

Central Lancashire Online Knowledge (CLoK)

Title	The “active struggle” of the hybrid middle manager: exploring the notion of ethical resistance
Type	Article
URL	https://clock.uclan.ac.uk/54316/
DOI	https://doi.org/10.1108/jmd-07-2023-0215
Date	2024
Citation	Conroy, Mervyn, Kempster, Steve and Remke, Robyn (2024) The “active struggle” of the hybrid middle manager: exploring the notion of ethical resistance. <i>Journal of Management Development</i> , 43 (5). pp. 727-739. ISSN 0262-1711
Creators	Conroy, Mervyn, Kempster, Steve and Remke, Robyn

It is advisable to refer to the publisher’s version if you intend to cite from the work.
<https://doi.org/10.1108/jmd-07-2023-0215>

For information about Research at UCLan please go to <http://www.uclan.ac.uk/research/>

All outputs in CLoK are protected by Intellectual Property Rights law, including Copyright law. Copyright, IPR and Moral Rights for the works on this site are retained by the individual authors and/or other copyright owners. Terms and conditions for use of this material are defined in the <http://clock.uclan.ac.uk/policies/>



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

Journal:	<i>Journal of Management Development</i>
Manuscript ID	JMD-07-2023-0215.R2
Manuscript Type:	Original Article
Keywords:	Ethics, Middle management, Narratives, Leadership

SCHOLARONE™
Manuscripts

The 'active struggle' of the hybrid middle manager:

Exploring the notion of ethical resistance

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-employment 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

1
2
3 caregivers and administrators creates a triple bind for which the HMMs must navigate. To study
4 this third bind, we examine narratives of HMMs.
5
6
7

8
9 Our article is structured as follows. First, we explore antagonism in hybrid middle manager work
10 that provides exploration of the double bind and the notion of ethical resistance. Second,
11 MacIntyre's argument for virtue ethics connected to an institutional narrative unity – the
12 organisational purpose – is explored in the context of health care. Third, we outline our research
13 approach using narrative method derived from Czarniawska (1997). The narratives of ethical
14 resistance in the work of these hybrid middle managers are outlined. Fourth, we highlight this
15 manifestation of ethical resistance in hybrid middle manager work and the complexity of our
16 notion of balancing a triple bind. Finally, in our conclusion we discuss the implications for
17 hybrid manager work and issues for health policy
18
19
20
21
22
23
24
25
26
27
28
29

30 **Hybrid Middle Managers: Beyond the double bind**

31
32 Perspectives on the role of middle management have undergone revision over the last decade.
33
34 Moving from the oft cited narrative of middle managers as intransigent and resistant to change,
35 the inertia in the system 'to be co-opted, side-lined or disposed of' (Huy, 2002: 32); and to a role
36 that mediates sense-making of organizational purpose, direction and desired outcomes (Balogun
37 & Johnson, 2005). Rather than seeing middle managers as a block, middle managers have been
38 shown to be a significant asset (see for example: Floyd & Lane, 2000; Huy, 2002; Mantere,
39 2008; Raes, Heijltjes, Glunk & Roe, 2011).
40
41
42
43
44
45
46
47
48
49
50

51 The vertical role of middle management (Raes et.al., 2011) reflect a structural dynamic of middle
52 managers as a 'linchpin between the strategic apex and the operating core, supplying information
53
54
55
56
57
58
59
60

1
2
3 upwards and consuming decisions passed downwards' (Balogun, 2003: 70). Floyd and Lane
4
5 (2000) assert that middle managers should not be seen as 'passive objects whose role can be
6
7 manipulated by the organization for its own ends' (2000: 155). Rather they emphasize a role of
8
9 'championing, facilitating, synthesizing and implementing – focus on communicating
10
11 information between the operating and top levels of management' (2000: 158). Mantere (2008)
12
13 broadens middle manager agency as 'an individual's capacity to have a perceived effect upon the
14
15 individual's work on an issue an individual regards as beneficial to the interests of his or her
16
17 organization' (298); a sense of protecting the organizations interests and purpose through
18
19 discourse framing. Yet such framing discourse is situated in a context of complexity and
20
21 vulnerability to the precarious position of being in the middle (Currie & Procter, 2005). Sims
22
23 (2003) has explored the vulnerability of middle managers. He suggested middle managers face a
24
25 complex task of sense-making through story-telling between vertical relationships with direct
26
27 reports and senior managers. Sims describes a third audience, the self, and the often
28
29 incommensurable task to align the three different sense-making narratives with an integrative
30
31 sense of purpose. Such incommensurability is likely to generate further tension and stress within
32
33 the context of a HMM in light of the triple bind we have outlined.
34
35
36
37
38
39
40

41 It is important to note that middle managers routinely take on a variety of roles. Rather than
42
43 seeing a middle manager as a 'pure play' – someone who identifies closely with being a manager
44
45 – Burgess and Currie suggest the 'hybrid' middle managers often dominate the management
46
47 population (2013: 134). A hybrid reflects a person that is 'skilled in an alternative profession'
48
49 (2013: 134). From a strategic perspective, they can look both ways: towards the senior manager
50
51 big picture which requires an understanding and engagement with operational detail and the
52
53 ability to translate the abstract organisational vision into a realizable endeavor. In addition,
54
55
56
57
58
59
60

