a triple bind. Finally, in our conclusion we discuss the implications for hybrid manager work and issues for health policy

Hybrid Middle Managers: Beyond the double bind

Perspectives on the role of middle management have undergone revision over the last decade. Moving from the oft cited narrative of middle managers as intransigent and resistant to change, the inertia in the system 'to be co-opted, side-lined or disposed of' (Huy, 2002: 32); and to a role that mediates sense-making of organizational purpose, direction and desired outcomes (Balogun & Johnson, 2005). Rather than seeing middle managers as a block, middle managers have been shown to be a significant asset (see for example: Floyd & Lane, 2000; Huy, 2002; Mantere, 2008; Raes, Heijltjes, Glunk & Roe, 2011).

The vertical role of middle management (Raes et.al., 2011) reflect a structural dynamic of middle managers as a 'linchpin between the strategic apex and the operating core, supplying information

upwards and consuming decisions passed downwards' (Balogun, 2003: 70). Floyd and Lane (2000) assert that middle managers should not be seen as 'passive objects whose role can be manipulated by the organization for its own ends' (2000: 155). Rather they emphasize a role of 'championing, facilitating, synthesizing and implementing – focus on communicating information between the operating and top levels of management' (2000: 158). Mantere (2008) broadens middle manager agency as 'an individual's capacity to have a perceived effect upon the individual's work on an issue an individual regards as beneficial to the interests of his or her organization' (298); a sense of protecting the organizations interests and purpose through discourse framing. Yet such framing discourse is situated in a context of complexity and vulnerability to the precarious position of being in the middle (Currie & Procter, 2005). Sims (2003) has explored the vulnerability of middle managers. He suggested middle managers face a complex task of sense-making through story-telling between vertical relationships with direct reports and senior managers. Sims describes a third audience, the self, and the often incommensurable task to align the three different sense-making narratives with an integrative sense of purpose. Such incommensurability is likely to generate further tension and stress within the context of a HMM in light of the triple bind we have outlined.

It is important to note that middle managers routinely take on a variety of roles. Rather than seeing a middle manager as a 'pure play' – someone who identifies closely with being a manager – Burgess and Currie suggest the 'hybrid' middle managers often dominate the management population (2013: 134). A hybrid reflects a person that is 'skilled in an alternative profession' (2013: 134). From a strategic perspective, they can look both ways: towards the senior manager big picture which requires an understanding and engagement with operational detail and the ability to translate the abstract organisational vision into a realizable endeavor. In addition,

HMM can also look towards the caring medical practitioner who prioritizes patient care and healing and draws on medical/scientific knowledge to guide her practices. These managers then are pivotal in the organizational structure regarding the emergence and realization of strategy. However, what has not been explored is how virtue within the work of the HMM plays out in this pivotal role. How for example does professional socialization and the virtues contained within such socialization impact on their work?

Debates examining the hybrid middle manager have not addressed the notion of virtue within their workplace practices and role. For example, Currie & Procter (2005) highlight the agency of the middle manager and the associated insecurities of the role, but view such through a functionalist lens associated with planning, performance and measurement. Similar research is reflected in the work of McGivern et al (2015). They identified two primary HMM identities – incidental and willing – and how these HMM managed these identities. The incidental HMM's held management at arm's length protecting the professional identity; the willing HMM embraced the notion of the management rational for rationalizing health care for the greatest good. Despite limited exploration of role tensions, the professionally unattractive nature of hybridization is highlighted: 'managerialism [and] being accused of selling out, or turning to the dark side' (2015: 425). Related research connected with HMM work in the health sector identified tensions between clinical and economic considerations (Waitzberg et al, 2022). They offer up the notion of dual agency for all professions – managers and clinicians – as a means for reconciling the economic and clinical misalignment. Although not explicit, their work points to alignment by making explicit the tensions. The recent work of Kirkpatrick, Altanlar and Veronesi (2023) highlights issues associated with static and sometimes declining HMM numbers in the health sector compared to the growth of HMMs in other sectors and questioning why that

might be. They encourage the need for qualitative research to explore underlying aspects shaping the lived experience of being a HMM in the health sector.

We seek to offer up a new lens through which to examine HMM work by drawing on the work of MacIntyre's (1985) institutional narrative based practice virtue ethics – a neo-Aristotelean perspective – to look at the triple bind they find themselves in the middle of and how they seek to function. That is to fulfil their duty of care the first bind, but also adopt a commitment to effectiveness or efficiency to ensure that the hospital remains financially solvent and therefore sustainable, the second bind; and a third bind associated with organisational purpose and the Aristotelian notion of narrative unity, which we examine next.

