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RESEARCH ARTICLE

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From relationship orientation to task orientation: On the digitalization of clinical leaders

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Abstract

This paper studies how clinical leaders perceive their leadership tasks in the context of virtual interactions. We ask whether distant leadership involves a shift from relationship orientation to more task- and control-oriented leaders in hospital settings. We explore two cases involving 10 clinical leaders in a university hospital in Norway. The study indicates that the leaders were aware that lack of direct communication hampers relationship-oriented leadership, which weakens efforts to develop a common identity in the clinics. The absence of direct communication reduces opportunities for relationship-oriented leadership, which may hamper the development of social and self-controls in professional organizations. However, clinical leaders are dependent on professionals' social and self-controls to perform at high levels. Large distances reduce leaders' ability to build personal relations with their staff. On the other hand, professionals in healthcare are highly educated, and thus they are to a large degree self-governed. The possible effects of distant leadership may consequently not be that harmful in clinical settings.

KEYWORDS
communication, control, distant leadership, hospitals, leadership

1 | INTRODUCTION

During the last few decades, healthcare organizations have experienced profound innovations in medical technologies and undergone worldwide managerial and organizational reforms (Malmmose, 2019). Along with these contextual changes, which have affected daily life in the hospitals' clinical departments, the functions and technologies of the accounting information systems (AIS) have also contributed to altering the managerial and leadership tasks inside the clinics. The volume of virtual interactions is increasing and will grow even more in the future (Norman et al., 2020).

Consequently, clinical leaders now experience new leadership tasks. More virtual interactions imply physical separation between leaders and staff. Although professional staff such as doctors and nurses are highly self-governing, separating leaders from their staff may weaken the leaders' legitimate standing as managers and coordinators within clinical activities. A department head responsible for many employees in a large clinical unit at a university hospital stated the following in an interview on the topic of distant leadership:

> *Face-to-face meetings are definitely best. There's no doubt about that because you get the non-verbal communication, and it's easier to bring things up, in a sense (…). But the phone for specific issues, clarifications, that's fine! I'm very used to using Skype. And I think Skype can be … well, great if you already have a relationship with the person … but virtual communication … no, it make things difficult to be leader in the clinics.*

This quote indicates that virtual interaction and distance can bring new challenges for clinical leaders. From this point of view, the more interpretive research has focused on how clinical leaders interpret and perform their decision-making and their uses of AIS (Broadbent & Laughlin, 1997; Nyland & Pettersen, 2004; Pettersen, 1999). However, we know little about how technology and virtual structures impact daily organizational life as seen from the leaders' point of views (Avolio et al., 2014; Norman et al., 2020). Adding to this stream of research, a relevant research question is how clinical leaders perceive their leadership tasks in the context of more virtual interactions. How is distant leadership mediated by technologies different from face-to-face leadership? In this article, we ask how indirect and distant communication challenges leadership tasks in knowledge organizations, such as hospitals. Our focus is on clinical leaders' perception of being geographically distant from their employees. Our context is the professional organization, meaning that professional self- and social controls are essential. More specifically, we wish to explore whether distant leadership involves a shift from relationship orientation to task and control orientation in such organizations.

The huge structural changes within the hospital sector have caused many leaders to be physically separated from their employees (Antonakis & Atwater, 2002) so that they perform their leadership tasks by what we may call remote or distant leadership (Solstad et al., 2020). In addition, leaders and staff meet each other face to faceless often today than before because communication is increasingly taking place via social media.[1] The speed of online communication is increasing dramatically, the cost of sending information is decreasing, and we use the Internet more often in interacting with others.

To study this topic, we explore two case studies involving clinical leaders in a university hospital in Norway, where the researchers asked about the leaders' experiences in performing their tasks remotely and in using different communication channels. The focus of the study is the distance between the leaders and the staff. Ten interviews were conducted with leaders at different levels in the organization. The study indicates that physical and organizational distances affect the conditions of leadership. It also shows that the informants were aware that the lack of direct communication limits opportunities for relationship-oriented leadership, which hampers developing a common identity in the clinics. Our findings also show that the leaders considered communication via social media to be more like information distribution, which can be perceived as distant control rather than distant leadership.

[1] Remote management became even more relevant during the wave of COVID-19 pandemic from early 2020 and onwards, when a large portion of management took place (temporarily) via social media.

The article is structured as follows. First, we describe the phenomenon of distant leadership before discussing the concepts of leadership and control. We also address leadership and communication. We then describe our case study and the research methods used before presenting our empirical findings. Our findings are then discussed, followed by our conclusions.