1
2
3 HMM can also look towards the caring medical practitioner who prioritizes patient care and
4 healing and draws on medical/scientific knowledge to guide her practices. These managers then
5 are pivotal in the organizational structure regarding the emergence and realization of strategy.
6
7 However, what has not been explored is how virtue within the work of the HMM plays out in
8 this pivotal role. How for example does professional socialization and the virtues contained
9 within such socialization impact on their work?
10
11
12
13
14
15
16
17

18 Debates examining the hybrid middle manager have not addressed the notion of virtue within
19 their workplace practices and role. For example, Currie & Procter (2005) highlight the agency of
20 the middle manager and the associated insecurities of the role, but view such through a
21 functionalist lens associated with planning, performance and measurement. Similar research is
22 reflected in the work of McGivern et al (2015). They identified two primary HMM identities –
23 incidental and willing – and how these HMM managed these identities. The incidental HMM's
24 held management at arm's length protecting the professional identity; the willing HMM
25 embraced the notion of the management rational for rationalizing health care for the greatest
26 good. Despite limited exploration of role tensions, the professionally unattractive nature of
27 hybridization is highlighted: 'managerialism [and] being accused of selling out, or turning to the
28 dark side' (2015: 425). Related research connected with HMM work in the health sector
29 identified tensions between clinical and economic considerations (Waitzberg et al, 2022). They
30 offer up the notion of dual agency for all professions – managers and clinicians – as a means for
31 reconciling the economic and clinical misalignment. Although not explicit, their work points to
32 alignment by making explicit the tensions. The recent work of Kirkpatrick, Altanlar and
33 Veronesi (2023) highlights issues associated with static and sometimes declining HMM numbers
34 in the health sector compared to the growth of HMMs in other sectors and questioning why that
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 might be. They encourage the need for qualitative research to explore underlying aspects shaping
4 the lived experience of being a HMM in the health sector.
5
6

7
8
9 We seek to offer up a new lens through which to examine HMM work by drawing on the work
10 of MacIntyre's (1985) institutional narrative based practice virtue ethics – a neo-Aristotelean
11 perspective – to look at the triple bind they find themselves in the middle of and how they seek
12 to function. That is to fulfil their duty of care the first bind, but also adopt a commitment to
13 effectiveness or efficiency to ensure that the hospital remains financially solvent and therefore
14 sustainable, the second bind; and a third bind associated with organisational purpose and the
15 Aristotelian notion of narrative unity, which we examine next.
16
17
18
19
20
21
22
23
24
25

26 **Virtue ethics and narrative unity aligned with organisational purpose**

27

28
29 Drawing from (MacIntyre 1985), virtue is a behavioral disposition (or quality of character) to act
30 towards practice excellence in a variety of situations. Because of its orientation to practice,
31 virtues are culturally based. A person's virtues disposition draws upon a deep rooted and
32 complex multilevel relationship with values, emotions, interests, attitudes and expectations. The
33 HMMs in this study developed their commitment and pursuit of excellent health care practices
34 from the antecedents of their own virtue dispositions; this is then refined through moral debate
35 within their own practice based community (MacIntyre 1985) e.g. social services, medical
36 professions, and police services. Thus the virtues disposition of the HMM was to a duty to health
37 care, which prioritized the needs of their patients and other relevant stakeholders in specific
38 communities. For example, the HMMs' community is health and social care mental health
39 services. Prior to moving into management, the HMMs had invested themselves in clinical work
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 through a commitment to developing skills in enabling mental health care, choices of where to
4 work, who to work with, where to work and how the work should be done.
5
6

7
8
9 The virtues disposition of health care HMMs can become manifest as a felt sense of *eudaimonia*
10 through their work because the delivery of healthcare excellence is connected to an ongoing
11 narrative as a shared sense of purpose or *telos* (Aristotle, 1985). For McCann & Brownsberger,
12 (1990: 227–228) ‘the overriding good’ is in the form of a shared *telos* or quest. For example, in
13 the British healthcare context, Robertson (2016) argues that financial pressures can affect patient
14 care. Community *telos* (purpose) allows members (such as HMM’s) to both contribute to and
15 develop their own sense of what MacIntyre describes as a narrative quest – their personal
16 journeys towards a meaningful purpose. The personal narrative quest is part of a larger dynamic
17 namely a narrative unity – which is of significance to this research. The narrative unity
18 encompasses the following three interconnect elements: the narrative quests of the community of
19 practitioners; the continuing investment of each member in their practice virtue disposition; and
20 the generation of virtue outcomes (such as excellent health care) that are thus integral to a
21 community’s narrative unity (MacIntyre 1985).
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39

40 An intervention that seeks to break this narrative unity, such as a movement from health care in
41 favour of effectiveness or efficiency (for example, management targets such as patient waiting
42 lists or funding pressures), may generate perversion (Pidd, 2005) or virtues betrayal (Krantz,
43 2006); or corruptions to the institutional narrative unity. Our notion of ethical resistance (that we
44 shall show drawn from our data) captures this sense of protecting the individual’s narrative quest
45 and protecting historic institutional narrative unity that encompasses the organisation’s *telos*, and
46 virtues practices. For the HMM this represents their past as clinicians and why they chose to
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 work in health care in the first place. From a more recent perspective, Sinnicks (2021: 263)
4 draws on MacIntyre to suggest ‘we reflect on the best forms of work so that we can strive to
5 ensure the very best activities’ which support our flourishing in the world. Therefore, their role
6 as a HMM was not to push through the breakup of the narrative unity, but to sustain the narrative
7 by bridging any gaps that emerge. Protecting the narrative unity and their narrative quest in the
8 connected virtuous endeavour of excellence in healthcare becomes manifest as the notion we
9 shall develop of ethical resistance.
10
11
12
13
14
15
16
17
18
19