Virtue ethics and narrative unity aligned with organisational purpose

Drawing from (MacIntyre 1985), virtue is a behavioral disposition (or quality of character) to act towards practice excellence in a variety of situations. Because of its orientation to practice, virtues are culturally based. A person's virtues disposition draws upon a deep rooted and complex multilevel relationship with values, emotions, interests, attitudes and expectations. The HMMs in this study developed their commitment and pursuit of excellent health care practices from the antecedents of their own virtue dispositions; this is then refined through moral debate within their own practice based community (MacIntyre 1985) e.g. social services, medical professions, and police services. Thus the virtues disposition of the HMM was to a duty to health care, which prioritized the needs of their patients and other relevant stakeholders in specific communities. For example, the HMMs' community is health and social care mental health services. Prior to moving into management, the HMMs had invested themselves in clinical work

through a commitment to developing skills in enabling mental health care, choices of where to work, who to work with, where to work and how the work should be done.

The virtues disposition of health care HMMs can become manifest as a felt sense of *eudaimonia* through their work because the delivery of healthcare excellence is connected to an ongoing narrative as a shared sense of purpose or *telos* (Aristotle, 1985). For McCann & Brownsberger, (1990: 227–228) 'the overriding good' is in the form of a shared *telos* or quest. For example, in the British healthcare context, Robertson (2016) argues that financial pressures can affect patient care. Community *telos* (purpose) allows members (such as HMM's) to both contribute to and develop their own sense of what MacIntrye describes as a narrative quest – their personal journeys towards a meaningful purpose. The personal narrative quest is part of a larger dynamic namely a narrative unity – which is of significance to this research. The narrative unity encompasses the following three interconnect elements: the narrative quests of the community of practitioners; the continuing investment of each member in their practice virtue disposition; and the generation of virtue outcomes (such as excellent health care) that are thus integral to a community's narrative unity (MacIntyre 1985).

An intervention that seeks to break this narrative unity, such as a movement from health care in favour of effectiveness or efficiency (for example, management targets such as patient waiting lists or funding pressures), may generate perversion (Pidd, 2005) or virtues betrayal (Krantz, 2006); or corruptions to the institutional narrative unity. Our notion of ethical resistance (that we shall show drawn from our data) captures this sense of protecting the individual's narrative quest and protecting historic institutional narrative unity that encompasses the organisation's *telos*, and virtues practices. For the HMM this represents their past as clinicians and why they chose to

work in health care in the first place. From a more recent perspective, Sinnicks (2021: 263) draws on MacIntyre to suggest 'we reflect on the best forms of work so that we can strive to ensure the very best activities' which support our flourishing in the world. Therefore, their role as a HMM was not to push through the breakup of the narrative unity, but to sustain the narrative by bridging any gaps that emerge. Protecting the narrative unity and their narrative quest in the connected virtuous endeavour of excellence in healthcare becomes manifest as the notion we shall develop of ethical resistance.

For purposes of clarity when we speak here of professional and managerial practices we mean: professional as complex socialized activity (MacIntyre, 2007: 187) reflecting expectations and assumptions, skills, standards and codes of conduct of the profession adapted in a particular context; in this case that of health care. When we speak of management, we seek to reflect an organizational set of management functions and drawing on Mintzberg (1973) – decisional, informational, and interpersonal.

We next outline our methodology to explore and reveal the active struggle of HMM's.

Methodology

The central research question is: How do hybrid middle managers undertake their dual roles and address conflicting professional and managerial practices alongside the pursuit of organisational purpose? The context from which we examine HMM work is that of the UK National Health Service (NHS).

Participants and Data Collection

The research site was gained by one of the authors who was working as a clinician in psychological services within the mental health provider arm of an NHS Trust. With the approval of the Trust CEO access was given to the Trust Mental Health managers.

The ages of the HMM in this study ranged from early thirties to late fifties, a mix of genders and with lengths of service ranging from five to thirty years. They were from a range of different hospital inpatient and outpatient wards and community services. The main fieldwork consisted of in-depth lightly-structured interviews with a total of thirty-eight managers over a period of twelve months. Seventeen of the thirty-eight were interviewed twice to add a longitudinal component to the study. All the managers interviewed were leading the implementation of a range of government and local change initiatives with the aim of improving mental health services. The interviews sought to collect narratives based on their experiences of leading organizational change. On average the interviews were sixty minute in length and with the permission of the respondent interviews were recorded and transcribed.

