



Revista de Administração Pública

ISSN: 0034-7612

ISSN: 1982-3134

Fundação Getúlio Vargas

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Revista de Administração Pública, vol. 55, no. 5, 2021, September-October, pp. 1034-1076

Fundação Getúlio Vargas

DOI: <https://doi.org/10.1590/0034-761220200792>

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Understanding professional stratification and hybridisation in the medical profession: exploratory evidence from Brazilian federal university hospitals

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This paper explores drivers, implications, and trends of professional stratification and hybridisation in the medical profession employed in Brazilian substituir por: federal university hospitals (HUFs). Drawing on exploratory findings, we examine some repercussions of the migration of university hospitals to EBSERH, a public company established by the federal government to manage and organise HUFs integrated into the Unified Health System (SUS). Our research shows that transferring hospital administration to EBSERH has led to further internal stratification of the medical workforce. The shift from the logic of medical-academic professionalism to the new logic of business-like healthcare, with the adoption of distinct job contracts and more managerial logics of work and control, may well be changing subjective and formal links established between professionals, universities, and hospitals. We identify and discuss trends towards hybridisation and dehybridisation. These findings are relevant because this shift can have profound implications for the academic nature of HUFs and for the future of professionalism within these health and teaching organisations.

Keywords: professional stratification; hybridisation; medical profession; federal university hospitals.

Compreendendo a estratificação profissional e hibridização na profissão médica: evidências exploratórias de hospitais universitários federais brasileiros

Este artigo explora motivadores, implicações e tendências de estratificação e hibridização profissional na profissão médica atuante em hospitais universitários federais brasileiros (HUFs). Com base em achados exploratórios, examinamos algumas das repercussões da migração dos hospitais universitários para a EBSERH, uma empresa pública criada pelo governo federal para gerenciar e organizar os HUFs vinculados ao Sistema Único de Saúde (SUS). A pesquisa mostra que a transferência da administração hospitalar para a EBSERH tem acarretado maior estratificação interna da força de trabalho médica. A mudança da lógica de profissionalismo médico-acadêmico para uma nova lógica empresarial de saúde, com a adoção de distintos regimes empregatícios e formas de trabalho e controle mais gerenciais, podem estar alterando vínculos subjetivos e formais estabelecidos entre os profissionais, as universidades e os hospitais envolvidos. Tendências em direção à hibridização e desibridização foram identificadas e discutidas. Esses achados são relevantes tendo em vista que tais movimentos podem representar implicações profundas para a natureza acadêmica dos HUFs e para o futuro do profissionalismo nessas organizações de saúde e ensino.

Palavras-chave: estratificação profissional; hibridização; profissão médica; hospitais universitários federais.

DOI: <http://dx.doi.org/10.1590/0034-761220200792>

Article received on November 03, 2020 and accepted on August 30, 2021.

[Original version]

ISSN: 1982-3134



Comprendiendo la estratificación e hibridación profesional en la profesión médica: evidencia exploratoria de los hospitales universitarios federales de Brasil

Este artículo explora impulsores, implicaciones y tendencias de la estratificación y la hibridación profesional en la profesión médica empleada en los hospitales universitarios federales brasileños (HUFs). A partir de hallazgos exploratorios, examinamos algunas de las repercusiones de la migración de los hospitales universitarios a la EBSEH, una empresa pública creada por el gobierno federal para administrar y organizar los HUFs integrados en el Sistema Único de Salud (SUS). Nuestra investigación muestra que la transferencia de la administración hospitalaria a la EBSEH ha llevado a una mayor estratificación interna de la fuerza laboral médica. El cambio de la lógica del profesionalismo médico-académico a una lógica empresarial en salud, con la adopción de diferentes regímenes de empleo y modos de trabajo y control más gerenciales, puede estar alterando los vínculos subjetivos y formales que se establecen entre los profesionales, las universidades y los hospitales involucrados. Se identifican y discuten tendencias hacia la hibridación y deshibridación. Estos hallazgos son relevantes porque tales cambios pueden tener profundas implicaciones para la naturaleza académica de los HUFs, así como para el futuro del profesionalismo dentro de estas organizaciones de salud y educación.

Palabras clave: estratificación profesional; hibridación; profesión médica; hospitales universitarios federales.

ACKNOWLEDGMENTS

This study was financed in part by the Coordenação de Aperfeiçoamento de Pessoal de Nível Superior (CAPES) - Brazil - Finance Code 001.

1. INTRODUCTION

This study has been triggered by a backdrop of changes in the Brazilian public sector, which has been experiencing a wave of reforms aligned with the New Public Management (NPM) doctrine (Bresser-Pereira, 1996; Bresser-Pereira & Spink, 2005; Paes de Paula, 2005). Similar to Anglo-Saxon nations, debates over the infusion of business-like methods, practices, and discourses into public sector organisations have been intense in Brazil over the last decades (Costa, 2008; Gaetani, 2003; Persson, Porto & Lavor, 2016; Secchi, 2009). In such a pro-managerialisation scenario, NPM-type reforms emerge with the potential to heavily impact the foundations of public professionalism in many fields of service provision (Esposito, Ferlie & Gaeta, 2017; Ferlie & Geraghty, 2005), including professions which are historically perceived as powerful, successful, and influential, such as medicine, for example.

In fact, some implications and tendencies can already be seen in relation to the medical profession employed in Brazilian federal university hospitals (HUFs). The migration of HUFs to a new national management body – the Brazilian Hospital Services Company (EBSEH) – has arisen as a managerial response to tackle deep-seated problems of infrastructural precariousness and understaffing in these hospitals in view of the stagnation in economic growth and government's efforts to control and reduce public spending (Persson & Moretto, 2018). Established in 2011 as a public company regulated by private law, EBSEH can be conceived as a type of publicisation (Schweizer & Nieradtka, 2001), an example of softer NPM or quasi-market hybrid forms (Denis, Ferlie & Van Gestel, 2015; Ferlie & Geraghty, 2005; Osborne & Gaebler, 1992) that are set up by the government to take on the delivery of non-exclusive public services such as education and healthcare. The EBSEH enterprise is owned and funded by the state, but holds greater administrative and financial autonomy (Lei nº 12.550, de

15 de dezembro de 2011) to operate in line with the business-like managerialism in the organisation and running of teaching and healthcare services within HUFs.

It is our contention that this managerial shift can impact not only on organisational structures and modes of managing public organisations but also on the ways public service professionals are organised and controlled in the public sector division of labour. With the advent of this company, the internal fragmentation of the medical workforce has apparently been reinforced, since doctors who are EBSEH's employees have distinct job contracts and usually integrate the rank & file doctoring group, more engaged with patient care, while doctors and professors employed directly by the universities tend to hold higher positions in the hospital administration and in medical schools, thus composing different elites of hybrid professionals. The new form of hospital organisation and management also includes the adoption of more managerial modes of work control and therefore alterations in organisational subjective and formal links (Kramer & Faria, 2007), or institutional patterns of assumptions, values, beliefs, and rules by which professionals act upon, interact with, and interpret organisational domains (Haveman & Gualtieri, 2017; Reay & Hinings, 2009; Thornton & Ocasio, 1999). This is a relatively new reality for forty HUFs across Brazil and thousands of doctors working in these public healthcare and teaching organisations. Therefore, there are elements around such a professionalism-managerialism relationship in teaching hospitals that require more clarification, especially in national contexts in which neoliberal and managerialist projects have come to be seen as a "remedy for all ills" in the public sector, as it seems to be the case of Brazil these days.

In this paper, **we draw on exploratory findings derived from an initial study to explore drivers, implications, and trends of professional stratification and hybridisation in the medical profession employed in HUFs**, considering the new system of hospital administration. Albeit interrelated, stratification and hybridisation do not confound. The former refers to a broader process of fragmentation of a given professional workforce into segments of workers (Alvehus, Eklund & Kastberg, 2019) on account of division of labour, specialisation, new roles, or hybridism, for instance; the latter can be seen as a type of professional stratification which occurs when professionals assume managerial or leadership positions, a process that often leads to the emergence or reinforcement of professional hybrid elites (Freidson, 1985, 1994). Put simply, professional hybridisation means the mixture of professional and managerial institutional logics, involving increasingly blurred identities, principles, practices, discourses, and behaviours (Croft, Currie & Lockett, 2015; Hendrikx & Van Gestel, 2017; Kirkpatrick, 2016; Reay & Hinings, 2009; Waring, 2014). Historically, we shall argue, the logic of hybridisation has been a constitutive characteristic of Brazilian teaching hospitals, owing to the close interface between clinical, academic, and managerial roles. These intertwined roles used to be dominated by doctors-professors-managers, or triple-hybrids, thus implying the formation of hybridised professional identity, work, and organising principles shaping participants' behaviour in this particular organisational field.

Despite a growing body of literature exploring the processes of the changing cultures and identities of hybrid elites within the medical profession (Croft et al., 2015; Denis et al., 2015; Martin, Bushfield, Siebert & Howieson, 2021; McGivern, Currie, Ferlie, Fitzgerald & Waring, 2015; Spyridonidis, Hendy & Barlow, 2015), there is a need for further research to clarify the

economic, cultural, and political implications and trends of professional stratification and hybridism within traditional professions working in teaching hospitals, including tendencies towards more variable degrees and forms of hybridisation and even coexisting contradictory dehybridisation logics among medical professionals and academics within this organisational domain. In this sense, our interest lies in understanding how physicians and professors working in university hospitals have been interpreting and coping with their migration to EBSEH and its logic of management and organisation. We argue that the shift from the logic of medical-academic professionalism to the new logic of business-like healthcare may have profound implications for the academic nature of Brazilian HUFs and for the future of professionalism within these health and teaching organisations.

The structure of this paper is as follows. First, we briefly outline theory about professional stratification and hybridisation, which we draw upon to understand the impact of managerial reforms on HUFs in Brazil. Next, we provide an overview of EBSEH, its position within the national health system, and institutional relationships with universities, the Ministry of Education (MEC), and the Ministry of Health (MH). After describing the qualitative research methods we used in the study to obtain, analyse, and theorise empirical data, we present and discuss exploratory findings. We then conclude by discussing theoretical and practical implications of our findings for future research agenda.

2. UNDERSTANDING PROFESSIONAL STRATIFICATION AND HYBRIDISATION

There is a number of theoretical perspectives that help us understanding processes of change in classic professional domains such as medicine. Proletarianisation and deprofessionalisation theses, for example, focus on a postulated general loss of the ability of professions to institutionally control the various dimensions of professional autonomy (Coburn, Rappolt & Bourgeault, 1997), whereas the alternative reprofessionalisation standpoint sustains that professional communities are able to carry out an internal reorganisation of their work to actively minimise the impact of external threats while retaining important aspects of their professional dominance (Freidson, 1985). For Freidson (1989), despite all assaults on the medical profession, doctors are still the hegemonic professional category in healthcare, either individually or collectively (Light, 1991; Light & Levine, 1988). Drawing on the American medical system, Freidson formulates the concept of professional dominance to argue that the medical profession maintains institutional control over the content of healthcare work, users, actions of other subordinate health occupations, and health policy in general through commands, influence, and cultural authority derived from its medical expertise (Allsop, 2006; Coburn, 1994, 2006; Ferlie & Geraghty, 2005; Starr, 1982). Accordingly, the reprofessionalisation thesis claims that the medical profession has been able not only to shape the organisation and terms of medical work “but also to dominate significant fields of social activity” (Waring, 2014, p. 689). In other words,

the medical profession dominates the medical care system in the production of medical knowledge, in the division of labor in medicine, in the provision of health services, and in the organization of medicine (Navarro, 1988, p. 57).