20 For purposes of clarity when we speak here of professional and managerial practices we mean:
21 professional as complex socialized activity (MacIntyre, 2007: 187) reflecting expectations and
22 assumptions, skills, standards and codes of conduct of the profession adapted in a particular
23 context; in this case that of health care. When we speak of management, we seek to reflect an
24 organizational set of management functions and drawing on Mintzberg (1973) – decisional,
25 informational, and interpersonal.
26
27
28
29
30
31
32
33
34

35 We next outline our methodology to explore and reveal the active struggle of HMM’s.
36
37

38 **Methodology**

39
40
41
42 The central research question is: How do hybrid middle managers undertake their dual roles and
43 address conflicting professional and managerial practices alongside the pursuit of organisational
44 purpose? The context from which we examine HMM work is that of the UK National Health
45 Service (NHS).
46
47
48
49
50

51 **Participants and Data Collection**

1
2
3 The research site was gained by one of the authors who was working as a clinician in
4 psychological services within the mental health provider arm of an NHS Trust. With the
5 approval of the Trust CEO access was given to the Trust Mental Health managers.
6
7
8
9

10
11 The ages of the HMM in this study ranged from early thirties to late fifties, a mix of genders and
12 with lengths of service ranging from five to thirty years. They were from a range of different
13 hospital inpatient and outpatient wards and community services. The main fieldwork consisted of
14 in-depth lightly-structured interviews with a total of thirty-eight managers over a period of
15 twelve months. Seventeen of the thirty-eight were interviewed twice to add a longitudinal
16 component to the study. All the managers interviewed were leading the implementation of a
17 range of government and local change initiatives with the aim of improving mental health
18 services. The interviews sought to collect narratives based on their experiences of leading
19 organizational change. On average the interviews were sixty minute in length and with the
20 permission of the respondent interviews were recorded and transcribed.
21
22
23
24
25
26
27
28
29
30
31
32
33

34 35 **Narrative Analysis**

36
37
38
39 Following data capture the interviews were condensed into narratives by initially using the
40 categories defined by Gabriel (2000) as epic, tragic, comic and romantic and then further
41 categorised into stories, themes and a serial (Czarniawska 1997).
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

Insert Table 1 about here

1
2
3 In the first column we see the poetic modes from Gabriel (2002), in the second column are the
4 titles given to the narratives analysed and in the third column provides the clash of virtues
5 conveyed in the narratives.
6
7
8
9

10
11 The final stage of the three-way synthesised narrative approach incorporated Boje's (2001)
12 notion of 'antenarrative' to include pre-employment elements. A full and detailed description of
13 this novel approach can be found in ([author details withheld for purposes of review]).
14
15
16
17

18
19 These condensed narratives were presented to mental health service managers across the region
20 to ensure these represented their social reality. Two focus groups were undertaken with (70 and
21 51 respectively – forming two management development events) and they were asked the
22 question: How closely do the findings compare with your experience? The focus groups were
23 structured to allow the managers to comment on the narratives. These 8 extracted quotes capture
24 the essence of the affirmed strong verisimilitude: #1 - *'This is so refreshing – for the first time*
25 *someone has articulated what it is like for us to be on the front line of change in the NHS.* #2 -
26 *'Exactly right.'* #3 - *'That is just how it is for us.'* #4 - *'It is nice to know that others feel the*
27 *same.'* #5 - *'I can identify with the stories.'* #6 *'That's it that's how it is for us.'* #7 *'I think you*
28 *have captured it very well.'* #8 - *'I think you have got the breadth of experiences just right'* ([p.
29 239: published reference withheld for review purposes]).
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45

46 Findings

47
48

49 Strikingly the narratives all had a common overarching theme, that of ethical resistance. The four
50 example narratives below use much of the participant's original language. However, it needs to
51 be noted that these have been edited, but such editing is only for length and clarity. The full set
52
53
54
55
56
57
58
59
60

1
2
3 of unabridged narratives can be found in [published reference withheld for review purposes]: 99-
4
5 160). We begin with an example of ethical resistance as wary compliance.
6
7

8
9 ***Narrative #1) Cuckoo Reform: Ethical resistance as these changes are damaging people***
10