Narrative Analysis

Following data capture the interviews were condensed into narratives by initially using the categories defined by Gabriel (2000) as epic, tragic, comic and romantic and then further categorised into stories, themes and a serial (Czarniawska 1997).

Insert Table 1 about here

In the first column we see the poetic modes from Gabriel (2002), in the second column are the titles given to the narratives analysed and in the third column provides the clash of virtues conveyed in the narratives.

The final stage of the three-way synthesised narrative approach incorporated Boje's (2001) notion of 'antenarrative' to include pre-emplotment elements. A full and detailed description of this novel approach can be found in ([author details withheld for purposes of review]).

These condensed narratives were presented to mental health service managers across the region to ensure these represented their social reality. Two focus groups were undertaken with (70 and 51 respectively – forming two management development events) and they were asked the question: How closely do the findings compare with your experience? The focus groups were structured to allow the managers to comment on the narratives. These 8 extracted quotes capture the essence of the affirmed strong verisimilitude: #1 - *'This is so refreshing – for the first time someone has articulated what it is like for us to be on the front line of change in the NHS. #2 - 'Exactly right.' #3 - 'That is just how it is for us.' #4 - 'It is nice to know that others feel the same.' #5 - 'I can identify with the stories.' #6 'That's it that's how it is for us.' #7 'I think you have captured it very well.' #8 - 'I think you have got the breadth of experiences just right'* ([p. 239: published reference withheld for review purposes]).

Findings

Strikingly the narratives all had a common overarching theme, that of ethical resistance. The four example narratives below use much of the participant's original language. However, it needs to be noted that these have been edited, but such editing is only for length and clarity. The full set

of unabridged narratives can be found in [published reference withheld for review purposes]: 99-160). We begin with an example of ethical resistance as wary compliance.

Narrative #1) Cuckoo Reform*: *Ethical resistance as these changes are damaging people

> As a service manager in my mid-forties, I've seen a lot of changes in the way healthcare functions. And, some of those changes have been for the greater good of the organisation and society. And, I get that work is hard – that is okay. I like to work hard. No one goes into healthcare because it is easy – or for the money for that matter. I do what I can to take care of myself – I work out at the gym, I do my best to eat healthily, and I even make sure to take all my holiday time. But, lately, I don't know, this is just different. This new NSF is harder. Before, with other organisational changes, I felt like I was a bridge between the organisation and my staff. I actually felt quite important – quite powerful. I could help make the change possible by bridging the new initiatives and my staff, making their job easier. But, this time, well, this new framework is different. It isn't just the new framework. It feels like the entire organisation is changing – taking over. It reminds me of a cuckoo bird who lays her eggs in other birds' nests. The organisation is leaving me with all the hard work – It's like I have to raise this new baby bird that isn't even mine. And, the baby cuckoos are putting stress and strain on the rest of the nest. My staff cannot take the extra work – the extra time. So, I feel like a foster mom who has to raise someone else's kids. I am trying to take care of my staff while also implementing this new initiative for the higher ups [senior management] – Sue.

Sue is utterly committed to making sure the implementation of the new initiative is successful – or at least as successful as possible. However, her narrative reveals a tension between accomplishing the change initiative and the negative consequences of that change. Moreover, this tension is not a mere inconvenience, this is a deeply personal and emotional burden that wears on Sue's stamina and personal health. Her narrative offers clear insight into the personal tensions and emotions manifest as a consequence of her virtue ethics disposition towards providing quality clinical care for her patients and responsible management for her employees while trying to implement the new initiative. The cuckoo (representing the UK Government's change programme ('Agenda for Change') has been implanted into the nest (the work) and is throwing out the eggs (the internal goods of health care) produced by the collective practice

virtues of Sue and her colleagues. The use of the cuckoo as a metaphor to describe the parasitic nature of the programmatic demands reveal the unintended stress the initiative places on her staff – the 'nest.' As she explains, the 'nest' feels the strain as she has to devote energies and resources towards the unanticipated (unwanted?) guest (the cuckoo). Willmott's (1993) concept of the colonisation of subjectivities becomes relevant here. The cuckoo lays its egg in a strange bird's nest knowing that when the nest-owning bird returns she will raise the cuckoo chick as her own. Only when the chick grows into a cuckoo is the damage of individual selfishness inflicted as the imposter throws the rightful offspring out of the nest. The modernisation and managerial programme of change chimed with one of Sue's allegiances at first – just another government initiative. However, later, the damage of ideological individualism comes to light, and for Sue, the tragedy in terms of the impact on her well-being unfolds.