In this sense, reprofessionalisation can be seen as a form of countervailing logic in the medical profession to limit loss of dominance (Light, 1995) through internal reorganisation and re-definition of its practices, identities, discourses, and institutional boundaries under bureaucratic and commercial pressures, like the expectations of health corporations, managers, and clients, for instance (Waring, 2014). Consequently, the medical profession is becoming more hierarchical, bureaucratic, and stratified in order to protect or extend its influence over the content and provision of healthcare (Coburn et al., 1997). For example, among the strategies employed by doctors to retain clinical or technical autonomy are their efforts to adapt protocols and rules according to their needs through negotiation and reinterpretation of these forms of control; to do so, doctors try to persuade or intervene in the development of regulatory tools and standards or at least influence their implementation (Numerato, Salvatore & Fattore, 2012).

Freidson (1985, 1994) then describes the advent of new internal hierarchical professional segments or strata composed of elites and rank & file professionals in the face of more bureaucratic, marketised, and managed workplaces (Waring, 2014). For Freidson (1985), the process of stratification within the medical profession results in the emergence of stronger knowledge elites and administrative elites in addition to a larger group of rank & file practitioners (Freidson, 1985, 1994; Kirkpatrick, 2016; Waring, 2014). In this vein, professional elites or leaders can reclaim moral authority and public support so as to address collective interests and manage changes (Allsop, 2006; Waring, 2014; Waring & Currie, 2009). That is why Freidson's accounts on reprofessionalisation are also known as a theory of professional restratification.

In medicine, this idea of professional restratification is nothing new. For long scholars have argued that doctoring is increasingly fragmented, diverse, and hierarchical (Allsop, 2006; Coburn, 2006; Coburn et al., 1997), with political and knowledge elites at the top; corporate, managerial, and governance elites next; practice or technical elites; and rank & file practitioners at the bottom of the pyramid (Waring, 2014). Insofar as professionals are increasingly working in more managed bureaucratic workplaces (Waring & Currie, 2009), the restratification results in intra-professional hierarchies at the points of "professional-organisational intersection", where the institutional boundaries between the profession, the state, and market organisations meet and blur (Waring, 2014, p. 698). Such internal hierarchisation of medical work within managerial environments then leads the elite doctors to incorporate or strategically adjust to new institutional logics, or systems of cultural elements and organising principles (e.g., familiar, managerial, market, religious, academic logics) (Haveman & Gualtieri, 2017; Reay & Hinings, 2009; Thornton & Ocasio, 1999), in order to act as advocates to safeguard the professional prerogatives of medicine. As Freidson (1994, p. 9) states,

[...] professionalism is being reborn in a hierarchical form in which everyday practitioners become subject to the control of professional elites who continue to exercise the considerable technical, administrative and cultural authority that professions have had in the past.

This means that by adapting to new institutional systems of values, beliefs, and normative expectations (Haveman & Gualtieri, 2017), medical professional elites have managed to reevaluate

and reorganise their work so as to maintain professional autonomy as a whole, though at the expense of the autonomy of their rank & file peers (Waring, 2014). In this case, some practitioners lose autonomy and power to an elite of professionals who seek to maintain or even expand their relative power, status, and influence through formal engagement with managerial roles (Freidson, 1985; Kirkpatrick, 2016). This progressive involvement of doctors in management has been characterised by Freidson (1985, 1994) as a process of internal differentiation of the medical profession in which elite groups deliberately choose to take up an active role in management as a response to external forces and threats (Kirkpatrick, Jespersen, Dent & Neogy, 2009; Noordegraaf, 2015). Such a process of restratification is well exemplified by the emergence of professional hybridisation, which occurs when professionals take on managerial logics (Croft et al., 2015; Kirkpatrick, 2016), hence becoming more accountable for aggregate organisational performance (Freidson, 1994). In medicine, the category of hybrid doctor-managers (e.g., medical directors, clinical research leaders, physician chief executives, hospital superintendents, heads of health units, etc.) depicts a prime example (Waring, 2014).

Freidson's restratification conception, therefore, represents a fertile starting point for understanding expert occupations and for an organisational sociological analysis of hybrid professional-management roles (Kirkpatrick, 2016; Waring, 2014). Hybridity denotes a mixture of professional background and managerial practices, cultural elements, and responsibilities (Croft et al., 2015; Hendrikx & Van Gestel, 2017; Kirkpatrick, 2016). As such, hybrid professionals are usually found at intermediary positions between a profession and the wider organisation, performing administrative or leadership roles to coordinate the interfaces between professional and organisational tasks (Waring, 2014). According to Waring (2014, p. 688), these hybrid professional managers entail a "recombination and blurring of distinct professional and organisational modes of working". This means professionals are being drawn into more bureaucratic, standardised, and hierarchical roles, hence performing their expert work in more managerial ways (Waring & Currie, 2009) in a hybridisation process which makes professional and organisational boundaries more blurred and entwined. Ultimately, therefore, hybridisation may be conceived as a form of organisational professionalism, an institutional logic (Thornton & Ocasio, 1999) that contrasts with the more traditional logic of collegial occupational professionalism (Evetts, 2006; Waring, 2014), and it thus being used increasingly as a discourse of managerial control, hierarchy, and rational-legal forms of organisational decision-making.

The literature on institutional logics is rapidly developing, closely associated with the institutionalist school of organisational analysis. Institutional logics, in this vein, are socially constructed systems of cultural elements and organising principles (Haveman & Gualtieri, 2017; Reay & Hinings, 2009) including "historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality" (Thornton & Ocasio, 1999, p. 804), be it a profession, the market, a corporation, or a religion, for example (Thornton, 2004). There are a small number of alternative and high-level institutional logics which reflect the presence of such major social subsystems. It is also possible that they go on to interact and create hybrid forms.

The case of hybrid professionalism thus combines professional and managerial logics through socialisation and reshaping of professional identity around managerial imperatives and more flexible working practices (Evetts, 2006), particularly in how professionals coordinate work, how

they establish authority, and what values, beliefs, and rules they share (Noordegraaf, 2015). For the medical profession, the effects of hybrid professionalism have been inscribing medical practice within more rationalised, standardised, and accountable principles of work organisation, “over and above individual autonomy, discretion and judgment” (Kirkpatrick et al., 2009, p. 643). Doctors then treat their cases within highly managed organisational environments (Noordegraaf, 2015), thus constituting an administrative elite that play an active role in management and leadership by “setting standards, reviewing performance, and exercising supervision and control” (Freidson, 1985, p. 26).

The logic of managerialism, therefore, underlies hybridised professionalism, as it reframes the connections between professions and managerial patterns of action, interaction, and interpretation in often ambiguous, malleable, and complex processes in which traditional professional fields cope with managerialisation by absorbing, adapting, or even resisting to it (McGivern et al., 2015). In this vein, the increasing managerialisation of medical work represents an intricate transition from the logic of professionalism to the logic of managerialism, thus involving changes in the interests, power, and political dynamics of the medical profession within wider managerial environments. This points to previous research that has found that although the dominant institutional logic of healthcare provision has changed from medical professionalism to business-like managerialism, there are still competing institutional logics interacting and coexisting in this organisational domain (Reay & Hinings, 2009).

In this sense, whereas some authors emphasise that restratification through hybridisation implies co-optation or colonisation of medical professionals into managerialist reasoning (Coburn et al., 1997; Freidson, 1985, 1994; Jacobs, 2005; Llewellyn, 2001; Waring, 2014; Waring & Currie, 2009), others sustain that professionals can resist, or even play with, managerial logics (McGivern et al., 2015). Therefore, considering that different, and even rival, institutional logics may coexist within an organisational field (Reay & Hinings, 2009), and that both logics of pure professionalism and managerialism are mutually intertwined in ambivalent and subtle ways (Noordegraaf, 2015), the recombination and blurring of professional and organisational identities, practices, values, beliefs, and rules can give rise to a variety of plural, complex, uneasy, unstable, and even contradictory hybrid relationships (McGivern et al., 2015; Noordegraaf, 2015; Waring, 2014) and conflicting institutional logics (Reay & Hinings, 2009).

It is worth mentioning, lastly, that the introduction of the NPM in many healthcare systems worldwide has boosted the infusion of business-like healthcare logics (Reay & Hinings, 2009) and, consequently, the involvement of doctors in management. The growth of such managerial hybridisation in healthcare organisations thus becomes an obvious course (Kirkpatrick et al., 2009; McGivern et al., 2015), despite some remaining debate over the extent to which doctors are committed or linked to management roles (Fitzgerald et al., 2006), and research suggesting different professional reactions to management (Degeling et al., 2006). Therefore, professional stratification through a hybridisation process is widely seen as likely to occur in contemporary healthcare settings in the literature and also as a double-edged sword, that is to say, a dynamic, contradictory, and nuanced process which depicts how professionals are co-opted into management but also how they can resist to, buffer from, or even dominate bureaucratic or managerial logics of organising expert work in contexts of organisational change (McGivern et al., 2015), as we shall see in the following sections.

3. NPM REFORMS, FEDERAL UNIVERSITY HOSPITALS, AND EBSERH

Since the 1980s Brazil has undergone a period of stagnation in economic growth and rising public debt (Bresser-Pereira, 1996). In this economic context, the need to reduce government expenditure and redesign state bureaucracies incited the emergence of a political liberal consensus around the adoption of an approach of dependent and associated economic development, neoliberal policies for fiscal stabilisation, and NPM-type reforms in the public sector. The Brazilian government thus became firmly committed to implementing key elements of the NPM, seen as the ideal model to organise and manage the public sector and to promote economic recovery (Bresser-Pereira, 1996; Paes de Paula, 2005).

Among the NPM-style strategies applied in Brazilian reforms, privatisation has certainly been a strong trend since the 1990s; this, however, has not been the only alternative to replace centralised bureaucratic public administrations. Publicisation reforms (Schweizer & Nieradtka, 2001) appear as a softer or quasi-market NPM alternative (Ferlie & Geraghty, 2005) to the transferring of non-exclusive public services to private non-profit organisations (Ferreira, 2003; Morais, Albuquerque, Oliveira, Cazuzu & Silva, 2018) and publicly held companies regulated by private law (Bresser-Pereira, 1996). In the public health sector, the EBSERH public enterprise is a recent example of publicisation carried through with the aim of reorganising hospital administration and managing teaching and healthcare services provided by HUFs, which represent about 28% of all public hospitals owned and operated by the federal government (La Forgia & Couttolenc, 2008).

EBSERH was set up by the Law n. 12550 in December 2011 under strong criticism from university communities. Linked to the Ministry of Education (MEC), which operates most teaching hospitals in the country (La Forgia & Couttolenc, 2008), the company became an indirect administrative body of the federal executive branch in charge of the National Programme for Restructuring Federal University Hospitals (REHUF) through management contracts with the universities (Lei nº 12.550, de 15 de dezembro de 2011). In short, the REHUF aims at restructuring and revitalising HUFs integrated into the Unified Health System (SUS). Established by the Federal Constitution of 1988, the SUS provides universal and free of charge healthcare through a comprehensive, participative, and decentralised system that has been widely recognised as a successful example of healthcare reform in Latin America (Atun et al., 2015).