2 | THEORETICAL FRAMEWORK

The setting of this study is the Norwegian hospital sector, which has experienced the global reform trend called new public management (NPM) reforms, which have been implemented within the other Western European countries as well (Malmmose, 2019). The aim of NPM was to implement management ideas from the private business sector into the public sectors (Christensen & Lægereid, 2010; Hood, 1995). One element of these reforms was the numerous mergers between previously independent hospitals in Norway to make the hospitals more efficient and more like large business companies (Solstad et al., 2020). The mergers have created structures with units spread across several locations with large distances between them. These changes necessitated organizational forms that involve many levels of control. Leaders in clinical departments may therefore act at a distance from the everyday operations in the clinical units. Our initial premise is that geographical distances are important contingencies under which leaders have to act and relate with their colleagues. The traditional assumption is that leaders and employees are geographically and physically close to each other. According to Yukl (2013), distant leadership must be exercised without daily, close and direct (face-to-face) contact between the parties involved because physical interaction is reduced and may be completely absent. Antonakis and Atwater (2002) define distant leadership as a configuration between physical distance, perceived social and cognitive distance, and frequency of interaction. The interaction between managers and employees will therefore change (Howell et al., 2005). With this background, we use a theoretical framework developed from the concept of hybrid leadership, management control, information richness, and distant leadership.

2.1 | The hybridity of clinical leadership and the self-governing professionals

The literature in this field acknowledges that clinicians have a significant impact on work processes and on planning, performance, and costs (Oppi et al., 2019). Furthermore, the above-mentioned reforms have turned clinicians into accountable managers (Jacobs, 2005; Llewellyn, 2001; Pettersen & Solstad, 2014). Clinical leaders are bridging the communication between the strategic top levels in hospitals and the day-to-day clinical activities. They both manage highly professionalized workforces and are accountable for clinical and medical activities. Management accounting and control have become main components of the clinical leaders' day-to-day tasks (Kurunmäki, 2004). Thus, clinical leaders have become hybrid leaders, as they are professionals engaged in managing professional work, professional colleagues, and other staff (Fitzgerald & Ferlie, 2000).

"Hybrid" roles, framed by both professionalism and managerial logics, have been diffused across healthcare systems globally (Doolin, 2001; Fitzgerald & Ferlie, 2000; Kirkpatrick et al., 2009; Kurunmäki, 2004; Pettersen & Solstad, 2014). These role changes, where professionalism and managerialism can be characterized as "competing institutional logics" (Olsen & Solstad, 2020; Reay & Hinings, 2009), represent changing social frames which provide meaning to activity and condition sense making, action, and identity (Thornton et al., 2012).

In this article, we introduce the concept of "hybridity" to position our theoretical framework towards an interpretative approach. Our research question is how individual clinical leaders, as hybrid professionals, interpret their actions and decision-making amid today's profound technological changes. The interpretations of the technological changes in these organizations rely upon the actors' beliefs and experiences, which guide their behaviors, and their interpretative schemes of reality (Broadbent & Laughlin, 1997). Interpretative studies in hospitals have focused on clinicians' adjustments to managerial and leadership duties (Jacobs et al., 2004; Nyland & Pettersen, 2004). As hybrid leaders in

the clinics, these professionals must cope with conflicting logics and act as distant leaders across organizational levels and distances.

Studies of management controls in healthcare have concluded that professionals' social and self-controls are core elements in motivating high performance (Carlsson-Wall et al., 2011). In his seminal work, Hopwood (1974) accordingly argued that organizational controls are dependent on social, self-, and administrative controls. We may identify management as mainly administrative controls, whereas social controls are derived from interaction with colleagues, education, and group norms. Self-controls, on the other hand, are based on personal values that motivate action. Shared value, knowledge, and assumptions within the professional domains shape how professionals identify, categorize, and interpret information and actions (Scott, 2001). Hospitals are knowledge-intensive organizations and are strongly governed by their professionals' competences and norms (Kurunmäki et al., 2003; Pettersen & Solstad, 2014). Social controls in hospitals are most often managed in a lateral manner among professional colleagues in order to reduce the cognitive distance (Bay, 2011; Choi et al., 2011).

Accordingly, clinical leaders are expected to be more relationship oriented than task oriented to act as guides in these settings. This speaks in favor of direct communication rather than distant leadership. However, professionals in the healthcare sector are highly self-governed, and, consequently, they may not need leadership as much. However, we argue that guiding the professionals in hospitals implies that the staffs' behavior is influenced by signals between the leaders and the staff.

2.2 | Leadership, management controls, and information richness

Communication between leaders and their staff and interpretations of messages are also influenced by the communication channel itself, that is, the medium through which the message is expressed (Daft & Lengel, 1986). The media may be face-to-face conversations, Skype calls, various types of videoconferencing, telephone calls, e-mails, text messages, notices, or other common information read on the intranet. The relationship between the sender and receiver also influences the communication and interpretation of the message. When someone receives an inquiry or message, it is important to know who the sender is. In other words, the sender becomes a frame of interpretation (Antonakis & Atwater, 2002).