Sue also uses the metaphor of the bridge. In her role as a hybrid manager she had been able to accommodate the institutional demands alongside historic practices. In a sense, tensions were accommodated because the institution is broadly aligned with the clinical orientation. However, the insatiable demands of the cuckoo for organizational efficiencies and changes to meet imposed government initiatives and targets (external goods) have led Sue to question her resolve and grow wary in her persistence. She is finding it more difficult to maintain and sustain the narrative unity representing excellence of clinical care.

More traditional or obvious forms of resistance would have Sue respond to the contradictory nature of the new programme initiatives with refusal, rejection, or even sabotage. However, because Sue is committed to the larger narrative unity, she warily complies with the programme requirements and does her best to sustain her own employees and their patients. Sue does enough

to accommodate the broader strategic initiative in a manner that sustains the historic sense of narrative unity.

The second story illustrates Jane's covert ethical resistance to protect the narrative unity through diversion.

Narrative #2) Subversive: Ethical resistance as paying lip service but doing things your own way as we know best

> I wouldn't say it was diversion, although I guess, now that I say it, it does sound rather 'alternative.' In my experience as a senior manager, sometimes my role is to create pathways – rivers or currents – that aren't always apparent at first glance to help achieve whatever is most important. In this case, it started off as an interest in mood disorders. An outpatient nurse wanted to change her position for a more challenging role. After talking with her for a bit I discovered that we shared common goals. We came to realize that there are other like-minded people in the hospital, so we got together a group of people who had no common base, apart from their interest in mood disorders. The group was rather diverse because we came from several different places within the hospital. But, we eventually became a coherent little group with ideas on how to develop better services for people with mood disorders. We wanted to establish better practices to make sure clinicians who had specific skills were able to use them where and when necessary. And, we were very keen to develop a partnership style of working. I think what we all had in common was that we saw our clinical work rooted in partnership with patients, clients, or whatever we personally called them and we wanted our service to develop in ways that honored those partnerships. Eventually we were invited to become part of the Clinical Governance Development Programme [CGDP], which is part of this larger Agenda for Change. The CGDP included six days of training, which wasn't all that useful. But, more than that, the training gave us the space and time out of the hospital to meet up, plan out what we were doing and to achieve various steps on the way towards our goal. I guess you could say we were a bit bad because we sat and listened to the presentations from the CGDP managers and were given tasks to complete for the programme, but we then just went and did our own thing – Jane.

For this manager 'rivers,' and 'currents' convey what it means to be leading organizational change. Jane comments that she has been deliberate in setting up her own covert current to achieve a better outcome with other like-minded clinical managers. They believe their approach is more useful or relevant than the new programme initiative. Her approach is divergent because she creates an alternative process – a form of covert rebellion that offers a parallel methodology

to the official programme processes. She recognizes the conflict of approaches between the programme initiative and her own model, but rather than overtly seeking to persuade senior managers of her alternative ways forward, she and her colleagues just set about doing their alternative approach as a quicker and better way than that suggested by the programme initiative. Their alternative method reflects their shared commitment to viewing their work as a partnership with their patients. In part, these actions help to sustain the collective pursuit of the narrative unity – patients as partners; and it drove them to divert their energies away from the official programme towards their covert, alternative approach.

The ethical resistance we identify in this divergent narrative reflects a response to the efficiency-oriented management approach of the programme imitative, which clashes with the historic clinical based practice that Jane and her colleagues prefer. Although Jane is a hybrid manager, she does not seek to resolve the clash through conversation with her peer managers. Rather she is covert in her resistance towards the Agenda for Change. She seeks to provide alternative pathways or options for the partnership-based 'clinical' stance where different clinical practitioners come together to debate how best to act in any given situation and include the patient and their experience/story in that mix. The virtue ethics encapsulated here is Jane's disposition to activity that is congruent with her own purpose, her narrative quest, which is aligned with her colleagues of sustaining the narrative unity of pursuing health care excellence. Their collective interpretation of achieving this is through practice virtues that generate the internal good of clinical excellence.

The next form of ethical resistance – subversion – also offers an alternative approach, in a similar covert fashion.