HUFs constitute an important ramification of the SUS, particularly in relation to the provision of secondary and tertiary healthcare and higher education health services. Nevertheless, despite huge heterogeneity among university hospitals across the country (Machado & Kuchenbecker, 2007), for years these teaching medical facilities have been facing major challenges of understaffing, shortage of medical supplies and equipment, lack of investments, and deficient financial and administrative capacities. As La Forgia and Couttolenc (2008) note, university-based teaching hospitals cost more than non-teaching hospitals due to the additional costs related to teaching and research activities, intensive recourse to high-tech equipment, and clinical treatment of more complex, hence more costly, health conditions. In this context, Persson and Moretto (2018, p. 279) explain that EBSERH

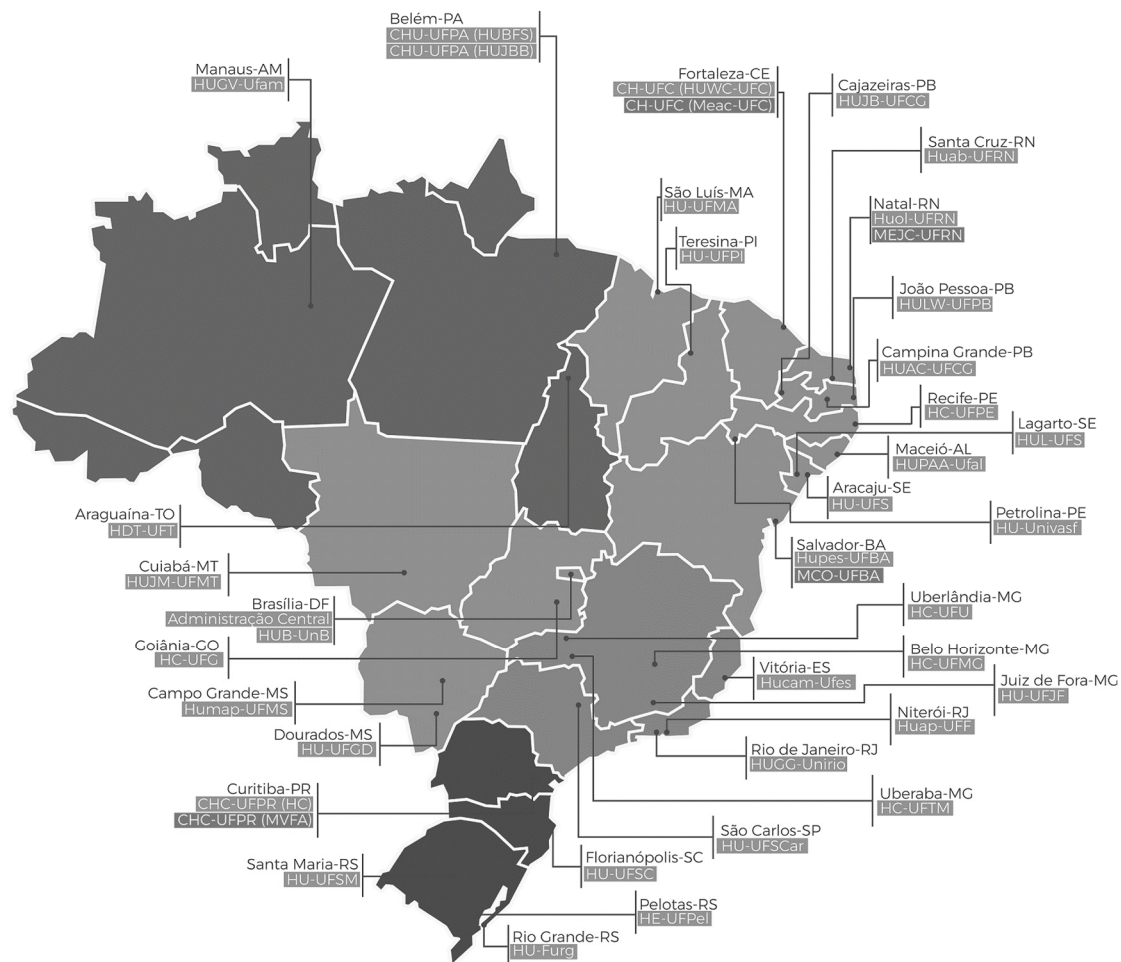
emerges as a new organizational apparatus proposed by the federal government to manage public federal university hospitals and solve the severe problems of precariousness and staff shortage in these institutions, in view of the Brazilian economic crisis.

EBSERH is owned by the Union, with its funds being defined annually by government decree (Vieira, 2016) and its activities regulated by statute. The company cannot sell services to individuals insofar as all medical-hospital services delivered must be entirely and exclusively linked to the SUS. This means that although holding substantial administrative, operational, and financial autonomy, EBSERH must comply with the National Health Policy established by the Ministry of Health (MH). However, the company can operate according to a business-like approach, particularly in what concerns staff recruitment and management practices. In order to have their hospitals managed by EBSERH, federal universities have to accede to the company through management contracting, which involves situational assessments, goals setting, and a one-year period to conclude the migration process (Vieira, 2016).

It is worth noting that EBSERH arises as a hybrid entity influenced by the World Bank's recommendations of trade liberalisation, decentralisation, delegation of health services to the private sector, and scaling down government-run health systems (World Bank, 1993), along with the promising idea of modernisation (Sodré, Littike, Drago & Perim, 2013) through the logic of business managerialism. As Persson and Moretto (2018, p. 289) point out, the company's goals of efficiency, performance targets, pragmatism, productivity, strategic management, and so forth are "justified by the efforts to eradicate an administrative inefficiency associated with the provision of health and education public services".

Indeed, the Brazilian government viewed EBSERH as the only feasible alternative to regularise the illegal outsourcing of workforces employed in university hospitals through support foundations, to expand their staff numbers through the use of private sector – hence more flexible – types of job contracts, to improve hospital management, resources, and performance, and to efficiently meet ever-increasing demands for infrastructure, teaching, research, and high complexity care (Andreazzi, 2013; Luedy, Mendes & Ribeiro, 2012; Sales & Peixe, 2020; Sodré et al., 2013). Managerialisation was thus conceived as the best approach to reorganise and run the network of federal teaching hospitals, despite criticism of the impact of the logic of managerialism upon universities' autonomy (Soares, 2016; March, 2012) and the formative nature of their hospitals by virtue of enhanced administrative systems, greater emphasis on clinical services, and performance-driven ways of work.

Currently, EBSERH is responsible for managing forty out of fifty HUFs in Brazil, thus constituting the largest chain of public hospitals in the country (see Figure 1). Its own workforce comprises about 36,800 workers, including approximately 7,200 employed physicians. In addition, the company now manages over 22,000 university public servants (including administrative staff, doctors, and other health professionals) who were already working in university hospitals before the migration. EBSERH's estimated budget for 2021 is R\$ 6.68 bn, which represents 0.15% of the total government expenditure for the year (Portal da Transparência, 2021).

FIGURE 1 CHAIN OF HUFs BEING MANAGED BY EBSERH

Source: Adapted from EBSERH (2021).

In this paper, we pursue a line of argument that, as an expression of NPM approach in healthcare, EBSERH may lead to reinforced stratification of the medical workforce and to stronger engagement with the institutional logic of business-like healthcare through new forms of formal and psychological links developed between doctors, universities, and hospital administration. On the one hand, the centralisation of management in EBSERH is expected to increase intraprofessional disparities between university hybrid elites and rank & file doctors and other health workers employed by the company. By being treated more as “employees” than as “professionals”, doctors who work for the company are being allocated mainly to the rank & file position, with a presumably larger gap between them and other areas of hospital administration and medical education. For example, despite the opportunities to get involved in residency supervision and lower-level management roles, many company’s medical employees feel that they face restrictions or have limited incentives to take on more complex or time-consuming teaching and research activities, as well as higher-level management. On the other hand, the expanded logic of managerialisation

aimed at financial recovery may have significant effects on academic-hybrids' work and professional identities. This is because increased efforts to meet the demands for medical services have become a priority, whereas teaching and research have been relegated in the hospitals' operations. This means clinical care is now more dissociated from academic work, which ultimately suggests a trend towards dehybridisation processes changing old patterns of professional identity and roles among universities' medical academics, as we shall discuss further.

4. RESEARCH METHODS

This paper draws on qualitative exploratory data derived from a study conducted in the field of HUFs in Brazil between September 2019 – December 2019. The study was designed to gather data at two analytical levels (see Figure 2): at the meso level (drivers and implications of the advent of the EBSEH company demarcating changes in HUFs), and at the micro level (impacts on HUFs and new trends for the medical workforce). The overall background of this first stage empirical study was the transfer of HUFs from university autonomous management to EBSEH from 2011 onwards.

The pilot study involved in depth, computer-assisted semi-structured interviews with seven purposively selected expert participants in different settings, including managerial and academic elite doctors (5), a healthcare professional (1), and a senior professor-manager (1) with expertise on university hospitals administration, health policy, and public management reforms (the Appendix includes further information on the interviewees). In terms of sample size (Vasileiou, Barnett, Thorpe & Young, 2018), we followed Sandelowski' (1995) suggestion of defining a qualitative sample size as large enough to provide new and richly textured information about the phenomenon under investigation, but small enough to allow in-depth analysis of qualitative data obtained. Also, we adopted Malterud, Siersma and Guassora's (2016) notion of "information power", according to which the more useable information the sample holds, the lower number of participants is needed. For the purpose of an early stage of a larger ongoing study, therefore, our sample size was quite suitable for an initial understanding of a phenomenon that has not been studied in Brazil before. Individuals were selected for interviews on the basis of their past and present experience and expertise in the field of teaching hospitals. They provided highly relevant insights and narratives about the migration of university hospitals to the company and its implications for doctoring, including changes such as novel institutional logics, forms of management and work organisation, professionals' relationships, identity formation, new and reshaped formal and psychological links.

In addition, our qualitative study design rested on multiple sources of data comprising not only interviews but also a variety of publicly available policy documents such as reports, laws and regulations, official communication, and newspaper stories. The documentary data provided us with contextual and insightful information both at the meso and micro levels. In combination, these data sources (see supplemental material: Appendix) composed an extensive discursive corpus for a textually oriented analysis based on triangulation between primary intensive data sources (in-depth interviews) and secondary extensive data sources (documents) (Rothbauer, 2008).