In addition, the message itself is filtered through the communication channel. Here we find support in a theory that shows how communication channels have different abilities to handle several signals simultaneously: the "media richness theory" developed by Daft and Lengel (1986). Important dimensions are the possibility of immediate/spontaneous reaction and feedback, the possibility of personal forms of expression/interaction between the parties, and the use of natural (spoken) language. Direct face-to-face communication is the richest communication (see Figure 1). At the opposite end of the scale, we find the least rich communication, where only text is presented without an addressee, such as on a physical notice board or via the intranet.

Daft and Lengel (1986) emphasize that written information should not be used for messages that can be interpreted in different ways. In this case, direct conversations would be a richer communication channel than e-mail because nonverbal communication (body language and tone of voice) and direct feedback can ensure that the receiver interprets the information more in accordance with the intention of the sender. One feature of the new digital forms of communication is that it can take place independently of time and space, that is, asynchronously. Digital channels make it possible to send a large number of messages vertically in the organization, but the amount of information can easily lead to information/digital overflow (Dixon, 2016).

We may assume that distant leadership increases the likelihood of different interpretations of messages which are delivered by less rich media. Diverse interpretations can lead to increased uncertainty and ambiguity among the professional staff in an organization (Antonakis & Atwater, 2002). Daft and Lengel's (1986) model shows that rich sources of information have a great capacity to process different types of information and enable more coherence among staff's interpretations. These sources of information are facilitated by relationship-oriented leadership based

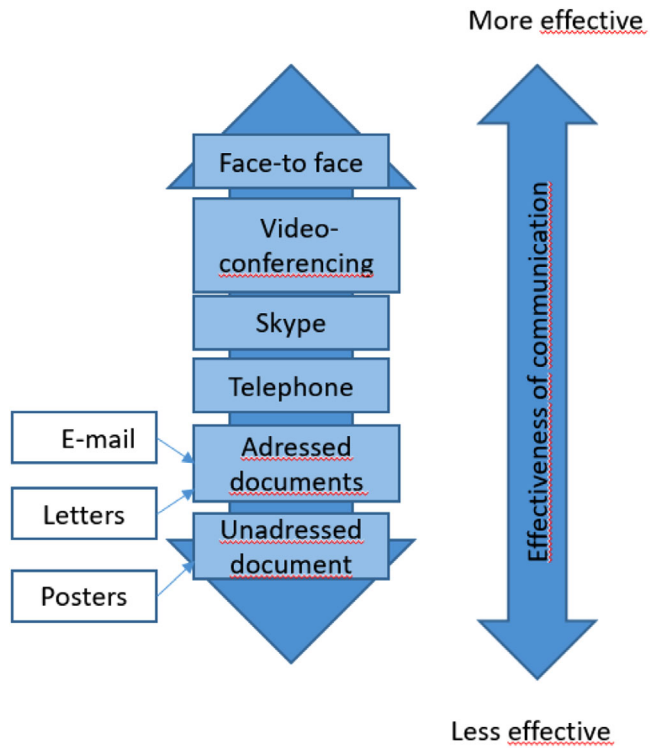

FIGURE 1 The ability of various communication channels to communicate information (adapted from Daft & Lengel, 1986) [Colour figure can be viewed at wileyonlinelibrary.com]

on personal and direct involvement between the parties. Less rich sources of information, on the other hand, are rules, procedures, and reports in documents, and they are associated with more task-oriented leadership and management, which we may call administrative controls.

2.3 | Distant leadership

Researchers have identified distant leadership as a problem, particularly because of the physical distance between the actors involved (see, e.g., Antonakis & Atwater, 2002; Howell et al., 2005; Stoopendaal, 2015). Distance is considered a key contextual factor in leader–staff relationships (Chenhall, 2003). The problem with distant leadership is that those involved do not meet daily, meaning that there is little or no direct, face-to-face contact and that the actors are supposed to communicate through less rich media. The possibility of seeing and interpreting body language and having direct eye contact is lost, and communication between the actors thus becomes more limited.

The literature in the field points to limited research on distant leadership (Henderson & Wakslak, 2010; Stoopendaal, 2015). Distance between leaders and staff is not necessarily geographical distance, but the term may also include other dimensions of distance, such as organizational, cultural, social, and cognitive distances (Antonakis & Atwater, 2002). Hinds and Bailey (2003) studied distributed teams and found that physical distance between leaders and staff reduced the ability to develop common understandings among the parties. Furthermore, distance can encourage different narratives, beliefs, and subcultures in an organization, which develop different perceptions of reality among the staff.