Narrative #3) I shred it: Ethical resistance as deciding ourselves what is important and only responding when chased

> Well, this won't win me any awards for good behaviour, but my new strategy to deal with the endless bureaucratic requests for documentation and paperwork is to play forgetful. Normally I am very good at keeping track of details – it's what makes me a good service manager and mental health clinician. But, lately, all these new requirements to documents EVERYTHING is out of control It is too much. And, it completely stresses out my staff. If they followed every new rule and processed every piece of paperwork, and filled out every required form, they would never work with any patients! So, my new, slightly naughty strategy is to put the requests on my desk – I have a huge pile of them – and I just leave them. Or, I may even put the request underneath other paperwork. And, I figure, if no one comes looking for that particular form, or requests that particular bit of paperwork, then I just eventually shred the documents and move on. If no one misses the paperwork than it must not have been all that important to begin with. And, we are all better able to do our jobs – Tim.

Tim's narrative is similar to Sue's story in the ways he attempts to serve as a bridge between the bureaucratic demands of the Agenda for Change and the historic clinical practice seeking health care excellence. He is able to use his hybrid middle manager role to give him scope to adopt a process of *not* addressing the organizational requirements because he sees this as having the effect of diminishing excellence in health care. However, Tim's narrative is dissimilar to Sue, but like Jane, in the sense that he is manages do the work that he believes is important – clinical care for patients and responsible management for his employees – but avoids the bureaucratic paperwork associated with the new programme initiative that he believes to be unimportant. Tim's resistance is oriented towards the long term in that he hopes that, eventually, the new programme work will go away. In this sense, Tim's resistance is more classical in that he is avoiding doing the new tasks assigned to him. However, unlike more public forms of resistance that are designed to solicit a response from management (i.e. more traditional work stoppages like strikes and boycotts), Tim's work stoppage is covert and subversive. His hope is that the supporters of the new programme will not notice that certain elements of the change are not implemented, thus freeing Tim to ignore them completely.

The final narrative illustrates ethical resistance as a form of deflection.

Narrative #4) My staff need me: Ethical resistance as being there emotionally for your staff

Sorry – I didn't mean to cry. I am just really tired – and a bit sick. I have a cold I cannot shake. Sorry -- It's just been a long few months. This new initiative – Agenda for Change – is really stressing me out. Which, is weird. I am a Ward Manager – I am used to stressful situations. But, usually the stress comes from handling a difficult patient, or, occasionally, a stressed out employee. But, this is different. This new program is so micro-managed. I've never seen so many forms that have to be completed! So much bureaucracy! Seriously. It is impossible. Every position has to be evaluated. Every staff member given a new job description. And, with the constant threat of redundancies, hour reductions, which really means a pay cut, and relocations of staff – everyone is on edge because they are worried about their own job security and financial stability. I wish I could just leave – and I guess I could. I could go out on sick and stress leave. It's my right. But, then where would that leave my group? They would have to deal with all this on top of their patients. This isn't their fault. They are just trying to do their best to do their jobs. It isn't their job to deal with all this new bureaucracy. If I go, who will be here to protect them? They will end up all stressed like me and that could jeopardize the safety of the patients. But, to be honest, if it were not for my staff needing me I would have gone off sick… definitely. [pause] I will be fine – I just keep telling myself that [chuckles to self] and occasionally I slip into the closet for a bit of a cry – Pat.

Pat's narrative highlights the emotional strain created by the programme changes. Pat described needing to take time off and recover from her stress-induced illnesses, but she felt obligated to stay and care for her staff. Her concern for her employees outweighed her ability to care for her own personal needs: 'If it were not for my staff needing me I would have gone off sick definitely.' Telling her story of the dilemma she felt inside brings tears to this manager's face. She felt that if she took time off sick then her staff would not be able to avail themselves of her support, which would leave them feeling completely demoralized. The tears convey how she felt for her staff during this period; she wanted to care for them because they were caring for vulnerable patients on the ward but the cost to her personally was significant (such moral courage echoed in Sekerka and Bagozzi, 2007). This kind of loyalty to staff by managers and to managers by staff came through strongly in the stories told within the context of organizational change.