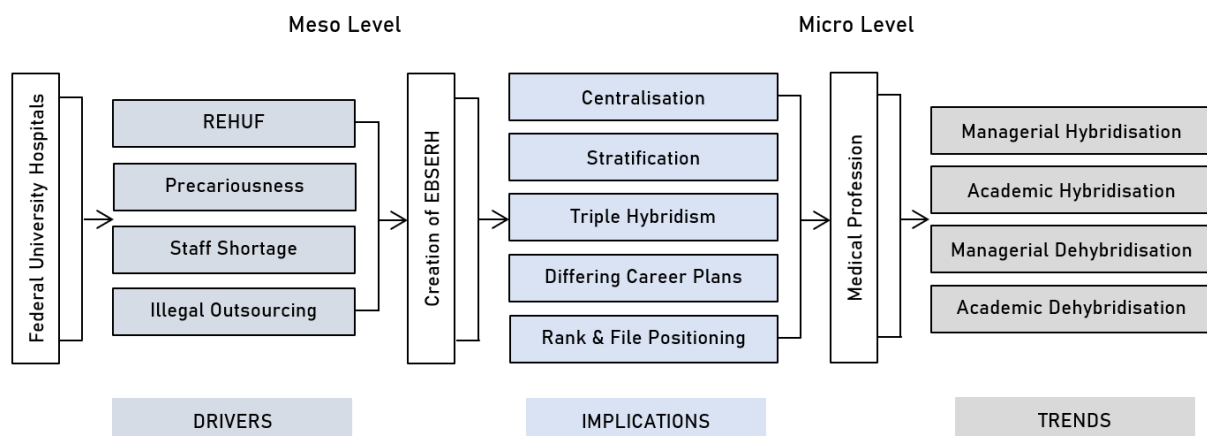
The data analysis approach was based on a combination of deductive and inductive research logics. Whereas guided by a predefined theoretical-analytical framework the analysis was data-driven, thus favouring the emergence of new conceptions. The systematisation and organisation of data began just after the transcription of all interviews and documents compilation. Transcriptions and other text documents were gathered to compose a discursive corpus which was then entered in the software package NVivo 11.

The analysis started with a process of open codification (Strauss & Corbin, 1998) through close line-by-line reading of the data. In this procedure, 1st order concepts were extracted (Gioia, Corley & Hamilton, 2012) from the discursive corpus faithfully retaining informants' terms, notions, and ideas. Stage two coding consisted of axial coding, with more focused coding to identify 2nd order themes or main narratives through similarities, differences, connections, and other discursive patterns. Taken together, these themes provided coherent description and identification of drivers, implications, and trends (see supplemental material: Box B). The stage three coding went on as an iterative and reflexive process guided by our theoretical framework to distil themes into aggregate categories. This process involved reviewing and refining data to answer the study questions.

5. FINDINGS

Our exploratory data help explain the main drivers that have triggered important institutional changes in the field of HUFs in Brazil, precisely in what concerns the establishment of the EBSEH company (see Figure 2).

FIGURE 2 FRAMEWORK OF INSTITUTIONAL CHANGES IN HUFs



Source: Elaborated by the authors.

5.1 Drivers of Reforms in HUFs

At the meso level, we found four drivers of institutional changes in the organisation and management of HUFs, culminating in the establishment of the EBSEH company. Interviewee PSI-01 highlighted that the National Programme for Restructuring Federal University Hospitals (REHUF) is one of the major policies for these hospitals in recent years. This programme was launched by the government in 2010 to “*restructure and revitalise federal university hospitals integrated into the Unified Health System (SUS)*” by providing these hospitals with material and institutional conditions such as improvements in managerial processes, infrastructure, modernisation, staffing increase, and introduction of a shared funding system (Decreto nº 7.082, de 27 de janeiro de 2010; Portaria Interministerial nº 883, de 05 de julho de 2010). Having its coordination delegated to EBSEH in 2012 (Portaria nº 442, de 25 de abril de 2012), the REHUF can be seen as the first step of the company creation, which is then conceived as the second important policy to solve the crisis in HUFs.

Although expanding university hospitals' funding, the REHUF was not entirely successful in solving the precariousness crisis in these hospitals. According to our documentary data, EBSEH emerged as an organisational solution to accomplish REHUF' goals through introduction of the logic of business-like healthcare for more efficient management of hospitals facilities. However, respondents suggested that far from solving the issues the company has only been able to mitigate them, as “*problems related to management, purchasing of materials, and, let's say, problems of organisation in service contracting, including maintenance services, are still somewhat difficult*” [PSI-01]. Our data comprise several documents from news media, unions, representative institutions, and lawsuits that endorse such a narrative of continuing infrastructural precariousness and advent of new issues in teaching hospitals under EBSEH's control. For example, some documentary data report that “*all university hospitals are in crisis*” [Brasil de Fato online newspaper] due to “*lack of resources*”, “*broken equipment*” [APUFPR report], “*outdated salary*” [FENAM report], “*unsanitary work conditions*” [Jornal do Brasil online newspaper], “*moral harassment*” [G1 RS online newspaper], among other critical situations.

Another powerful argument that discursively supported the migration of HUFs to EBSEH claimed that the transferring would be the best solution to solve staff shortages and illegal outsourcing of workers hired by universities support foundations. According to the EM Interministerial nº 00127/2011/MP/MEC, for long HUFs have suffered with “*constraints imposed by the civil service employment regime that is peculiar to direct administrations and autarchies, particularly concerning recruitment and management of workforce*”. Respondent PSI-04 similarly noted that “*for a long time we had few places for public servants due to that slowness of the public service, of the system to recruit people and get them started*”. In this context, contracting workers through universities support foundations and allocating them to hospitals was an alternative to handle chronic understaffing issues, albeit such an ingenious solution had led to countless judicial actions in the Court of Auditors and Federal Prosecutions Office (EMI nº 00383/2010/MP/MEC).

[...] [the foundation] *is a juridical person which theoretically cannot hire people to work as public servants [at the university]. So, these workers were hired by the foundation through CLT [private sector job contract] and were allocated to work within the hospital as if they were public servants, just like federal civil servants. [...] This was a way that “evaded” the general rule, which was the government hiring new public servants [PSI-04].*

EBSERH was then introduced by the government as the only viable way to regularise unlawful job contracts. Furthermore, in terms of tackling understaffing, closer connections between the company and other ministerial bodies of the federal executive branch seem to be facilitating reasonable institutional development in federal teaching hospitals, which are now considered to be in a more stable condition. Interviewee PSI-04 illustrates such a positive view: *“In terms of staffing I think we’re now in a much better situation than before”*. Likewise, PSI-01 stated that *“EBSERH comes as a solution to staffing issues. It has 28k employees today and pretty much all of them are working in the hospitals. So, this has brought a breath”*.

However, more sceptical discourses emerged from our data. Some interviewees depicted EBSERH as a bad, poor solution. PSI-03, for example, noted that the company *“hasn’t hired the number of workers that was agreed in the contract. Let’s say that it has accomplished 60% of what has been promised in terms of staffing”*. In the following quote, EBSERH is also acknowledged as “a necessary evil”, as universities were devoid of objective conditions for recomposing their own workforces and proper funding. The creation of the company was strongly rebuffed from the outset, especially by leftist social groups, despite the fact that EBSERH was established during the government of the *Partido dos Trabalhadores* (Workers Party).

At a given moment, it [EBSERH] became a necessary evil. Without EBSERH we would have died; with EBSERH we would have a chance to survive. That’s how it happened. [...] In my opinion, EBSERH is gonna be closed down someday and replaced by another solution because it is just been tolerated. Nobody has indeed swallowed it [PSI-06].

5.2 Implications for the Medical Profession

Moving on to the micro level analysis, an important identified implication of the new system of organisation and management of HUFs for the medical work involves centralisation of control, investment, and personnel management in EBSERH, which has now become the central power of decision-making. This in fact corresponds to one of the main aspects of the company's managerial logic, that is, *“implementation of a single core management system to generate quantitative and qualitative indicators for goals setting”* (Lei nº 12.550, de 15 de dezembro de 2011). Doctors' perceptions on centralisation divide. Interviewee PSI-01 argued, for example, that *“EBSERH has become a centre of knowledge development related to large-sized hospital management [...] which will certainly allow for the development of university hospitals”*. In contrast, centralisation is seen as violating university autonomy, since *“The hospital is no longer part of the university but of*

EBSERH” [PSI-05], which leaves doctors with “no voice in defining the personnel and functions” they want [PSI-04]. In addition, more centralised modes of control would contribute to erode doctors’ well-established clinical autonomies, such as freedom to set their own work plans and schedules, as participant PSI-07 observed.

These exploratory data vividly show that the internal stratification of the medical workforce has been reinforced. Reinforced because data consistently confirm that doctoring employed in HUFs has been historically segmented, even prior the advent of EBSERH. There has always been a formal differentiation between doctors-professors and doctors in terms of employment, positions, and career plans. For instance, PSI-02 described that:

There was a clear division between doctors who were professors and those who were hospitals’ practitioners only. So, we could see a hierarchical division in terms of filling positions. There was a greater tendency for doctors-professors to take on managerial roles within the hospital.

In fact, the medical profession employed in teaching hospitals is usually highly segmented not just on account of diverse medical specialities but notably owing to the involvement of doctors in academic work and management roles, which often leads to the emergence of knowledge elites and managerial elites. In addition to these professional elites, HUFs also present a distinctive case of triple-hybridism of practice, knowledge, and managerial elites. This is because many doctors employed in these hospitals perform patient care, teaching, and research simultaneously. In that some of them take on managerial roles as well, they end up forming an elite of triple-hybrid professionals (doctor-professor-managers). Our preliminary data support the idea of a tradition of triple-hybridism in university hospitals, as doctors-professors are still seen as the main professional stratum to take on hospital management. However, many academic hybrids appear to be moving away from management more recently, which signals triple-hybridisation may be eroding. The following excerpt illustrates the taken-for-granted dominance of doctors-professors in management roles:

For long, due to the lack of an adequate process of professionalisation, the medical hegemony was pretty much absolute. [...] So, I think such a hybrid nature you’ve mentioned is a historic, concrete, important, and significative reality, albeit certainly causing some problems to the institution’s development too. Today we can see professionals with more varied backgrounds [doing management] [PSI-01].

In this context, the condition of being a “professor” is perceived as potentially reinforcing managerial hybridisation, as doctors are considered as key players in health management, especially because hospital organisation is often arranged according to medical expertise and technologies. As PSI-01 noted, “intense segmentation [of medical work] implies the presence of doctors in at least some aspects of management”. Respondent PSI-04 similarly argued that “it’s easier to teach doctors management than teaching managers medicine. Just to say that doctors have a certain importance regarding management as they know the full operation [of the hospital]”. Furthermore, academic hybrids are conceived as the main professional group in establishing a well-matched connection

between teaching, medical assistance, and management within university hospitals, considering their particularities and educational nature:

So, I think that, considering the peculiarities of a university hospital, doctor is the one who should be in charge. However, if not a doctor, it must be another health professional. Anyway, he must get trained to run a complex institution such as a university hospital. What I am saying is that, yes, I think it's the doctor for many reasons, but he has to get qualifications to manage. It's not enough to be politically influential and elected by the university community. He must know how to manage. This means the professionalisation of public health [PSI-06].

In this sense, findings point out that the dominance of these two categories of medical professionals usually produces intermingled professional identity and work logics within hospital workplaces and medical schools. PSI-03 recalled that “*people used to confuse doctors with professors, professors of medicine with hospital's doctors. People find it difficult to distinguish them, actually*”. Moreover, many medical practitioners have become recognised by their peers as members of a practice elite on account of their expertise and support to teaching tasks, owing to their close relationship with students and residents. Under the university control, the opportunity for doctors to perform clinical professorship in the hospital was an important driver of blurred and hybridised professional logics, as “[...] *any doctor working in a university hospital is a prospective professor*” [PSI-06].