In the long run, distant leadership may therefore lead to both task and process conflicts, which are difficult to resolve because of the larger distances between the immediate leader and the employees/followers. A reduced distance between parties in terms of values expressed by the leaders and those expressed by the individual staff members

is of vital importance for the positive involvement among professionals in performing high-quality service production (Carlsson-Wall et al., 2011).

Distant leadership also appears to challenge leaders' efforts to motivate professional staff, and the larger distance between leader and staff members may negatively affect the professionals' motivation, their involvement, and engagement (Howell et al., 2005) because leaders have limited opportunities to interact directly with their colleagues. As stated by Hopwood (1974) and Carlsson-Wall et al. (2011), distant leaders are less able to guide their professional colleagues by social and self-controls, which constitute organizational controls as well as administrative task-oriented controls.

In a relationship-oriented leadership style, the leaders involve their colleagues, and they participate in their everyday work by increasing coordinated engagement (Behrendt et al., 2017). It is argued that perceived closeness to the leader can be an important motivating factor, and we may assume that this applies particularly to knowledge organizations, where staff members' work is based on professional skills. When leaders exercise distant leadership (geographically or in other ways), the opportunity for relationship building is reduced. The leaders then move towards becoming more task oriented. Task-oriented leaders focus on the accomplishment of common objectives, and they work through defining and quantifying tasks, procedures, and structures (Yukl, 2013). Tasks, procedures, and structures are systems that are more easily communicated by less rich media. However, distant leaders communicating through less rich media shift their role from leadership to management and control, which focus more on administrative controls and less on social and self-control elements.

3 | EMPIRICAL SETTING AND METHOD

3.1 | The context

Reforms in the hospital sector have motivated hospital mergers, which have created large organizations with great distances between each geographical hospital unit.[2] Clinical leaders may therefore be placed far from their employees. In order to understand how the professionals' leaders perceived their situation, a qualitative study was conducted (Yin, 2014). The setting is a large university hospital in northern Norway in 2018, with approximately 7000 employees. This hospital was established about 10 years ago and merged the larger university hospital with two smaller, generalized hospitals.

These two merged hospital units are situated 300 and 249 km away from the main hospital location. Clinical and unit leaders, being at levels two and three in the managerial hierarchy, do not work in the same geographical location as their staff. In fact, leaders and staff may have several hours to drive between the locations. The empirical data were based on two different case studies. The first case focuses on distant leadership in one of the remote locations in this merged hospital (Laupstad & Kirkerud, 2018). The other case explores the increasing use of social media and digitalization as modes of communication between leaders and staff in a large clinical department (Kvamme, 2018). The cases partly overlap because the data were concerned with the interface between distant leadership and the use of social media. Our study then comprises physical distance both as geographical distance and virtual nonphysical interaction. The cases are based on the leaders' own experiences.

[2] The number of independent hospitals in Norway was reduced from 54 to 4 health enterprises between 2001 and 2007. For example, in the northernmost enterprise, the University Hospital consists of the hospital in Tromsø and those in Narvik and Harstad, at 230 and 300 km, respectively, from Tromsø. The managers of the various departments and clinics are thus responsible for employees up to 300 km away.

TABLE 1 Interview statistics, Case 1: Use of social media in communicating

Informant number	Position	Date	Length of interview (min)	Location of interview
1	Clinic leader	February 21, 2018	31	Informant's office
2	Clinic leader	March 5, 2018	49	Informant's office
3	Department leader	March 6, 2018	40	Informant's office
4	Department leader	March 13, 2018	48	Informant's office
5	Department leader	March 13, 2018	25	Meeting room

TABLE 2 Interview statistics, Case 2: Geographical distance

Informant number	Position	Date	Length of interview (min)	Location of interview
1	Unit leader	March 6, 2018	20	Meeting room
2	Unit leader	March 5, 2018	28	Researcher's office
3	Unit leader	March 1, 2018	22	Meeting room
4	Unit leader	March 9, 2018	30	Informant's office
5	Unit leader	March 16, 2018	28	Informant's office

3.2 | The research design

Before entering into the research setting, the authors had followed the university hospital by studying the merger processes over several years (Solstad et al., 2020). In order to further prepare for this present study, we gathered relevant documents in order to understand more about the challenges facing leaders who less often than before meet directly with their staff. These documents supplement our informants' statements, which are addressed in the empirical part of this paper. During the interviews, the informants were also asked to supplement their answers by indicating situations where distance was a contextual factor.

The top leadership team of the university hospital approved the study to be performed in spring 2018. Semistructured interviews were conducted with 10 leaders in the two cases; see the interview statistics in Tables 1 and 2. This sample of leaders was strategic, based on the informants' knowledge of the organization regarding the number of years leaders were employed in the hospital. These 10 leaders were included in this study mainly based on their functions as clinic and unit leaders with colleagues and middle managers working in distant locations of the hospital. Further, they were leaders in large surgical and medical clinics and units.