11
12 As a service manager in my mid-forties, I've seen a lot of changes in the way healthcare
13 functions. And, some of those changes have been for the greater good of the organisation
14 and society. And, I get that work is hard – that is okay. I like to work hard. No one goes
15 into healthcare because it is easy – or for the money for that matter. I do what I can to take
16 care of myself – I work out at the gym, I do my best to eat healthily, and I even make sure
17 to take all my holiday time. But, lately, I don't know, this is just different. This new NSF is
18 harder. Before, with other organisational changes, I felt like I was a bridge between the
19 organisation and my staff. I actually felt quite important – quite powerful. I could help
20 make the change possible by bridging the new initiatives and my staff, making their job
21 easier. But, this time, well, this new framework is different. It isn't just the new
22 framework. It feels like the entire organisation is changing – taking over. It reminds me of
23 a cuckoo bird who lays her eggs in other birds' nests. The organisation is leaving me with
24 all the hard work – It's like I have to raise this new baby bird that isn't even mine. And, the
25 baby cuckoos are putting stress and strain on the rest of the nest. My staff cannot take the
26 extra work – the extra time. So, I feel like a foster mom who has to raise someone else's
27 kids. I am trying to take care of my staff while also implementing this new initiative for the
28 higher ups [senior management] – Sue.
29
30
31
32

33 Sue is utterly committed to making sure the implementation of the new initiative is successful –
34
35 or at least as successful as possible. However, her narrative reveals a tension between
36
37 accomplishing the change initiative and the negative consequences of that change. Moreover,
38
39 this tension is not a mere inconvenience, this is a deeply personal and emotional burden that
40
41 wears on Sue's stamina and personal health. Her narrative offers clear insight into the personal
42
43 tensions and emotions manifest as a consequence of her virtue ethics disposition towards
44
45 providing quality clinical care for her patients and responsible management for her employees
46
47 while trying to implement the new initiative. The cuckoo (representing the UK Government's
48
49 change programme ('Agenda for Change') has been implanted into the nest (the work) and is
50
51 throwing out the eggs (the internal goods of health care) produced by the collective practice
52
53
54
55
56
57
58
59
60

1
2
3 virtues of Sue and her colleagues. The use of the cuckoo as a metaphor to describe the parasitic
4 nature of the programmatic demands reveal the unintended stress the initiative places on her staff
5 – the ‘nest.’ As she explains, the ‘nest’ feels the strain as she has to devote energies and
6 resources towards the unanticipated (unwanted?) guest (the cuckoo). Willmott’s (1993) concept
7 of the colonisation of subjectivities becomes relevant here. The cuckoo lays its egg in a strange
8 bird’s nest knowing that when the nest-owning bird returns she will raise the cuckoo chick as her
9 own. Only when the chick grows into a cuckoo is the damage of individual selfishness inflicted
10 as the imposter throws the rightful offspring out of the nest. The modernisation and managerial
11 programme of change chimed with one of Sue’s allegiances at first – just another government
12 initiative. However, later, the damage of ideological individualism comes to light, and for Sue,
13 the tragedy in terms of the impact on her well-being unfolds.
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29

30 Sue also uses the metaphor of the bridge. In her role as a hybrid manager she had been able to
31 accommodate the institutional demands alongside historic practices. In a sense, tensions were
32 accommodated because the institution is broadly aligned with the clinical orientation. However,
33 the insatiable demands of the cuckoo for organizational efficiencies and changes to meet
34 imposed government initiatives and targets (external goods) have led Sue to question her resolve
35 and grow wary in her persistence. She is finding it more difficult to maintain and sustain the
36 narrative unity representing excellence of clinical care.
37
38
39
40
41
42
43
44
45
46

47 More traditional or obvious forms of resistance would have Sue respond to the contradictory
48 nature of the new programme initiatives with refusal, rejection, or even sabotage. However,
49 because Sue is committed to the larger narrative unity, she warily complies with the programme
50 requirements and does her best to sustain her own employees and their patients. Sue does enough
51
52
53
54
55
56
57
58
59
60

1
2
3 to accommodate the broader strategic initiative in a manner that sustains the historic sense of
4 narrative unity.
5
6

7
8
9 The second story illustrates Jane's covert ethical resistance to protect the narrative unity through
10 diversion.
11
12

13
14 ***Narrative #2) Subversive: Ethical resistance as paying lip service but doing things your own***
15 ***way as we know best***
16
17

18 I wouldn't say it was diversion, although I guess, now that I say it, it does sound rather
19 'alternative.' In my experience as a senior manager, sometimes my role is to create pathways
20 – rivers or currents – that aren't always apparent at first glance to help achieve whatever is
21 most important. In this case, it started off as an interest in mood disorders. An outpatient
22 nurse wanted to change her position for a more challenging role. After talking with her for a
23 bit I discovered that we shared common goals. We came to realize that there are other like-
24 minded people in the hospital, so we got together a group of people who had no common
25 base, apart from their interest in mood disorders. The group was rather diverse because we
26 came from several different places within the hospital. But, we eventually became a coherent
27 little group with ideas on how to develop better services for people with mood disorders. We
28 wanted to establish better practices to make sure clinicians who had specific skills were able
29 to use them where and when necessary. And, we were very keen to develop a partnership
30 style of working. I think what we all had in common was that we saw our clinical work
31 rooted in partnership with patients, clients, or whatever we personally called them and we
32 wanted our service to develop in ways that honored those partnerships. Eventually we were
33 invited to become part of the Clinical Governance Development Programme [CGDP], which
34 is part of this larger Agenda for Change. The CGDP included six days of training, which
35 wasn't all that useful. But, more than that, the training gave us the space and time out of the
36 hospital to meet up, plan out what we were doing and to achieve various steps on the way
37 towards our goal. I guess you could say we were a bit bad because we sat and listened to the
38 presentations from the CGDP managers and were given tasks to complete for the
39 programme, but we then just went and did our own thing – Jane.
40
41
42
43