Pat, and many others, described outcomes of Agenda for Change with some staff winning financially, while others had their jobs downgraded and lost out financially. The programme set up employees in competition with each other and created fear, anxiety and mistrust. Pat was caught in a paradox and conflict of roles. She saw her role as manager to enable the process – so staff did not miss out on programme benefits – and at the same time her role to protect the staff. In this way, the notion of an institutional narrative unity to achieving internal goods of excellence of health care was being undermined by Agenda for Change's orientation to external goods (rewards and promotion). Pat sought to sustain these internal goods by attending to the needs of the staff. Yet, at the same time, she implemented the new policies of Agenda for Change so that her staff were not disadvantaged. However, Pat's story isn't a story of mere protection – she deflects the encroachment of the new programme (and it negative outcomes). She serves as a barrier who is able to neutralize the detrimental initiatives while still empowering her staff to continue with their commitment to care. She does not have to do this. Pat engages in ethical resistance because she could, in good conscious, explain to her staff that these negative outcomes are not her idea and is, therefore, not responsible. However, because of her virtue ethic disposition of care, a disposition that gives priority to others over herself, she positions herself as a shield that deflects the negative changes, even when it costs her own mental and physical health.

Discussion

The examination of the work of HMM work through the lens of virtue ethics has highlighted the presence of 'ethical resistance' (Conroy, 2010: 220) as a process of seeking to 'protect [institutional] practices from being corrupted.' The four narratives of 'ethical resistance', which

are connected by an underlying set of aligned practice virtues, seek to help achieve the overriding good – wellbeing for all in the community. This is set against perceived notions of corrupting influence on the managers' working lives (Fleming and Spicer, 2003). The narratives point to 'ethical resistance' of HMMs engaging in a covert and complex discursive struggle to manage and balance the competing demands of a triple bind: attentive to the management and organizational requirements, responsive to colleagues and professional identities, and commitment to the institutional purpose – narrative unity. Framing this triple bind within the NHS context and through MacIntyrean language, the strategic neo-liberal revision acts as a brutal change to the institutional collective telos and sense of narrative unity. The ethical virtues resistance captures the HMMs' struggle as they 'quest to (re)author their selves as moral beings' (Clarke et. al., 2009: 323) to protect the organisation's narrative unity and protect themselves. MacIntyre explains that, 'the story of my life is always embedded in the stories of those communities from which I derive my identity. I am born with a past and to try to cut myself off from that past in the individualistic mode is to deform my present relationships' (1985: 221). Therefore, HMMs cannot be detached from the 'emotional investment in existing social configurations and interpersonal relationships and […] agreements about behaviour, political choice, and mutual obligation' (Krantz, 2006: 224). Yet they are caught as middle managers in the managerial first bind to embrace organizational initiatives and pressures emanating from the changing neoliberal market ideologies.

We need to emphasise that our use of ethical resistance is distinct from more common interpretations of resistance as dissent or protest (Piderit, 2000). Building on Piderit, where resistance to change can be considered as multi-dimensional and positive, the role of the HMM generates a context where ethical resistance is more about accommodation; that is, balancing the

triple bind through the HMM's agency, power, and role within the organisational structure. While the HMMs' define their experiences in the form of change management, from an ethical resistance perspective, their narratives instead reveal attempts to manage continuity in the face of mounting uncertainty, contradiction, and paradox (Gosling, 2017).

Our theoretical contribution is thus to extend understanding of the notion of the double bind. We suggest the need for reframing the previous assumptions of the binary tension between professional and managerial roles. The research offered here provides insight to the need to embrace a third aspect that of organisational purpose. Not as an extension of the managerial role, but rather as a narrative rooted in antecedent influence of assumptions and practices revealed through the lens of virtue ethics in the form of telos, and narrative unity (MacIntyre, 2007).

Additionally our theoretical contribution has implications for how we understand resistance within managerial roles. The triple bind illustrates a complex dynamic that HMM are situated within and seek to accommodate. Indeed the pursuit of organisational purpose and sustaining the notion of the narrative unity of what they and their colleagues are seeking to realise provides a richer insight and potentially informative explanation of managerial behaviours.

The importance of exploring this theoretical contribution is to bring new insight to managerial roles and the implications this has for the people who occupy such roles. For example, the narratives explored in this research reveal that managing all three allegiances in HMM work carries a heavy burden in terms of the HMM's wellbeing. The sustainability of the HMM role in the health context, and maybe beyond, is questionable; the personal cost is too great. Yet, given the irreplaceable and invaluable roles these managers play in the larger organisational structure, organisations would struggle to survive without them. Interestingly, Sinnicks (2021: 263) does

focus on practices that are 'excellence-focused' practices and the 'promise of practices to provide us with an understanding of the best work for humankind' and our flourishing. It is precisely this flourishing that the hybrid managers are defending with their ethical resistance. In this way the narratives offer a real sense of these managers knowing deep down not only what is right for their practices but what is right for humankind. The narratives of the HMM make it clear that they do not enjoy their work, it puts their own wellbeing and flourishing in jeopardy, and they risk stress and emotional burn out by performing this work. With the risk of more and more HMMs suffering and leaving their roles, organisations run the risk of jeopardizing their own security if they are not better prepared to protect these valuable employees. Further, organisations risk making the role of HMM so undesirable that the best and most creative workers will avoid pursuing these roles, even if that means forgoing a promotion or increased salary. The stakes are also high for the wider flourishing of society if the stone hiding this conceptual understanding of the HMM work is left unturned.