Nevertheless, the introduction of different career plans by EBSEH was considered a significant institutional change affecting the relationship between medical practice and academic work. This is because the shift has led to the coexistence of different professional groups being regulated by distinct employment regimes and job contracts (i.e., university's public servants vs EBSEH's employees). According to the EMI nº 00383/2010/MP/MEC, “*The corporate organisation will allow for the hiring of professionals under the private sector employment regime and the establishment of a system of paying and personal management that is compatible with the reality of the sector*”. In other words, the company can hire workers under the same rules that regulate job contracts in the private sector – the so-called Brazilian Consolidation of Labour Laws (CLT). Public servants who work for federal universities, however, are regulated by a distinct public sector employment system called the Unified Juridical Regime (RJU). As a result, the migration of university hospitals to EBSEH is perceived as “*splitting a little more*” [PSI-04] a professional medical workforce which was already quite fragmented. Interview and documentary data suggest that in the short-to-medium term the enhanced stratification of the medical workforce may lead to at least three troublesome outcomes. The first concerns to increasing workplace conflicts:

[...] This distortion will greatly undermine the development of the university hospital in the next years, maybe in the next decades. Because there are CLT workers alongside RJU workers working for different salaries, different careers plans, with different managers. The introduction of the CLT regime into the university hospital was one of the major problems of EBSEH [PSI-06].

At this moment, there's a differentiated hiring system, a differentiated working system, a differentiated paying system. You've got different people doing the same job but getting different pays. It can't be like that. It can't be like that anywhere. It doesn't work anywhere [PSI-07].

EBSERH's employees earn nearly twice as much the salaries of public employees although performing the same work. High-ranking managers are granted high pays and privileges. If there's a bank holiday on Tuesday, they'll be off the whole week (Jornal do Brasil, 2019).

Secondly, the presence of two different career plans in HUFs can result in a tendency for the recruitment of doctors with no academic profile or interest, thus preventing many doctors from becoming a practical elite by virtue of strong engagement in teaching tasks, as used to happen in the past. PSI-05 described that this is already an issue at some teaching hospitals: *"As the salaries [paid by universities] to hire professors are no longer attractive in the market, we're falling short of professors in the university hospital and the course [of medicine] is now facing a sort of 'crisis of professors'"*. Thirdly, the fragmentation of the medical workforce and a rising number of doctors with no or low involvement in academic work due to the nature of their job contracts and greater focus on clinical care, can be harmful to university hospitals' educational mission, for *"This will impair the final goal of the university hospital, which is providing healthcare while teaching students"* [PSI-06].

The above narrative directly relates to rank & file differential positioning, another important theme that emerged from data. The rank & file group includes doctors engaged in direct clinical care. Data attest that doctors employed by EBSERH are being allocated to perform mainly health assistance. As participant PSI-03 described, *"they [doctors hired by EBSERH] are going to work in outpatient clinics, emergency, and so on. They're going to do a heavier job I think"*. PSI-05 also stated that these professionals *"are going to work as clinical physicians, basically"*. Likewise, respondent PSI-04 observed that *"in our hospital, considering that they're newly-arrived, the majority of them are performing clinical functions, not managerial functions"*.

5.3 Trends of Professional Stratification and Hybridisation

Figure 3 illustrates some identified potential tendencies for the medical workforce employed in HUFs. These trends point to four main narratives around managerial and academic hybridisation and dehybridisation logics. We present these four narratives below.

FIGURE 3 TRENDS IN THE MEDICAL PROFESSION WORKING IN HUFS

	HYBRIDISATION	DEHYBRIDISATION
MANAGERIAL	strong subjective links training and qualification in management financial rewards political influence cumulative experience in management	underprivileged status hostility weak professional retention managerial centralisation new forms of control reluctance to take responsibility
ACADEMIC	strong subjective links academic status power retention teaching-learning processes inclination to academic career	disappointment reduced scope for academic work weak professional retention managerial centralisation

Source: Elaborated by the authors.

5.3.1 Managerial hybridisation

Data suggest that some doctors tend to assume managerial hybrid roles on account of strong subjective links they develop with the university hospital and their professional peers. Here, subjective links relate to psychological attachments, such as sense of belonging, affiliation, self-fulfilment, and cooperation, that play an important role in (re)shaping professionals' identities, work practices, organising principles, and behaviours. For instance, interviewee PSI-04 noted that the sense of commitment with the hospital administration is often a subjective driver of the enactment of management logics within teaching hospitals. He gave the following quote:

She [hospital superintendent] is someone who puts her heart in the hospital, you know. She owes everything to the university. She was almost retiring, as she's 66, and didn't need to prove anything to anyone. Even so, she decided to take on this challenge to improve the hospital.

The importance of getting formal training and qualification in management in promoting hybrid professionalism was highlighted in interviews. PSI-04 commented, for instance, that “*in view of the difficulties in the labour market, we note that medical professionals are increasingly seeking to get qualification in management too*”. Formal education in management through MBAs and masters degrees seems to integrate the institutional professional logic of many doctors engaged in managerial tasks within university hospitals. Management knowledge is rather legitimated in interviewees' discourses:

However, this professional [doctor] needs to learn how to manage, because in this area there's a certain prevailing concept, and I saw it a lot: if a guy is a good doctor, respected, knows how to do diagnosis and treatments, has good relations with people, so this guy is gonna be director. But sometimes he ends up being a terrible director because he has no qualification in management. So, being a good doctor doesn't mean to be a good director. There's no such a relation [PSI-06].

I think that doctors don't... medical knowledge is not enough to run a huge health unit, right, like a huge city health department or a large-sized hospital. I think our knowledge is insufficient. [...] But I also consider that a manager doesn't have enough knowledge to run health institutions [PSI-02].

A professional career development that favours cumulative experience in management is another key factor that stimulates doctors' involvement in management roles and leadership positions within university hospitals. For example, PSI-06 commented that for long he had been *"involved with the university hospital administration. I was support director, I was deputy head for four years, and director-general between 1996-2000"*. Similarly, PSI-01 commented that he had been head of the hospitals' infectious diseases department before making the decision to be a candidate to the director general position: *"On account of that experience, which was a small but meaningful experience in terms of learning, I decided to run for director general of the hospital"*. Some doctors and academic hybrids (doctors-professors) had been initially taken on coordination positions in academic and clinical departments before willing or incidentally moving on to more strategic managerial roles in hospital administration. PSI-04 illustrated that: *"I've been actively participating in the Department of Ophthalmology, engaging in undergraduate lessons and management"*.

A different system of financial rewards implemented by EBSEH is in the centre of the criticism around the new form of hospital organisation. Economic gains paid by the company are now about fifteen times the values that used to be paid by the university for those holding management roles in the hospital. PSI-03 noted, for example, that under EBSEH's administration *"the director-general of the hospital earns more than the university's rector"*. In this context, data suggest that some professors and doctors employed by the university are willing to take on management roles within EBSEH's governance so as to earn these attractive compensations. Therefore, such a system of excessive rewards constitutes a strong objective economic factor that may lure professionals to managerial hybridisation to the detriment of more subjective motivators. As PSI-06 suggested, *"people may want to assume [management positions] because they're longing for these rewards [...]. This can certainly create distortions"*.

The opportunity to keep or even expand some degree of political influence also emerges as another key element to foster managerial hybridisation in university hospitals. As an example, PSI-07 emphatically stated that *"Doctors will never let anyone else run the hospital. Never will"*. By "doctors" the interviewee refers to university's physicians and academic hybrids who form administrative and knowledge elites with *"stronger voice"* [PSI-04]. Likewise, PSI-03 attested that *"[...] professors of health departments, who are in the power structure of the university hospital, want to hold management positions. I think it's hardly likely for them to leave these positions to doctors who were just hired by EBSEH"*.

5.3.2 Managerial dehybridisation

If the institutional logic of managerial hybridisation is a clear tendency for the medical profession working in HUFs, so is the logic of managerial dehybridisation. By dehybridisation we mean the willing or induced negative reaction to managerialism. Figure 3 points to an association between managerial dehybridisation and underprivileged status among medical professionals working in public teaching hospitals. Overall, engagement in hospital administration is often conceived as hindering other professional activities like specialised clinical and academic work. For example, interviewee PSI-01 commented that *“management is an activity that hinders the academic career, it really does. It’s very difficult to reconcile them very well”*. Furthermore, our exploratory findings illustrate that managerial hybridism often leads to hostility from colleagues. Participant PSI-06 gives an illustrative example: *“A professor who assumes management roles is, let’s say, a bit frowned upon. ‘This guy is pro-rector, department head, clinical director, chief of service... What’s he doing there?’ He’s not esteemed at all”*.

Data revealed that medical professionals with long careers within the university hospital used to valorise subjective links such as status, vocation, autonomy, and academic purposes, even if earning less than they would do in private medicine. Nonetheless, precarisation of labour relations and more constrained conditions of medical work may lead to weaker professional retention, hence pointing to a trend towards managerial dehybridisation. In economic terms, EBSEH’s career plan seems promising for young doctors in their early career on account of good starting salaries; nevertheless, strong affective attachments may not be fostered by these new job arrangements, thus preventing doctors to build a long-term commitment and career in the university hospital. For example, more flexible job contracts tend to favour increased turnover, as *“the job is CLT regulated, people who are not pleased with the workplace simply quit”* [PSI-03]:

Young doctors don’t think in the long term; this is one of their characteristics. So, they’re gonna join [the university hospital] because the starting salary is good. However, as time passes, they tend not to stay. That’s the matter. Not building links up. [...] When I started to work in this university hospital, a huge group [of doctors] stayed in the hospital because while the career moved forward the salary got better and our attachment to the hospital grew up. I think EBSEH means the opposite [PSI-06]. Of course! This is obvious. With these new labour rules, new forms of job contracts, everything gets much easier: just kick them out! Over and done [PSI-07].

As previously explained, the advent of EBSEH is implying novel logics of organisation and management in HUFs. The company is strongly committed to creating *“[...] conditions to substantially improve management standards, with the adoption of advanced tools for result control and transparency”* (EMI nº 00383/2010/MP/MEC). These include *“a model of administrative, budgetary, and financial management based on results and effective spending control”* (EM Interministerial nº 00127/2011/MP/MEC). Additionally, new forms of control comprise *“performance goals, execution time, and indicators”* and *“systems of monitoring and evaluation containing standards and criteria”* (Lei nº 12.550, de 15 de dezembro de 2011). Despite possible local variations, these new management tools are being implemented to all hospitals integrated into the company, pointing to increased managerial centralisation, as we have already discussed. In this context, the company is believed to

exert “*greater control over doctors*” [PSI-03], albeit it is not clear the extent to which new and centralised managerial forms of control impact on clinical autonomies. Our data suggest that formal links such as financial rewards may become a more salient institutional logic in justifying professionals’ adaptation, compliance, or subordination to enhanced organisational goals and control mechanisms.

Another relevant theme that may signal managerial dehybridisation refers to perceived reluctance to take responsibility among some doctors and medical academics. According to respondent PSI-07, for example, some professionals “*just don’t care. They don’t want to work. They don’t want to make a commitment to the institution*”. Similarly, PSI-04 commented:

Professors no longer want to take responsibility for the hospital. They want to give their master lessons, to be due in complex surgeries, to decide on their own schedule, to see an X number of patients while teaching; but sometimes they don’t want to be in [management].