44 For this manager 'rivers,' and 'currents' convey what it means to be leading organizational
45 change. Jane comments that she has been deliberate in setting up her own covert current to
46 achieve a better outcome with other like-minded clinical managers. They believe their approach
47 is more useful or relevant than the new programme initiative. Her approach is divergent because
48 she creates an alternative process – a form of covert rebellion that offers a parallel methodology
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 to the official programme processes. She recognizes the conflict of approaches between the
4 programme initiative and her own model, but rather than overtly seeking to persuade senior
5 managers of her alternative ways forward, she and her colleagues just set about doing their
6 alternative approach as a quicker and better way than that suggested by the programme initiative.
7
8 Their alternative method reflects their shared commitment to viewing their work as a partnership
9 with their patients. In part, these actions help to sustain the collective pursuit of the narrative
10 unity – patients as partners; and it drove them to divert their energies away from the official
11 programme towards their covert, alternative approach.
12
13
14
15
16
17
18
19
20
21
22

23 The ethical resistance we identify in this divergent narrative reflects a response to the efficiency-
24 oriented management approach of the programme initiative, which clashes with the historic
25 clinical based practice that Jane and her colleagues prefer. Although Jane is a hybrid manager,
26 she does not seek to resolve the clash through conversation with her peer managers. Rather she is
27 covert in her resistance towards the Agenda for Change. She seeks to provide alternative
28 pathways or options for the partnership-based ‘clinical’ stance where different clinical
29 practitioners come together to debate how best to act in any given situation and include the
30 patient and their experience/story in that mix. The virtue ethics encapsulated here is Jane’s
31 disposition to activity that is congruent with her own purpose, her narrative quest, which is
32 aligned with her colleagues of sustaining the narrative unity of pursuing health care excellence.
33
34 Their collective interpretation of achieving this is through practice virtues that generate the
35 internal good of clinical excellence.
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50

51 The next form of ethical resistance – subversion – also offers an alternative approach, in a
52 similar covert fashion.
53
54
55
56
57
58
59
60

1
2
3 ***Narrative #3) I shred it: Ethical resistance as deciding ourselves what is important and only***
4 ***responding when chased***
5
6

7 Well, this won't win me any awards for good behaviour, but my new strategy to deal with
8 the endless bureaucratic requests for documentation and paperwork is to play forgetful.
9 Normally I am very good at keeping track of details – it's what makes me a good service
10 manager and mental health clinician. But, lately, all these new requirements to documents
11 EVERYTHING is out of control. It is too much. And, it completely stresses out my staff. If
12 they followed every new rule and processed every piece of paperwork, and filled out every
13 required form, they would never work with any patients! So, my new, slightly naughty
14 strategy is to put the requests on my desk – I have a huge pile of them – and I just leave
15 them. Or, I may even put the request underneath other paperwork. And, I figure, if no one
16 comes looking for that particular form, or requests that particular bit of paperwork, then I
17 just eventually shred the documents and move on. If no one misses the paperwork than it
18 must not have been all that important to begin with. And, we are all better able to do our
19 jobs – Tim.
20
21
22

23 Tim's narrative is similar to Sue's story in the ways he attempts to serve as a bridge between the
24 bureaucratic demands of the Agenda for Change and the historic clinical practice seeking health
25 care excellence. He is able to use his hybrid middle manager role to give him scope to adopt a
26 process of *not* addressing the organizational requirements because he sees this as having the
27 effect of diminishing excellence in health care. However, Tim's narrative is dissimilar to Sue,
28 but like Jane, in the sense that he is manages do the work that he believes is important – clinical
29 care for patients and responsible management for his employees – but avoids the bureaucratic
30 paperwork associated with the new programme initiative that he believes to be unimportant.
31
32 Tim's resistance is oriented towards the long term in that he hopes that, eventually, the new
33 programme work will go away. In this sense, Tim's resistance is more classical in that he is
34 avoiding doing the new tasks assigned to him. However, unlike more public forms of resistance
35 that are designed to solicit a response from management (i.e. more traditional work stoppages
36 like strikes and boycotts), Tim's work stoppage is covert and subversive. His hope is that the
37 supporters of the new programme will not notice that certain elements of the change are not
38 implemented, thus freeing Tim to ignore them completely.
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 The final narrative illustrates ethical resistance as a form of deflection.
4
5

6 ***Narrative #4) My staff need me: Ethical resistance as being there emotionally for your staff***
7

8
9 Sorry – I didn't mean to cry. I am just really tired – and a bit sick. I have a cold I cannot shake.
10 Sorry -- It's just been a long few months. This new initiative – Agenda for Change – is really
11 stressing me out. Which, is weird. I am a Ward Manager – I am used to stressful situations. But,
12 usually the stress comes from handling a difficult patient, or, occasionally, a stressed out
13 employee. But, this is different. This new program is so micro-managed. I've never seen so
14 many forms that have to be completed! So much bureaucracy! Seriously. It is impossible. Every
15 position has to be evaluated. Every staff member given a new job description. And, with the
16 constant threat of redundancies, hour reductions, which really means a pay cut, and relocations
17 of staff – everyone is on edge because they are worried about their own job security and financial
18 stability. I wish I could just leave – and I guess I could. I could go out on sick and stress leave.
19 It's my right. But, then where would that leave my group? They would have to deal with all this
20 on top of their patients. This isn't their fault. They are just trying to do their best to do their jobs.
21 It isn't their job to deal with all this new bureaucracy. If I go, who will be here to protect them?
22 They will end up all stressed like me and that could jeopardize the safety of the patients. But, to
23 be honest, if it were not for my staff needing me I would have gone off sick... definitely. [pause]
24 I will be fine – I just keep telling myself that [chuckles to self] and occasionally I slip into the
25 closet for a bit of a cry – Pat.
26
27
28