The two interview guides (Cases 1 and 2) were developed as open-ended questions and focused on some of the main concepts derived from the theoretical framework (see Online Appendix 1). In the interviews, we tried to ensure reliability by avoiding asking leading questions and by following up on vital topics. All interviews were tape-recorded and then transcribed and translated from Norwegian to English. While this process may lead to misunderstanding words and wrong interpretations, the two authors carefully performed a back-translation to reduce this problem. Analyses of the empirical materials included inserting descriptive codes into the text. These codes were then repeatedly labeled with subject codes to assist in interpretation and reflection. Some essential interview statements are extracted and used as citations in the presentation of data to enhance reliability. External validity is mainly dealt with as generalizability of the results, which is more detailed in the concluding section.

The interviews lasted from 30 min to 1 h, and they took place in the informant's office or in a meeting room in the hospital. The informants were doctors and senior nurses, but our data were not split into different professional groups. The departments of the participants have been anonymized.

The study was approved by the Privacy Ombudsman for Research and was conducted according to the general ethical guidelines for conducting qualitative studies.

4 | EMPIRICAL FINDINGS

The motivation for this study was based on the challenges leaders encounter in professional organizations like hospitals when they perform their leadership duties distant from their staff. These challenges were in fact brought up in discussions in the Norwegian Parliament as the National Plan for Health and Hospital Enterprise (2015) was discussed. Here it was decided that there must be leaders physically close to the clinical activities, especially when there are large units and geographically distant locations (National Plan for Health and Hospital Enterprise, 2015). The strategic documents for our university hospital stated that the hospital has to deliver high-quality services to all inhabitants irrespective of geographical differences and that leaders should be "communicative" and have a "relation-based leadership style" (The University Hospital of North Norway, 2015). Based on these documents, the board of the university hospital decided that all locations must have local (in place) leaders (University Hospital of North Norway, 2017).

The document referred to above constitutes a background for asking the leaders about how they perceive their distant leadership, due either to geographical or virtual distances. This question is even made more relevant as the strategic document underlines that leaders should have a "relation-based leadership style."

The main findings from the interviews are presented below and are based on the concepts of distant leadership, leadership, and communication as well as communication channels and rich information.

4.1 | Distant leadership

The informants' statements indicate that geographical distance is perceived as a key challenge in the everyday work of clinical leaders. One informant said that she missed seeing her staff "in the eyes" because then she can understand much more than just the words in an SMS or on the telephone. She further added: "on video you cannot observe how tired they are after having been on call duty all night." All participants missed the physical presence of their staff and expressed an increased feeling of not being able to cope with their leadership and managerial tasks:

> *The way it affects me is that I can't be present [at the other hospital units].* (Clinic leader)

> *It is demanding to have a leader across three locations. There are many complex questions that are linked to professional leadership, professional pride and professional identity.* (Department leader)

Distance involves a threshold to be breached, and it takes time to travel between locations:

> *The feeling of inadequacy. It's … I can't get everything done the way I'd like to …. It's the inadequacy because it's such a huge distance to some people …. Knowing that they're there and kind of all alone.* (Unit leader)

> *And obviously the geography means I'm in [hospital x] less often than I'm in [hospital y].* (Department leader)

The informants also indicated that employees who work at a distance from their immediate leader express a feeling of greater autonomy. These staff members are professional workers who identify strongly with both their clients and their tasks, indicating social and self-controls (Carlsson-Wall et al., 2011). The leaders in our cases felt that inquiries from these distant colleagues should be answered quickly to support them and thus reduce the cognitive distance:

> … *I think if you ask the heads of sections in the clinic, they'll probably say that they feel that we—as leaders at the department levels—deal with their requests promptly and that we are available to discuss things when they need. But obviously it's a loss not to have your immediate leader close at hand. You shouldn't underestimate the importance of being physically closely situated.* (Clinic leader)

All informants reported having regular and formal meetings involving all locations from near and far away in the university hospital. One of the leaders explained this by saying that they organize virtual meetings to facilitate the leadership team:

> … *but then again I feel the communication I am able to organise isn't always making it easy to understand for the distant participants … Because there's so much information and signals to take into account in terms of local and changing conditions far away*…. (Department leader)

This leader understands that distance affects the employees' interpretation of messages through social media and that virtual communication may create misunderstandings and thus hamper staff's identification with the clinic (Carlsson-Wall et al., 2011; Hopwood, 1974). Clinical staff are highly professional, and they are trained to work both independently and in teams. Accordingly, as hybrid leaders, our informants try to bridge managerial accountabilities with keeping in touch with their professional staff to reduce the cognitive distance (Kurunmäki, 2004; Llewellyn, 2001). This hybridity is challenging, as leaders in this study expressed feelings of inadequacy in the role of distant leaders since distance itself hampers the bridging between clinical activities and managerial duties. As one informant said: "I feel I should be several places. I write e-mails and SMSs, but really I don't know whether they read them or what they think."