Triggers of reluctance to take managerial tasks certainly vary for each medical professional but are likely to be associated to the previous themes, especially new forms of control and centralisation of political decision-making in the company. Such a reluctance to actively participate in hospital administration can be seen as another factor signalling “*that hybridisation is a process which is being superseded, although still very meaningful*” [PSI-01], which, according to our interviews, can erode triple-hybridism and ultimately undermine university hospital work: “*The absence of professors in the hospital’s administration impairs the university hospital’s role. I agree with that, and I think this is happening right now*” [PSI-06].

5.3.3 Academic hybridisation

As we can observe in Figure 3, academic status is a form of professional recognition which has the potential to promote or sustain academic hybridisation in the medical profession. Our data suggest that some doctors feel that their involvement with academic roles at renowned universities leads to a distinguished status, which is sometimes defined in marketing terms. For example, “[...] *if you say that you are a university professor this means a lot to patients. So, you’ve got this marketing aspect that makes huge difference. So, there’s a lot of colleagues who use this [academic status] as a marketing strategy*”, PSI-02 commented. Similarly, PSI-06 said that “*a doctor-professor brings with him a differential status, no doubt about it. He has a greater market value, let’s say*”. It is worth noting that academic status is not the same as the social prestige that doctors often hold in society. In fact, academic status is a form of recognition that adds a differential acknowledgement to doctors’ social standing not only in society but also within the profession itself. As PSI-05 noted, “*working in a university hospital gives you a status in society and within the [professional] category*”.

Just like in managerial hybridisation, strong subjective links with the university life appear as relevant factors in professionals’ identity formation and self-recognition vis-à-vis other colleagues within the medical grouping. Professors, for example, were regarded as having closer emotional attachments with the university community whereas physicians were depicted as more engaged with regular hospital work. Nevertheless, the affective identification of some doctors with the academic nature of the hospital and its potential “*to make a difference in society*” [PSI-01] by “*transforming*

health professionals' education" [PSI-02] stimulates them to commit to and undertake teaching tasks, regardless their formal links and main roles in the hospital. PSI-06 gave an illustrative example about that:

I am a professor and a doctor. But many of those who are in the university hospital are not teachers in formal terms although being excellent teachers in practice; they are teaching students in the emergency ward, in ambulatories, even though they are not linked to any teaching department, for instance. This philosophy of university hospital has to predominate.

Our preliminary data also show that the career of doctors who belong to the practice elite seems to be more attractive and exciting, as this group has more opportunities to engage in complex medical practices, teaching-learning processes, and residency supervision, although exempt from performing teaching for undergraduate students. For these academic hybrids, psychological attachments apparently have a significant weight on career development. For example, PSI-02 described that *"During on-call times, we used to host residents and students. So, they used to stay on duty with us. We were responsible for teaching in service, as we call it"*.

The involvement of doctors in academic roles is also explained by their inclination to an academic career. Our data vividly demonstrate that having *"the perspective of being a university professor"* [PSI-01] makes many medical professionals remain in the university after graduation, often completing medical residency before applying to job positions in the university as lectures or medical staff. Recognition factors such as vocation, devotion, passion, family influence, and intent of making a difference in society were cited by interviewees as shaping their choices for an academic career. The following quote is quite interesting to illustrate this point:

My family has an irresistible tendency towards teaching [laughs]. My mother was a teacher for many years, as were my sisters and brother. So, I have always had this propensity to teaching. During my academic training I used to get involved with tutoring. After that, during medical residency, I used to support graduates [...]. I've always liked to teach. As soon I got involved in a university hospital, I decided to devote my life to it because that was what I wanted to do [PSI-06].

Academic hybridisation also represents a political approach for power retention in the sense of maintaining or extending medical autonomies (e.g., flexible office hours, choice of type of clinics, level of occupations) and influence over the hospital administration, as doctors-professors are usually highly well-known figures in the university community. For example, respondent PSI-07 polemicized: *"Professors are the ones who campaign to elect the candidate they want there [in the hospital general directorate]. How many times has a non-academic doctor been elected? None"*. Likewise, PSI-01 noted that *"the corporatist weight is huge because of university's elections. So, the university has a substantial weight"* in the organisation of the teaching and medical work in the hospital.

5.3.4 Academic dehybridisation

The fourth narrative suggests a trend towards academic dehybridisation not only by virtue of new forms of administration and work dynamics under EBSEH's management but also due to some clinical practices perceived as obsolete, which results in disappointment and lack of motivation in doctors. For instance, disorganised work processes, adverse work conditions, continuous infrastructural problems, and lack of professional challenge were cited as factors that bring about frustration, demotivation, and discouragement, thus impairing the construction of a positive identification with the university hospital organisational environment. Interviewee PSI-02, for example, said that: *"I felt very discouraged when I saw the reality of the hospital, you know?"*. In this case, disappointment was associated with professionals' realisation that the university hospital was not that innovative and advanced as they had initially expected it to be.

Data show that rank & file physicians employed by EBSEH seem now more detached from teaching and, notably, research activities. Although involved in medical residency supervision, this group of doctors has low work incentives from the company and faces limitations (e.g., time, resources, bureaucracy) to undertake clinical research within hospital premises. This means that there might be a trend of reduced scope for academic work for a group of doctors that, in the past, used to develop advanced knowledge and practical skill for the hospital and the wider community. As PSI-05 noted, *"being professors is the last thing doctors working for EBSEH think about"*. Likewise, PSI-03 stated that *"this career more, let's say, more based on research, teaching, and extension will be lost in fact. There wouldn't be such kinds of possibilities; the university wouldn't offer [EBSEH's physicians] these possibilities for research and extension"*. In this vein, interviews suggest that such a trend might have a significant impact over the educational nature of the university hospital since part of its medical workforce will be less engaged in teaching work:

Many doctors have taught and are still teaching students, residents, and PhD candidates even though they are not professors; they are doing this integration [teaching and healthcare] which is absolutely fundamental. And I fear that we may lose that with this new regime and form of administration [PSI-06].

In addition, more flexible job contracts established by the company may be conceived as less attractive for a long-term career within the hospital and less likely to produce strong attachments between professionals and universities, thus undermining newly hired physicians' interest in academic roles and teaching development skills. The following quote is quite illustrative of this weak profession retention for hybrid academic work:

I believe that those links that many of us have created with the institution [...] tend to diminish, tend to become more like an employee-employer relation; and if things are not good for the employee he can leave to another institution [...] [PSI-06].

Although our exploratory data do not show strong evidence that rank & file doctors have lower status, their differential positioning appears to have been bringing about conflicts around work issues

as well as weaker emotional attachments with the university hospital. Data suggest that these rank & file practitioners tend to feel less motivated because of increased working hours, repetitive and basic patient-centred work, and insulation (low interaction with other peers). In this vein, discursive evidence points to higher turnover rates among EBSEH's employees:

We had some professionals that decided to quit, perhaps because they thought they would have an additional position, as other public servants used to have in the past. But [they didn't like] to stay there 24h per week doing basic health assistance. So, we had some professionals that decided to resign and gave up. So, I would say that, considering the situation and time in which they got admitted, it was somewhat less attractive [for them] compared to those positions in which people used to do fewer hours in their specific clinics [PSI-04].

This could be explained both by the different institutional logics pervading medical career in HUFs, involving formal links established between the company and employees (e.g., workload, job contract, salary, positions), and more fragile psychological links with the organisation (e.g., boredom, demotivation, sense of belonging, commitment, status).

Another theme that emerged around the tendency towards academic dehybridisation refers to centralisation of decision-making in EBSEH. For respondent PSI-06, for instance, *"EBSEH has brought a totally unusual agenda compared to what used to exist in the university hospital"* and this is challenging and changing important old professional logics, such as practices, authority, and work relations among academic hybrids. According to PSI-04, *"[doctors-professors] must be part of [the university hospital] structure with clearly defined roles. This ends up being difficult as they come from a time in which they were the ones who ruled the roost, they used to have it the way they wanted it"*. In this sense, centralisation associated with loss of autonomy may be moving new practitioners away from academic hybrid roles due to their positioning in clinical care and increased subordination to EBSEH's dominant institutional logics of management. Furthermore, insofar as the company becomes the reference point for newly hired medical professionals the nexus between their work and the teaching character of the university hospital seems rather opaque for many of them:

[EBSEH] simply hires the professional, the professional starts working, he enters the system, and the company starts demanding from him. There's nothing else. The professional doesn't know what he's doing there apart from what he already knows to do [clinical work] [PSI-07].

6. DISCUSSION AND CONCLUSIONS

Our analysis shows that professional stratification is not a new reality in Brazilian HUFs. In fact, the dominant institutional logic of the medical profession in this organisational field used to be that of a fragmented medical workforce, in which idiosyncratic ways of work organisation, specialty practice, employment regimes, systems of norms and beliefs have historically resulted in the presence of knowledge elites, technical elites, and managerial elites often leading to the formation of an elite of triple-hybrid professionals. We found that such a logic of professional triple hybridism in teaching hospitals stems from a mix of incidental and willing hybrid roles claiming (McGivern et al., 2015).

Put differently, it derives from complex, uneasy, and multifaceted relations between the logics of managerialism and medical-academic professionalism, since some doctors-professors choose deliberately to engage in management as a mid-career opportunity whilst others feel pressured to assume hospital administration at some stage in their career within the organisation (Martin et al., 2021; McGivern et al., 2015; Noordegraaf, 2015; Waring, 2014).

In terms of professional identity formation, our findings reveal that subjective links help hybrids (re)build and/or (re)frame both their “sense of self” (relation-to-self) and their reciprocal recognition with other colleagues (relation-to-other) while combining medical, academic, and managerial logics of work. Developing strong psychological attachments with the university hospital encourages a positive engagement in management (e.g., self-realisation, self-esteem, rewarding), thus leading to willing managerial hybridisation (McGivern et al., 2015). These types of recognition motivators also help justify taking management roles as a professional obligation (e.g., sense of responsibility, solidarity, duty) in the face of more passive or reactive role claiming (McGivern et al., 2015). Therefore, we argue that managerial hybridisation has substantive implications for professionals’ recognition, since it seems to disrupt old traditional logics of professional identity and acknowledgement in medicine in order to foment new ones within academic and increasingly managed organisational domains (Noordegraaf, 2015; Waring, 2014).

In more liminal spaces between professionals’ subjectivity, economic measures, and organising principles within university hospitals, the importance of cumulative experience and acquiring management competences was highlighted in the data. In fact, management experience and knowledge were rather legitimated in interviewees’ discourses. Such a narrative is in line with previous research that has shown that hybrids reconcile professionalism and management not only as conflicting institutional logics but also as complementary (McGivern et al., 2015). It is not clear in our data, however, whether such an incorporation of managerial logics is primarily resulting from co-optation of the management logic by medical professionals or, alternatively, from colonisation of the medical profession by the logic of managerialism (Freidson, 1985, 1994; Numerato et al., 2012; Waring & Currie, 2009). Further empirical studies are needed to clarify this question in the field of HUFs in Brazil.