29
30 Pat's narrative highlights the emotional strain created by the programme changes. Pat described
31 needing to take time off and recover from her stress-induced illnesses, but she felt obligated to
32 stay and care for her staff. Her concern for her employees outweighed her ability to care for her
33 own personal needs: 'If it were not for my staff needing me I would have gone off sick
34 definitely.' Telling her story of the dilemma she felt inside brings tears to this manager's face.
35 She felt that if she took time off sick then her staff would not be able to avail themselves of her
36 support, which would leave them feeling completely demoralized. The tears convey how she felt
37 for her staff during this period; she wanted to care for them because they were caring for
38 vulnerable patients on the ward but the cost to her personally was significant (such moral
39 courage echoed in Sekerka and Bagozzi, 2007). This kind of loyalty to staff by managers and to
40 managers by staff came through strongly in the stories told within the context of organizational
41 change.
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 Pat, and many others, described outcomes of Agenda for Change with some staff winning
4 financially, while others had their jobs downgraded and lost out financially. The programme set
5 up employees in competition with each other and created fear, anxiety and mistrust. Pat was
6 caught in a paradox and conflict of roles. She saw her role as manager to enable the process – so
7 staff did not miss out on programme benefits – and at the same time her role to protect the staff.
8
9 In this way, the notion of an institutional narrative unity to achieving internal goods of
10 excellence of health care was being undermined by Agenda for Change’s orientation to external
11 goods (rewards and promotion). Pat sought to sustain these internal goods by attending to the
12 needs of the staff. Yet, at the same time, she implemented the new policies of Agenda for
13 Change so that her staff were not disadvantaged. However, Pat’s story isn’t a story of mere
14 protection – she deflects the encroachment of the new programme (and its negative outcomes).
15 She serves as a barrier who is able to neutralize the detrimental initiatives while still empowering
16 her staff to continue with their commitment to care. She does not have to do this. Pat engages in
17 ethical resistance because she could, in good conscience, explain to her staff that these negative
18 outcomes are not her idea and is, therefore, not responsible. However, because of her virtue ethic
19 disposition of care, a disposition that gives priority to others over herself, she positions herself as
20 a shield that deflects the negative changes, even when it costs her own mental and physical
21 health.

22 Discussion

23
24 The examination of the work of HMM through the lens of virtue ethics has highlighted the
25 presence of ‘ethical resistance’ (Conroy, 2010: 220) as a process of seeking to ‘protect
26 [institutional] practices from being corrupted.’ The four narratives of ‘ethical resistance’, which

1
2
3 are connected by an underlying set of aligned practice virtues, seek to help achieve the
4
5 overriding good – wellbeing for all in the community. This is set against perceived notions of
6
7 corrupting influence on the managers' working lives (Fleming and Spicer, 2003). The narratives
8
9 point to 'ethical resistance' of HMMs engaging in a covert and complex discursive struggle to
10
11 manage and balance the competing demands of a triple bind: attentive to the management and
12
13 organizational requirements, responsive to colleagues and professional identities, and
14
15 commitment to the institutional purpose – narrative unity. Framing this triple bind within the
16
17 NHS context and through MacIntyrean language, the strategic neo-liberal revision acts as a
18
19 brutal change to the institutional collective telos and sense of narrative unity. The ethical virtues
20
21 resistance captures the HMMs' struggle as they 'quest to (re)author their selves as moral beings'
22
23 (Clarke et. al., 2009: 323) to protect the organisation's narrative unity and protect themselves.
24
25 MacIntyre explains that, 'the story of my life is always embedded in the stories of those
26
27 communities from which I derive my identity. I am born with a past and to try to cut myself off
28
29 from that past in the individualistic mode is to deform my present relationships' (1985: 221).
30
31 Therefore, HMMs cannot be detached from the 'emotional investment in existing social
32
33 configurations and interpersonal relationships and [...] agreements about behaviour, political
34
35 choice, and mutual obligation' (Krantz, 2006: 224). Yet they are caught as middle managers in
36
37 the managerial first bind to embrace organizational initiatives and pressures emanating from the
38
39 changing neoliberal market ideologies.
40
41
42
43
44
45
46
47

48 We need to emphasise that our use of ethical resistance is distinct from more common
49
50 interpretations of resistance as dissent or protest (Piderit, 2000). Building on Piderit, where
51
52 resistance to change can be considered as multi-dimensional and positive, the role of the HMM
53
54 generates a context where ethical resistance is more about accommodation; that is, balancing the
55
56
57
58
59
60

1
2
3 triple bind through the HMM's agency, power, and role within the organisational structure.