The informants agreed that maintaining personal relationships with colleagues in the distant units was highly important in order to create common values to facilitate coordination. They stated that being physically present with colleagues has symbolic effects, which create feelings of unity and collaboration in the clinic across physical distances. Reduced cognitive distances are considered important in team building with different professional groups when treating patients with multiple diagnoses and problems:

> …*very often you need to build relationships on Skype. You can't be physically with the people, you don't get to meet them very often, you can't talk with them across the table with a coffee.… So I think it's much more challenging being a distant leader. You get to know people after a while, but it takes a longer time. But you'll have to somehow be present in the other locations' places. When the colleagues at these locations come here, we have to create good meeting points. I think I really have to make an effort here.* (Unit manager)

> *So the main reason for visiting colleagues at the other locations is simply to show your face outside your local workplace, and I don't want to be the person that everyone's heard of and no one's ever seen.*… (Department leader)

As can be seen from these citations, these leaders recognize the importance of being physically present among colleagues at distant locations. The leaders clearly found distant leadership challenging, which implies that it is challenging to maintain relationship-oriented leadership when staff is physically spread around. The informants stated

that they tried to maintain virtual relationships, but the indirect medium does not permit rich information, which is necessary for building personal trust and group identity (Daft & Lengel, 1986).

4.2 | Leadership and communication

Clinical leaders are characterized as hybrid leaders because of the need to integrate clinical expertise and managerial duties (Kurunmäki, 2004; Pettersen & Solstad, 2014). Our informants are in the middle of these hybrid challenges, as they are not only accountable upwards to the top management of the hospital, but they also need to coordinate professional colleagues who are physically apart from their employees. According to literature in this field, coordinating in these settings should be based on culture and on common norms to reduce the cognitive distance between the professional staff (Bay, 2011; Choi et al., 2011).

For this reason, several informants emphasized direct contact as a prerequisite for building trust and developing personal relationships. They underlined that employees must be "seen" to feel that they are part of a team working towards common goals. One informant said that direct face-to-face contact is needed to create "team spirit":

> *It's quite simply through direct contact. There's usually not much time for social contact, except when there are leadership meetings and so on…* (Clinic leader)

> *…The thing is, well, no doubt if you made a ranking, well then people in fact would think it's more important to be physically present than to use Skype.* (Unit leader)

Informants felt that face-to-face meetings with employees were important in order to "see" the staff, which according to Daft and Lengel (1986) is the richest communication medium:

> *I think daily face-to-face contact with the staff is the most important thing.…* (Unit leader)

> *You narrow communication by using e-mail.* (Unit leader)

The informants stated that physical meetings were the best way to communicate with their staff, but this was difficult because of the geographical distances. They also underlined the existing problems of diverse interpretations of messages via indirect media, as they experienced noise in the communication channels. In addition, this indirect communication was often one way, relaying information rather than communicating:

> *The big challenge is that when you communicate via e-mail, it's not personal. There are lots of risks involved…e-mail…doesn't give you any opportunity to give an immediate response to what's actually in the message.* (Unit leader)

> *E-mail can be used more to clarify things. The good conversation does not take place there.* (Unit leader)

Several informants emphasized that e-mail can easily become one-way information that may make people misunderstand things and which may lead to goal distortion in the units:

E-mail easily becomes one-way communication … in a direct conversation I can explain more, and I'll get the body language as well. (Unit leader)

There may be nuances that you don't grasp at all when you talk on the phone or use Skype or e-mail… that you'd have noticed in body language …. (Unit leader)

The informants added that informal and ad hoc conversations were important leadership tools and that these opportunities disappear when staff are separated geographically. Distant leadership reduces opportunities for spontaneous conversations, informal dialogue, and small talk, which are important "glue" in organizations. One leader in a large department with many units distant from one another tried to walk around and talk with people. He said:

… and the staff can feel you notice them more than if you just communicate by e-mail. (Department leader)

However, this informal "walk and talk" was not possible in the distant locations, which implies that the context for leadership practices is different depending on whether leaders and employees are distant or close. One problem that was particularly emphasized was that staff do not necessarily read written information, such as e-mails:

It varies how closely the staff look at e-mails, and you can't guarantee that everyone's read a message. (Unit leader)

…it turns out time and again that not everyone's read information that's been e-mailed. (Unit leader)

The informants underlined that the lack of nonverbal communication in virtual relations also created leadership challenges. One informant put it this way:

…with e-mail you only get the words but none of the non-verbal communications. (Unit leader)

The introduction of digital platforms was mentioned as a possible efficiency gain that could lighten the workload of leaders but that could never replace direct communication. One informant commented that such platforms could also involve extra work:

…One example is the digital sick leave that requires logging in, checking and control, that is, control functions that the human resources department earlier used to do. (Department leader)

We observe that the leaders in this study found their work to be more challenging when using less information-rich sources, such as e-mail and other digital media. They pointed out that this communication was especially difficult, as leaders in this setting need to build personal relationships to coordinate with their professional coworkers. Our informants indicated that indirect communication most often was only one way, which we previously have argued is information processing and belongs to task-oriented leadership, administrative control, and managerial duties. The informants agreed that one-way communication and less interpretation of body language and direct eye contact increase diverse interpretations of messages among the staff. As our informants are hybrid leaders, we may also argue that the less rich communication media, such as digital platforms, may weaken their ability to integrate clinical actions and managerial tasks.

4.3 | Communication channels and rich information

All informants stated that they felt that direct face-to-face communication functioned best in relationship building:

> *By visiting people directly … I would say that's the best source of trust building … but of course, information is given also via e-mail and in meetings.* (Unit leader)

> *There's so much misunderstanding involved in e-mail.* (Clinic leader)

Problems with misinterpretation were underlined when leaders talked about their relations with distant colleagues. Many media were used, and informants replied that e-mail and phone calls were supplements to direct meetings. Phone calls were perceived as more personal and friendlier than sending an e-mail:

> … *you can always sit banging on your computer and sending e-mails, but I think it's friendlier and more direct communication if you pick up the phone and call someone.* (Department leader)

Several informants emphasized the importance of body language in face-to-face conversations. One of them said:

> *Body language and tone of voice can tell you more than written language.…* (Unit leader)

Many of the informants expressed concerns about challenges when trying to develop trust and motivation within a group of colleagues working distantly from the unit where the leader has been placed. They emphasized the importance of being present among their colleagues as a leader:

> *You lose this daily contact … here I know the people and I know what they are doing and thinking. I do not do that at the other distant locations—it is missing.* (Unit leader)

As hybrid leaders, the informants needed to reduce the cognitive distance from their staff in order to maintain high performance both in the clinical work and in managerial tasks. The informants agreed that physical meetings were the best media for establishing direct contact with the staff. These were situations that formed important parts of the leadership roles:

> *There's no doubt that face-to-face meetings have the greatest value … for putting an effort into the culture, for trying to achieve a common understanding.* (Clinic leader)

One informant emphasized that e-mail can work well as a mode of cooperation if you already know the recipient well:

> … *it makes a big difference if you know the person well and have a trusting relationship with the person receiving the message. The better you know the person, the easier it is to use written information like e-mail.* (Department leader)

Informants also mentioned the amount of e-mails as a problem, as they might receive between 40 and 100 e-mails every day. One informant explained:

> *I have a problem with the daily volume of e-mails. It gets to be an overload and easy to lose track. … If I forget to reply to an e-mail from an employee and it takes 3–4 weeks before you get a reminder, it's easy to feel disheartened and feel like a bad leader.* (Unit leader)

Another informant also emphasized the problem of overload in the mailbox:

> *If you're going to answer all the e-mails and take it seriously … then you'll be sitting in your office a lot, which decreases the time you can communicate with your staff in other ways.* (Unit leader)

The leaders reported trying to be conscious of how to communicate with distant colleagues, and they were especially concerned about uncritical use of e-mail:

> *Do I do it every day… or what? I hope I don't. I think I go through them all on Thursdays … I try not to bombard them.* (Department leader)

The following statement illustrates how a large number of e-mails challenges communication, as e-mails are thought to provide information rather than act as leadership tools:

> *Well, at least twice a day something that's important in terms of leadership, and then there's a lot of … there's a lot of info.* (Department leader)

The leaders in this study used many different communication media, but they all agreed that rich media, such as direct face-to-face contact, were most suitable for building and maintaining relationships and developing common identity among staff in their units. Media that enable rich information were preferred. When rich information is communicated, all five human senses are activated. But the distance between leaders and colleagues means that communication often takes place via indirect media, such as video, telephone, and e-mails. The informants experienced e-mail overload, and they, therefore, tried to restrict the use of e-mail. When colleagues know each other well, e-mails can function better in collaborative tasks. Nevertheless, leaders and staff who work in different locations most often communicate through less rich media (Daft & Lengel, 1986). This shift in media from direct communication to more indirect, and digitalized media can indicate a change from relation-based leadership styles to more task-oriented relations based on one-way information exchange.

5 | DISCUSSION AND IMPLICATIONS

This paper aims to explore how indirect and distant communication challenge leadership tasks in knowledge organizations such as hospitals. We ask whether distant leadership involves a shift from relationship orientation to more task- and control-oriented leaders in such organizations. Our empirical study included leaders who all use various communication media in their practices and part of whose staff work at a distance. The study indicates that physical and organizational distances are contexts that influence the conditions for leadership (Antonakis & Atwater, 2002; Avolio et al., 2014; Chenhall, 2003).