Economic measures such as financial compensations and opportunity to maintain or expand political influence also appeared as important drivers of managerial hybridisation among some doctors-professors. These findings reinforce previous debates on hybridisation as a reprofessionalisation process (Freidson, 1985, 1994) through which the medical profession rebuilds itself in the face of the managerialist logic to preserve some degree of economic and political dominance, even if that ultimately means losing technical or clinical autonomy. In this sense, managerial hybrids are induced to cooperate with organisational goals in return for being recognised as a special professional stratum and authorised by the organisation to exert some degree of autonomy and power over other colleagues. Previous research has shown that within the medical profession prevailing institutionalised patterns of action, interaction, and interpretation of organisational values and managerial discourses are enacted by hybrid doctor-managers, which are active in disseminating such patterns amongst their rank & file peers (Waring, 2014). Accordingly, our data show that in seeking to take on hybrid roles some

university doctors and academics are deliberately using the logic of management to preserve some degree of political power, to adapt to new formal organisational structures, to increase earnings, to distinguish themselves from other occupational groups, to replace non-professional general managers, and to better accommodate institutional changes (Waring, 2014; Waring & Currie, 2009; Ferlie & Geraghty, 2005).

Medical professionals' identity and work were represented as intermingled, a consequence of the inclination of many doctors to an academic career within university hospitals. Academic prestige and strong affective links with the university along with inclination to academia and a prospected lifelong career within the hospital help us understanding the historical academic hybridisation in doctoring. Moreover, career in teaching hospitals appears to be more attractive and exciting for physicians who belong to the practice or technical elite, as they usually find huge opportunities to get involved in more complex practical teaching-learning processes and medical residency supervision.

Our analysis reveals that the blurred and nuanced identity of triple hybrids is considered vital for the achievement of university hospitals' educational mission. However, the logic of triple hybridism may be threatened and subject to reshaping by new modes of management and hiring of rank & file practitioners to perform solely healthcare, along with new points of intersection and potential conflicts between professional and hybrid logics of work organisation in the medical field. Our data show, for example, that efforts to increase efficiency in meeting the demands for medical services have become an organisational priority, whereas teaching and research are now relegated in hospitals' daily operation. In other words, clinical care and hospital administration are much more dissociated from teaching and research activities, which impacts directly on both EBSEH's doctors and universities' academics. Empirically, these are interesting preliminary findings in line with previous research on multiple institutional logics coexisting in organisational fields (Reay & Hinings, 2009), in that these data signal the coexistence of hybridisation and dehybridisation logics among academic hybrids and managerial hybrids.

In this vein, data suggest a movement towards managerial dehybridisation especially among academic hybrids and company's rank & file doctors. Such a narrative indicates strengthened trends for academics and doctors to resist or distant from managerial logics in order to preserve more traditional academic logics and a certain medical "ethos" (Numerato et al., 2012; Waring & Currie, 2009). Indeed, some doctors in Brazilian teaching hospitals are choosing to move away from management while others feel pushed away by tighter forms of control and recruitment for management positions.

The first demarcated trend of managerial dehybridisation is willing dehybridisation, in which doctors-professors decide to leave management to concentrate on academic activities. On the one hand, subjective links such as self-fulfilment, devotion, and commitment to academic work are key factors in professionals' decision to remain distant from managerial logics. On the other hand, some professionals who had previously assumed administrative positions because they felt emotionally constrained to do so (e.g., sense of responsibility, duty, wish to contribute) are now choosing to relinquish management in view of new forms of organisation, management, and control under the EBSEH enterprise. For those who overvalue psychological attachments with

the university, formal distributive links such as salary compensations and increased bureaucratic workload seem less effective in stimulating their engagement with managerial logics within hospital administration.

Furthermore, this preliminary study shows that hybrid doctors-managers usually enjoy limited prestige among their peers and very often experience animosity and discrimination in the workplace due to their engagement with management and organisational targets, what is sometimes perceived by colleagues as a loss of medical professional identity (McGivern et al., 2015). Similarly, Waring and Bishop's (2013) study showed that hybrid managers have frequently reported hostility from their peers, being derisively depicted as "bad apples", "management narks" or "turncoats" (Kirkpatrick, 2016). Rank & file professionals also seem to have little influence over and esteem of more senior colleagues. In addition, our data endorses previous studies which have suggested that as far as hybrids perform more regulating work and focus on organisational interests, notably in contexts of resource limitations, they often change professional behaviours and relationships with colleagues (McGivern et al., 2015). In this way, intersubjective recognition links such as respect, sense of belonging, social valorisation, and integration may be replaced by feelings of polarisation, isolation, and fear. These findings may suggest that some hybrids are more willing to rebuff the managerialist logic (Waring, 2014) for the sake of self-preservation, to avoid antipathy or disrespect in the workplace, or to preserve medical or academic professional logics.

The second form of managerial dehybridisation is induced dehybridisation. This trend relates to new forms of coordination, engagement with business-like managerial discourses and practices, and increased centralisation of decision-making in EBSEH. Literature shows that hybrid professionalism combines professional and managerial institutional logics (Croft et al., 2015; Freidson, 1985, 1994; Hendrikx & Van Gestel, 2017; Kirkpatrick, 2016; Waring, 2014) through socialisation and reshaping of professional identity and work around managerial organising principles and more flexible working practices that impact on professionals' behaviour, their sense of common purpose, and unity within organisational domains (Reay & Hinings, 2009). In this vein, our study suggests that new systems of management and control are moving professors away from management, as some of them do not seem willing to comply with new forms of recruitment for managerial posts and are more reluctant to take administrative responsibility. Other doctors feel that their autonomies are being curtailed, since doctoring is now being managed under the business-like healthcare logic of "doing more with less".

The centralisation of hospital management in EBSEH is expected to increase intraprofessional disparities between university hybrid elites and rank & file practitioners and other health workers employed by the company. As seen, doctors who work for EBSEH are being allocated mainly to the rank & file position, but with a larger gap between them and other areas of hospital administration and universities' medical schools. Such fragmentation into subgroups, splitting hybrid elites from those who perform patient-centred routine tasks, denotes that managerial positions, material assets, and technological resources are more unevenly distributed throughout different professional strata (Noordegraaf, 2013). For example, the opportunities for company's medical employees to get involved in management are less likely than those university's health professionals usually have due to the differing nature of their formal and psychological organisational links. In other words, the

likely result of this reinforced professional stratification is to exacerbate groups isolation, exclusion, and subordination, since rank & file doctors now tend to be treated more as “employees” than as “professionals”.

Our analysis suggests that particularly among academic hybrids and doctors who can be seen as potential academics, disappointment, lack of motivation, little challenging work, perceived university’s low capacity for innovation, and conflicting sets of assumptions, values, and beliefs may lead to willing academic dehybridisation. Indeed, our study indicates that some academic hybrids may feel uninterested in performing teaching at the undergraduate level while EBSEH’s professionals are conceived as a group of medical employees with low or no interest in or advanced qualification to undertake academic activities, notably clinical research.

Data demonstrate, therefore, that induced academic dehybridisation may be a strong trend among EBSEH’s doctors, which can potentially erode triple-hybridisation in view of reduced scope for academic work and more centralised managerial logics of work. This, in turn, may lead to the decomposition of traditional academic work (Ferlie & Geraghty, 2005) and to the weakening of academics’ political representation within hospitals. Apparently, many doctors hired by the company see their work in the hospital like any other job; they seek to fulfil their working hours but do not seem eager to participate in decision-making, especially in what concerns the academic aspect of the hospital work. Therefore, changes in career plans, limited opportunities for teaching work for rank & file doctors, perceived precarisation of subjective (e.g., status, vocation, autonomy) and objective (e.g., job contract, level of occupation, work conditions) organisational links between EBSEH’s professionals, in addition to weaker professional retention, are factors that point to progressive academic dehybridisation.

In conclusion, our study contributes to trigger debates over how medical professionals and academics deal with changing institutional logics in HUFs managed by the EBSEH by analysing key policy documents and the responses of expert health professionals in this intriguing organisational field. Our research shows that the transferring of hospital administration to EBSEH has led to further internal stratification of the medical workforce. The shift from the logic of medical-academic professionalism to the new logic of business-like healthcare, expressed by the adoption of distinct job contracts and more managerial systems of control over work, may well be changing subjective and formal links established between professionals, universities, and hospitals. These findings are relevant because this ongoing process of change in the dominant institutional logic can have profound implications for the academic nature of HUFs and for the future of medical-academic professionalism within these health and teaching organisations. For example, micro-level changes in the interface between clinical, academic, and managerial roles performed by medical professionals, especially triple-hybrids, are impacting upon forms and degrees of academic and managerial hybridisation, which used to be constitutive characteristics of Brazilian teaching hospitals. By identifying contradictory trends towards hybridisation and dehybridisation involving the same professional category in a particular organisational field, our study adds new insights to previous research on professional stratification, hybridisation, and coexistence of competing institutional logics in organisations (Freidson, 1985, 1994; Kirkpatrick, 2016; McGivern et al., 2015; Numerato et al., 2012; Reay & Hinings, 2009; Thornton & Ocasio, 1999; Waring, 2014). These new intersections

between professional and managerial logics are indeed interesting counter intuitive early findings that, however, lack further empirical examination to deeply assess how doctors and professors seek to (re)build their professional identity and medical practice in relation to academic work and managerial practices under the company management logics.

Finally, we acknowledge the limitations of this initial study due to the limited sample of interviews and documents included in analysis. Albeit highly significant empirical materials, these data do not allow for generalisation to other non-federal teaching hospitals or healthcare subsystems operating in the SUS. However, we argue that the research outcomes have the potential to inform a theoretical and analytical framework to guide further research on the dynamic relationships between the logics of medical-academic professionalism and managerialism as well as their implications for Brazilian university hospitals.

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APPENDIX

BOX A PILOT INTERVIEW QUESTIONS (PIQ)

PIQ #1: What are the main trends informing and influencing public policy and government actions in the Brazilian healthcare sector? What is the prevailing policy regarding public university hospitals?

Introductory Question: To begin this interview, I'd like to ask you some questions about your professional experience and role in this university hospital.

1. **Let's begin by discussing your formation and your work as a healthcare professional. Can you tell me a bit about your professional career in the health sector?**

Follow up: What roles have you taken up so far?

Probe: What is your current position?

Follow up: How would you describe the work of your organisation?

Probe: Can you talk about the tasks you perform in this organisation?

Transition Question: Thank you for your responses. I'd like to now ask you some questions about the current trends and changes in the Brazilian public health sector.

2. **Since the 1990s the Brazilian government has been engaged in policy reforms to change the health system. How would you describe the current health policy reform agenda in Brazil?**

Probe: What are the main national organisational bodies responsible for carrying out these reforms?

Follow up: What are the national and/or international organisations that influence(d) health policy reforms undertaken in Brazil?

Probe: Can you tell a bit more about those organisations?

3. **What are the major changes occurring in the Brazilian health system, at national and regional levels?**

Prompt: How do you evaluate those changes?

Probe: What would be the positive and negative impacts of those changes on public health services delivery?

4. **The 1993 World Bank Report suggests that 'government-run health systems in many developing countries are overextended and need to be scaled back'. Do you agree with this statement?**

Prompt: Please tell me more about this.