4
5 While the HMMs' define their experiences in the form of change management, from an ethical
6
7 resistance perspective, their narratives instead reveal attempts to manage continuity in the face of
8
9 mounting uncertainty, contradiction, and paradox (Gosling, 2017).
10
11

12
13 Our theoretical contribution is thus to extend understanding of the notion of the double bind. We
14
15 suggest the need for reframing the previous assumptions of the binary tension between
16
17 professional and managerial roles. The research offered here provides insight to the need to
18
19 embrace a third aspect that of organisational purpose. Not as an extension of the managerial role,
20
21 but rather as a narrative rooted in antecedent influence of assumptions and practices revealed
22
23 through the lens of virtue ethics in the form of telos, and narrative unity (MacIntyre, 2007).
24
25
26

27
28 Additionally our theoretical contribution has implications for how we understand resistance
29
30 within managerial roles. The triple bind illustrates a complex dynamic that HMM are situated
31
32 within and seek to accommodate. Indeed the pursuit of organisational purpose and sustaining the
33
34 notion of the narrative unity of what they and their colleagues are seeking to realise provides a
35
36 richer insight and potentially informative explanation of managerial behaviours.
37
38
39

40
41 The importance of exploring this theoretical contribution is to bring new insight to managerial
42
43 roles and the implications this has for the people who occupy such roles. For example, the
44
45 narratives explored in this research reveal that managing all three allegiances in HMM work
46
47 carries a heavy burden in terms of the HMM's wellbeing. The sustainability of the HMM role in
48
49 the health context, and maybe beyond, is questionable; the personal cost is too great. Yet, given
50
51 the irreplaceable and invaluable roles these managers play in the larger organisational structure,
52
53 organisations would struggle to survive without them. Interestingly, Sinnicks (2021: 263) does
54
55
56
57
58
59
60

1
2
3 focus on practices that are ‘excellence-focused’ practices and the ‘promise of practices to
4 provide us with an understanding of the best work for humankind’ and our flourishing. It is
5 precisely this flourishing that the hybrid managers are defending with their ethical resistance. In
6 this way the narratives offer a real sense of these managers knowing deep down not only what is
7 right for their practices but what is right for humankind. The narratives of the HMM make it
8 clear that they do not enjoy their work, it puts their own wellbeing and flourishing in jeopardy,
9 and they risk stress and emotional burn out by performing this work. With the risk of more and
10 more HMMs suffering and leaving their roles, organisations run the risk of jeopardizing their
11 own security if they are not better prepared to protect these valuable employees. Further,
12 organisations risk making the role of HMM so undesirable that the best and most creative
13 workers will avoid pursuing these roles, even if that means forgoing a promotion or increased
14 salary. The stakes are also high for the wider flourishing of society if the stone hiding this
15 conceptual understanding of the HMM work is left unturned.

16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34 It is therefore most relevant that our emerging reconceptualization of the ‘bind’ within
35 managerial work (in particular HMM’s) is explored in subsequent research for further theoretical
36 development to inform policy, support practice and wider societal flourishing.

37 38 39 40 41 42 **Future Research**

43
44
45
46 With respect to the HMM role, a series of questions emerge from this research: Is ethical
47 resistance and the notion of triple bind limited to the health context? Does the overt practice
48 virtue of healthcare produce a very different manifestation of HMM work contrary to other
49 public-sector contexts where HMMs commonly practice? Examining other professions in the
50 public or third sector may highlight very different experiences of HMM work. The dominance of
51
52
53
54
55
56
57
58
59
60

1
2
3 neo-liberal policies impacting on the public sector in the UK would suggest we should see a
4 similar set of challenges for HMMs.
5
6

7
8
9 Regarding 'pure' managers do they exhibit ethical resistance and experience the triple bind? It
10 might be that the management antecedents of practice and identity have limited identification
11 with, and investment into, an institution's narrative unity, and thus may not be drawn into ethical
12 resistance to protect both the institutional unity and sense of personal identification. Even
13 though senior managers have greater agency than HMMs there may be a similar process of
14 accommodating government policy perceived as in tension with the manager's sense of what is
15 right for the institution.
16
17
18
19
20
21
22
23
24
25

26 And finally, from a support and development perspective, what forms of intervention can be
27 undertaken to address well-being for the HMM role? The role of the HMM is critical yet its
28 existence is likely to be under threat. Perhaps the first step is the acknowledgement of the
29 immense tensions that exist and become manifest in ethical resistance, and the HMM behaviour
30 may be often significantly misunderstood.
31
32
33
34
35
36
37
38

39 **Conclusion**

40
41
42 Little attention has been given to hybrid middle manager work. We have sought to make salient
43 recognition of hybrid middle managers seeking to preserve the organisational purpose that forms
44 the third bind placed on their everyday work. Typically, attention to the hybrid middle manager
45 role is associated with tensions and anxieties of local / team based versus managerial strategic
46 performativity to which historically embedded purpose is most rare. The notion of purpose as the
47 narrative unity that binds all together as pro-social attention is what we see as the third foci of the
48 hybrid middle managers and the tensions they seek to navigate.
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 It is hoped that this article will stimulate further research to explore the manifestation of practice
4 virtues in hybrid middle manager work in a variety of contexts. Moreover, enabling the notion of
5 the triple bind to become salient may have significant policy implications for the management of
6 health services and other contexts where HMMs are prevalent. Indeed our data and the narratives
7 we have presented show the pressures of HMM work and issues of well-being. There is a
8 striking need for attention to their work and the bind in which they are situated; in a sense
9 making HMM work not just tolerable and sustainable but purposeful. It would be a most sad day
10 if HMMs became an extinct species. Drawing from MacIntyre's notion of 'after virtue' and
11 dystopian predication, it may be that the hegemony of neo-liberal policies will lead to places
12 such as hospitals as places 'after *healthcare* virtue.'