It is therefore most relevant that our emerging reconceptualization of the 'bind' within managerial work (in particular HMM's) is explored in subsequent research for further theoretical development to inform policy, support practice and wider societal flourishing.

Future Research

With respect to the HMM role, a series of questions emerge from this research: Is ethical resistance and the notion of triple bind limited to the health context? Does the overt practice virtue of healthcare produce a very different manifestation of HMM work contrary to other public-sector contexts where HMMs commonly practice? Examining other professions in the public or third sector may highlight very different experiences of HMM work. The dominance of

neo-liberal policies impacting on the public sector in the UK would suggest we should see a similar set of challenges for HMMs.

Regarding 'pure' managers do they exhibit ethical resistance and experience the triple bind? It might be that the management antecedents of practice and identity have limited identification with, and investment into, an institution's narrative unity, and thus may not be drawn into ethical resistance to protect both the institutional unity and sense of personal identification. Even though senior managers have greater agency than HMMs there may be a similar process of accommodating government policy perceived as in tension with the manager's sense of what is right for the institution.

And finally, from a support and development perspective, what forms of intervention can be undertaken to address well-being for the HMM role? The role of the HMM is critical yet its existence is likely to be under threat. Perhaps the first step is the acknowledgement of the immense tensions that exist and become manifest in ethical resistance, and the HMM behaviour may be often significantly misunderstood.

Conclusion

Little attention has been given to hybrid middle manager work. We have sought to make salient recognition of hybrid middle managers seeking to preserve the organisational purpose that forms the third bind placed on their everyday work. Typically, attention to the hybrid middle manager role is associated with tensions and anxieties of local / team based versus managerial strategic performativity to which historically embedded purpose is most rare. The notion of purpose as the narrative unity that binds all together as pro-social attention is what we see as the third foci of the hybrid middle managers and the tensions they seek to navigate.

It is hoped that this article will stimulate further research to explore the manifestation of practice virtues in hybrid middle manager work in a variety of contexts. Moreover, enabling the notion of the triple bind to become salient may have significant policy implications for the management of health services and other contexts where HMMs are prevalent. Indeed our data and the narratives we have presented show the pressures of HMM work and issues of well-being. There is a striking need for attention to their work and the bind in which they are situated; in a sense making HMM work not just tolerable and sustainable but purposeful. It would be a most sad day if HMMs became an extinct species. Drawing from MacIntrye's notion of 'after virtue' and dystopian predication, it may be that the hegemony of neo-liberal policies will lead to places such as hospitals as places 'after *healthcare* virtue.'

References

Aristotle. (1985). *Nicomachean ethics*, trans. T. Irwin. Indianapolis: Hackett Publishing.

Balogun J (2003) From blaming the middle to harnessing the potential: creating change intermediaries. *British Journal of Management* 14: 69-83.

Balogun J and Johnson G (2005) From intended strategies to unintended outcomes: The impact of change recipient sensemaking. *Organization Studies* 26(11): 1573-1601.

Burgess N and Currie G (2013) The knowledge brokering role of the hybrid middle level manager: The case of healthcare. *British Journal of Management* 24(1): 132-142.

Clarke CA, Brown AD and Hope Hailey V (2009) Working identities? Antagonistic discursive resources and managerial identity. *Human Relations* 62(3): 323-352.

Conroy, M. (2010) *An Ethical Approach to Leading Change: An Alternative and Sustainable Application.* Basingstoke: Palgrave Macmillan.

Currie G and Brown, AD (2003) A narratological approach to processes of organizing in a UK hospital. *Human Relations* 56(5): 563-586.

Currie G. and Procter SJ (2005) The antecedents of middle managers' strategic contribution: The case of a professional bureaucracy. *Journal of Management Studies* 42(7): 1325-1356.

Czarniawska B (1997) *Narrating the organisation: Dramas of institutional identity*. Chicago: UCP.