A main empirical finding is that the leaders in this study were aware that the absence of direct communication reduced opportunities for relationship-oriented leadership, which is connected with the concepts of developing social and self-controls in professional organizations (Hopwood, 1974). Large distances reduce leaders' ability to build personal relations with their distant staff. We noticed that there are increasing virtual relations between leaders and their professionals, which may weaken the leaders' relationship orientation and the possibilities of creating common understanding and shared identity among participants in the hospital units. The leaders' feelings of inadequacy on account of

physical and organizational distances in our settings may also have to do with the large control spans that were introduced after the hospital merger about 10 years ago. At the present, there are three to four hierarchical levels between the top management and the middle managers interviewed in this study.

Due to their strong professional training, medical staff in hospitals are less guided by administrative controls. The literature in this field argues that leaders in hospitals rely heavily on professionals' self-controls to guide their actions (Carlsson-Wall et al., 2011). Studies of management controls in healthcare organizations corroborate that administrative controls have to be combined with social and self-controls to bridge the different logics deriving from medical and managerial traditions (Carlsson-Wall et al., 2011; Pettersen & Solstad, 2014). Close relationships support and develop common cultures and norms. Relationship-oriented leaders facilitate the building of identity and can support a feeling of community among colleagues. Here, large distances due to geography and the large control span between the actors may challenge the units' common value orientation. In the end, growing feelings of diversity and the lack of a sense of shared identity can result in reduced motivation among the staff to cooperate, which in turn results in reduced performance quality and goal achievement.

Our study also indicates that direct and informal conversations are important leadership and management tools but that such communication was reduced and replaced by virtual contact when staff work at a distance. This situation is characterized also by less small talk among colleagues, which is described as "glue in the organization." An overall impression of the informants' comments indicates that nonverbal communication via direct contact, as rich communication (Daft & Lengel, 1986), is highly valued in facilitating leadership practices and in relationship building.

We argue that management is characterized by mainly administrative controls, which are identified with task-oriented leadership. A large control span may strengthen the change towards more task orientation among leaders. Social controls, on the other hand, are derived from interaction with colleagues, education, and group norms, and such controls are supported by relationship-oriented leaders. Self-controls, as the literature shows (Carlsson-Wall et al., 2011; Hopwood, 1974) interact with administrative and social controls to support organizational controls. Self-controls are based on personal values that motivate action, and these kinds of controls in hospitals are most often managed in a lateral manner among professional colleagues in order to reduce the cognitive distance (Bay, 2011; Choi et al., 2011). This implies that clinical leaders are dependent on professionals' social and self-controls to encourage high performance.

Our findings indicate interrelations between leadership and management controls, as both leadership and management influence human behavior but constitute two different ideal, typical dimensions. Leadership is more person oriented, while control and administration are much more system oriented (Yukl, 2013). Both leadership and management control are thus instruments for the coordination of human behavior. Leadership is exercised in direct interaction with employees, while controls involve more indirect forms of systems and practices (Behrendt et al., 2017). Leadership is therefore linked to interpersonal relationships with the aim of motivating people to work towards the goals of the organization. Our findings revealed a tendency for leaders to consider communication via social media to be information distribution, which we define as controls. On this basis, we assume that increasing the use of indirect (nonface-to-face) communication leads to a shift from leadership to more control-oriented management behaviors.

Leadership generally requires communication via direct face-to-face contact, which Daft and Lengel (1986) consider a rich source of communication. Where the manager and employee had a well-established relationship, indirect communication was perceived by our informants to work better than in newly established relationships. Indirect communication (via social media) is often one-way communication, which provides little encouragement of dialogue. This exacerbates problems related to different interpretations of messages and increases noise in communication. Such noise can also increase the cognitive distance between managers and staff by creating uncertainty. The leaders in this study expressed a feeling of inadequacy in relation to the large geographical distances from their staff because the distant staff may feel left alone if there is a lot of indirect communication. On the other hand, the distance may also give staff more autonomy in this knowledge-intensive organization, which can support professional independence and discretion.

This study is based on the leaders' perceptions, and future research might complete our findings by including the professional employees in order to understand more about their reactions to the increasing number of virtual

interactions in hospitals. From the leaders' viewpoints in this study, we suggest that leaders who communicate with their colleagues by less rich media should be aware that such information may lead to different understandings of messages, which also can increase the cognitive gap between leaders and their staff. Accordingly, leaders become less able to reduce cognitive distance and guide their professionals' actions. As clinical leaders are hybrid leaders, a shift from relationship-oriented leadership towards task orientation may challenge the leaders' balance between clinical and managerial duties.

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