21 **References**

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

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

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

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

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

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

- 1
2
3 Currie G and Brown, AD (2003) A narratological approach to processes of organizing in a UK
4 hospital. *Human Relations* 56(5): 563-586.
5
6
7
8
9 Currie G. and Procter SJ (2005) The antecedents of middle managers' strategic contribution: The
10 case of a professional bureaucracy. *Journal of Management Studies* 42(7): 1325-1356.
11
12
13
14 Czarniawska B (1997) *Narrating the organisation: Dramas of institutional identity*. Chicago:
15 UCP.
16
17
18
19
20 Fleming P and Spicer A (2003) Working at a cynical distance: implications for power,
21 subjectivity and resistance. *Organisation* 10(1): 157-79.
22
23
24
25
26 Floyd SW and Lane PJ (2000) Strategizing throughout the organization: Managing role conflict
27 in strategic renewal. *Academy of Management Review* 25(1): 154-177.
28
29
30
31
32 Francis R (2013) *The Mid Staffordshire Foundation Trust Enquiry*. London: The Stationary
33 Office.
34
35
36
37 Gabriel Y (2000) *Storytelling in organisations: Facts, fictions and fantasies*. London: OUP.
38
39
40 Huy Q (2002) Emotional balancing of organizational continuity and radical change: The
41 contribution of middle managers. *Administrative Science Quarterly* 47: 31-69.
42
43
44
45
46 Kirkpatrick, I, Altanlar A and Veronesi, G (2023) Hybrid professional managers in healthcare:
47 an expanding or thwarted occupational interest? *Public Management Review* 25(5): 859-
48 878.
49
50
51
52
53
54 Krantz J (2006) Leadership, betrayal and adaptation. *Human Relations* 59(2): 221-240.
55
56
57
58
59
60

1
2
3 MacIntyre A (1985) *After Virtue: a study in moral theory*. London: Duckworth.

4
5
6 MacIntyre A (1988) *Whose Justice? Which Rationality?* London: Duckworth.

7
8
9
10 MacIntyre, A. (2007). *After virtue* (3rd ed.). London: Duckworth.

11
12
13 McCann DP and Brownsberger ML (1990) Management as a social practice: rethinking business
14 ethics after MacIntyre. *Annual of the Society of Christian Ethics* 10: 223-245.

15
16
17
18
19 McGivern, G, Currie G, Ferlie E, Fitzgerald L and Waring J (2015) Hybrid manager –
20 professionals' identity work: The maintenance and hybridization of medical
21 professionalism in managerial contexts. *Public Administration* 93(2): 412–432.

22
23
24
25
26
27 Mintzberg H (1973) *The nature of managerial work*. New York: Harper and Row.

28
29
30
31 Pidd, M. (2005) "Perversity in public service performance measurement", *International*
32 *Journal of Productivity and Performance Management*, Vol. 54 Issue: 5/6, pp.482-493,
33 doi: 10.1108/17410400510604601.

34
35
36
37
38
39 Piderit, S.K. (2000) Rethinking resistance and recognizing ambivalence: A
40 multidimensional view of attitudes toward an organizational change. *Academy of*
41 *Management Review*, 25(4): 783-794.

42
43
44
45
46
47 Raes AL, Heijltjes MG, Glunk U, and Roe RA (2011) The interface of the top management team
48 and middle managers: A process model. *Academy of Management Review* 36: 102-126.

- 1
2
3 Robertson, R. (2016) Six ways in which NHS financial pressures can affect patient care, *The*
4 *King's Fund Publications*. Accessed on 20/12/17 at
5 <https://www.kingsfund.org.uk/publications/six-ways>
6
7
8
9
10
11 Sekerka, LE, and Bagozzi, RP (2007) Moral courage in the workplace: Moving to and from the
12 desire and decision to act. *Business Ethics: A European Review* 16: 132-149.
13
14
15
16
17 Sims D (2003) Between the millstones: A narrative account of the vulnerability of middle
18 managers' storying. *Human Relations* 56(10): 1195-1211.
19
20
21
22
23 Sinnicks, M. (2021) "We ought to eat in order to work, not vice versa": MacIntyre, practices, and
24 the best work for humankind. *Journal of Business Ethics*, 174(2): 263-274.
25
26
27
28
29 Waitzberg, R, Gottlieb N, Quentin W, Busse R and Greenberg D (2022) How do managers and
30 physicians reconcile between financial and clinical considerations in hospitals.
31 *International Journal of Health Policy Management* 11(9): 1823-1834.
32
33
34
35
36
37 Willmott H (1993) Strength is ignorance; slavery is freedom: managing cultures in modern
38 organizations. *Journal of Management Studies* 30(4): 515-552.
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60

1
2
3 **Table 1: Virtue Clashes in Hybrid Middle Manager Work**
4
5
6
7
8
9

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

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