Fleming P and Spicer A (2003) Working at a cynical distance: implications for power, subjectivity and resistance. *Organisation* 10(1): 157-79.

Floyd SW and Lane PJ (2000) Strategizing throughout the organization: Managing role conflict in strategic renewal. *Academy of Management Review* 25(1): 154-177.

Francis R (2013) *The Mid Staffordshire Foundation Trust Enquiry*. London: The Stationary Office.

Gabriel Y (2000) *Storytelling in organisations: Facts, fictions and fantasies*. London: OUP.

Huy Q (2002) Emotional balancing of organizational continuity and radical change: The contribution of middle managers. *Administrative Science Quarterly* 47: 31-69.

Kirkpatrick, I, Altanlar A and Veronesi, G (2023) Hybrid professional managers in healthcare: an expanding or thwarted occupational interest? *Public Management Review* 25(5): 859-878.

Krantz J (2006) Leadership, betrayal and adaptation. *Human Relations* 59(2): 221-240.

MacIntyre A (1985) *After Virtue: a study in moral theory*. London: Duckworth.

MacIntyre A (1988) *Whose Justice? Which Rationality?* London: Duckworth.

MacIntyre, A. (2007). After virtue (3rd ed.). London: Duckworth.

McCann DP and Brownsberger ML (1990) Management as a social practice: rethinking business ethics after MacIntyre. *Annual of the Society of Christian Ethics* 10: 223-245.

McGivern, G, Currie G, Ferlie E, Fitzgerald L and Waring J (2015) Hybrid manager – professionals' identity work: The maintenance and hybridization of medical professionalism in managerial contexts. *Public Administration* 93(2): 412–432.

Mintzberg H (1973) *The nature of managerial work*. New York: Harper and Row.

Pidd, M. (2005) "Perversity in public service performance measurement", *International Journal of Productivity and Performance Management*, Vol. 54 Issue: 5/6, pp.482-493, doi: 10.1108/17410400510604601.

Piderit, S.K. (2000) Rethinking resistance and recognizing ambivalence: A multidimensional view of attitudes toward an organizational change. *Academy of Management Review*, 25(4): 783-794.

Raes AL, Heijltjes MG, Glunk U, and Roe RA (2011) The interface of the top management team and middle managers: A process model. *Academy of Management Review* 36: 102-126.

Robertson, R. (2016) Six ways in which NHS financial pressures can affect patient care, *The King's Fund Publications.* Accessed on 20/12/17 at https://www.kingsfund.org.uk/publications/six-ways

Sekerka, LE, and Bagozzi, RP (2007) Moral courage in the workplace: Moving to and from the desire and decision to act. *Business Ethics: A European Review 16:* 132-149.

Sims D (2003) Between the millstones: A narrative account of the vulnerability of middle managers' storying. *Human Relations* 56(10): 1195-1211.

Sinnicks, M. (2021) "We ought to eat in order to work, not vice versa": MacIntyre, practices, and the best work for humankind. *Journal of Business Ethics,* 174(2): 263-274.

Waitzberg, R, Gottlieb N, Quentin W, Busse R and Greenberg D (2022) How do managers and physicians reconcile between financial and clinical considerations in hospitals. *International Journal of Health Policy Management* 11(9): 1823-1834.

Willmott H (1993) Strength is ignorance; slavery is freedom: managing cultures in modern organizations. *Journal of Management Studies* 30(4): 515–552.

Table 1: Virtue Clashes in Hybrid Middle Manager Work

Category of Resistance	Example Narrative	Central virtue clash in the story
Epic (successful change story)	***Finding the flow***	leadership education vs. apprenticeship
	Subversive	evidence based management vs. partnership based clinical work
	I'm not having it!	manager decides vs. staff decide
Tragic (suffering loss through change)	***Cuckoo Reform***	doing a good clinical job vs. individual self interest
	Wasted Talent	using skills and talents vs. putting people in boxes
	Nobody to get angry with	Respecting that humans need time and resources to do a good job vs. efficiency measures and effectiveness standards
Comic	***Bite on the bottom***	meeting needs vs. meeting targets
	I shred it	clinician led vs. government led requirements

(entertaining/ farcical/ tragic)	***Gone Shopping***	locally managed case data vs. nationally managed case data
Romantic (showing care or love for another)	***Rose tinted glasses***	caring for people without caring about the cost vs. caring for the cost of caring for people
	My staff need me	management standardisation vs. clinical care
	Just absorb that crap!	buffering staff vs. bullying staff