Follow up: Do you think that the economic and fiscal crises Brazil is going through encourage measures towards more liberalisation, decentralisation and private finance of health services?

Prompt: Please tell me more about that.

Follow up: What do you expect from this scenario for the future?

Transition Question: Thank you for your responses. I'd like to now ask you questions regarding the current situation of university hospitals in particular.

5. **How would describe the current situation of the federal university hospitals?**

Follow up: What are the major problems these hospitals are going through these days?

Follow up: How do you see the advent of EBSEH company to organise and manage the federal university hospitals?

Probe: What changes in public university hospitals have you seen?

Prompt: Could you tell a bit more about these changes and their implications for the universities?

Transition Question: Thank you for your responses. I'd like to now ask you questions regarding the medical and healthcare professions employed in public university hospitals.

Continue

PIQ #2: How and to what extent do reforms in the Brazilian public health sector impact on the nature of medical and healthcare professions employed in public university hospitals?

6. Let's talk about medical and healthcare professions within university hospitals. How would you describe the role of health professionals in university hospitals?

Follow up: What does differentiate the healthcare practice within university hospitals from the clinical practice delivered in other health bodies (i.e. private hospitals, private clinic practice, GPs, etc.)?

Prompt: Please tell me more about the particularities of being a medical or healthcare worker in a university hospital.

Follow up: Can you tell me what made you want to work for university hospitals?

Probe: At the point that you made the decision to go to work in the public health sector, what most attracted you to this university hospital?

Prompt: Can you tell me a bit about how you feel about being a health professional of a public university hospital?

Transition Question: Thank you for your responses. I'd like to now ask you questions regarding recent changes in the hospital administration.

7. How would you describe the university's hospital administration?

Follow up: Would you say that the university's hospital administration is improving over the last few years?

Prompt: What are the major difficulties you may encounter when doing your job in this hospital?

Probe: Do you usually get easy access to the resources and assets you need to perform your tasks?

Follow up: How would you describe the decision-making process in this hospital?

Probe: Do you usually participate in deliberations and decisions concerning hospital management?

8. How would you compare the hospital administration under EBSEH and the hospital administration under the university itself?

Follow up: What changes in the hospital administration and operation have you seen since the university joined the company?

Prompt: How do you evaluate those changes?

Follow up: What would be the most significant impacts of those changes on the ways medical and healthcare professionals do their work?

Probe: Have you personally experienced some of these changes?

Prompt: Please tell me more about that.

PIQ #3: Do the changes introduced by EBSEH management reinforce professional stratification and hybridisation within public university hospitals?

9. It's well known that EBSEH has emerged to solve the severe problems of precariousness and staff shortage in the federal university hospitals. Based on your experience in the sector, how do you evaluate the performance of the company so far?

Prompt: Please tell me more about that.

10. How has EBSEH management altered the previous university hospital organisational structure?

Follow up: Can you tell what are the main management, administrative or leadership roles in the current hospital organisational structure?

Prompt: Can you explain to me how these roles and positions are distributed and filled up?

Follow up: Who are the professionals usually occupying the most strategic positions in this organisation?

Prompt: As far as you know, are doctor hired by the company considered to take up those management positions?

Probe: Could you give me an example of that?

Continue

11. Has EBSERH management resulted in a clearer differentiation between doctors and health professionals performing solely patient care and others undertaking different roles?

Follow up: What are the main tasks (i.e. patient care, teaching, research, management, etc.) carried out by doctors who are university's public servants?

Follow up: What are the main tasks (i.e. patient care, teaching, research, management, etc.) carried out by doctors who are EBSERH's employees?

PIQ #4: Do professional stratification and hybridisation entail or reinforce forms of subordination or internal inequalities amongst medical and health professionals employed in public university hospitals in Brazil?

12. Do you see yourself as a recognised and esteem professional in your professional area and organisation?

Prompt: Please tell a bit more about what makes you feel admired and respected in your workplace.

Prompt: Would you say that taking up management roles contributes to you to be professionally recognised by your colleagues?

Prompt: Would you say that taking up teaching and research roles contributes for you to be professionally recognised by your colleagues?

Prompt: Please tell more about what makes you think like that.

13. How would you describe the interrelationships between you and your colleagues in this organisation?

Follow up: Please tell me a bit about the peers you interact with most within the hospital.

Follow up: What does make you identify with your professional peers?

Follow up: Do you think the position you hold in the hospital shapes the level of interaction with your professional peers?

Prompt: Please tell more about that.

Follow up: Would you say that all your professional colleagues have the same degree of respect and acknowledgement?

Prompt: What makes you think like that?

Follow up: Have you ever experienced or witnessed some kind of hostility from your peers by virtue of playing a management or authority role?

Prompt: Could you talk a bit more about that situation?

Transition Question: Thank you for your responses. My final set of questions are focused on some economic and political issues related to the hospital administration.

14. Can you tell me about the current conditions for the hospital full operation in view of available resources and assets?

Follow up: There have been some movements organised by healthcare professionals to complain about the lack of material resources, noncompliance with labour laws and to claim for better working conditions. How do you evaluate those events?

Follow up: Do you think there is an even distribution of resources throughout the different professional groups working at this hospital?

Prompt: What makes you think this way?

15. Can you describe how usually discussions and decision-making processes regarding most strategic issues take place in this organisation?

Probe: Can you give an example of decision-making?

Follow up: Who are the people usually in charge of strategic decision-making?

Follow up: Do you think there are equal conditions enabling different professional groups to participate in decision-making procedures within this hospital?

Prompt: What makes you think this way?

Closing Question: Before we conclude this interview, is there something about your experience in this university hospital that you may want to share?

Source: Elaborated by the authors.

BOX B DATA OVERVIEW

1 ST ORDER CONCEPT EXAMPLES	2 ND ORDER THEMES	AGGREGATED CATEGORIES
<p><i>This is clearly a liberal, anti-state government, so everything it thinks has state interference should be minimised, transferred to the private sector. Everything that is possible [PSI-05].</i></p> <p><i>The government thinks of getting rid of public servants' stability, cutting pays. So this model is being pushed and bolstered with this set of reforms that aims at a more liberal government, a government under an increasingly more managerial perspective [PSI-03].</i></p> <p><i>Outsourcing has been a very clear movement, which has been going on throughout the whole country [PSI-05].</i></p> <p><i>[...] for university hospitals, EBSEH is unconstitutional. Why is it unconstitutional? Because the government, the state, creates public companies to explore economic activities, but healthcare isn't an economic activity, it's a social activity [PSI-03].</i></p>	<p>Neoliberal Ideology</p> <p>Soft NPM Reforms</p> <p>Regulatory Framework</p>	Drivers of Reforms in Federal University Hospitals
<p><i>Over the last eight or nine years, federal university hospitals have been taking advantage from two important public policies: one concerns funding provided by the REHUF, which has increased the budget of around R\$ 700-800 million annually from the Ministry of Health; the other is EBSEH [PSI-01].</i></p> <p><i>We lived in pretty much constant difficulties, issues such as the need to close hospital beds, shortages of medicines and several other materials, lack of proper equipment maintenance [PSI-01].</i></p> <p><i>It [EBSEH] prevented the university hospital from getting worse than it already was. But it didn't bring any benefits that I can clearly see [PSI-06].</i></p> <p><i>University hospitals and universities are linked to the Ministry of Education. There was a period of seven years without any staff recruitment. Basically we were forced to add staff because obviously we couldn't remain with no staff increase for seven years, right? [PSI-01].</i></p> <p><i>In terms of staffing, I think we are in a better situation than we were before. [...] In numbers, EBSEH came to bring many people in [PSI-04].</i></p> <p><i>[...] the situation was that the sources of medical work were diverse. So we had professors, doctors from the RJU [civil service job contract] workforce, CLT [private sector job contract] workers hired by support foundations who were entitled to all employment rights and everything, and precarious workers hired mainly by cooperatives or autonomous workers [PSI-01].</i></p> <p><i>University hospitals' workforce currently consists of 70,373 professionals, of which 26,556 are recruited through universities support foundations under diverse legal forms: private sector employment regime (CLT), service contracts (outsourcing) and other forms that characterise precarious employment links in the form of illegal outsourcing (EM Interministerial nº 00127/2011/MP/MEC).</i></p>	<p>REHUF</p> <p>Precariousness</p> <p>Staff Shortage</p> <p>Illegal Outsourcing</p>	

Continue

1 ST ORDER CONCEPT EXAMPLES	2 ND ORDER THEMES	AGGREGATED CATEGORIES
<p>EBSERH has some problems. One of them is centralisation. Everything is centralised in Brasilia. Local units, that is, hospitals spread across the country have pretty low autonomy [PSI-05].</p> <p>[...] they [EBSERH's doctors] have been told "hey, you guys are joining to perform functions that have been determined to increase the number of consultations" [PSI-04]. New hired doctors work in ambulatories, emergencies and so on. They do harder work, I would say [PSI-03].</p> <p>Actually, this is a well-rooted tradition, I mean, this idea that doctors have the competence to manage health organisation [PSI-01].</p> <p>People used to confuse doctors with professors, professors of medicine and hospital's doctors [PSI-03].</p> <p>Doctors were gradually assuming positions of technical leadership, if competent and acknowledged by their peers [PSI-01]</p> <p>I think that the best professional to manage a university hospital is a professor-doctor, for many reasons [PSI-06].</p> <p>From the perspective of professional organisation, we are very fragmented, very weakened especially due to those forms of job contracts that have been established in the last years [PSI-05].</p> <p>This is exactly one of the problems with EBSERH. This is a distortion that will impair greatly the development of the university hospital over the next years or decades maybe. Because you've got CLT workers along with RJU workers working for different salaries, under different career plans, different leaderships [...] [PSI-06].</p> <p>The university hasn't learned to deal with those different categories and regimes of work [PSI-03].</p> <p>So, they [doctors hired by EBSERH] are coming to perform more basic health assistance. I would say that at the beginning this might have led to some conflicts in this respect [PSI-04].</p>	<p>Centralisation</p> <p>Reinforced Stratification</p> <p>Triple Hybridism</p> <p>Differing Career Plans</p> <p>Rank & File Positioning</p>	<p>Implications for the Medical Profession</p>
<p>She [university hospital general director] is someone who puts her heart in the hospital, you know. She owes everything to the university. She was almost retiring, as she's 66, and didn't need to prove anything to anyone. Even so, she decided to take on this challenge to improve the hospital [PSI-04].</p> <p>However, this professional [doctor] needs to learn how to manage, because in this area there's a certain concept, and I saw it a lot: if a guy is a good doctor, is respected, knows how to do diagnoses and treatments, has good relations with people, so this guy is gonna be director. But sometimes he ends up being a terrible director because he has no management qualification. So being a good doctor doesn't mean to be a good director. There's no such a relation [PSI-06].</p> <p>I think that doctors don't... medical knowledge is not enough to run a huge health unit, right, like a city health department or a huge hospital. I think our knowledge is insufficient. I think the trend is to establish partnerships with professionals who have this kind of qualification [management]. But I also consider that a manager doesn't have enough knowledge to run health institutions [PSI-02].</p>	<p>Subjective Links</p> <p>Training and Qualification in Management</p>	<p>Managerial Hybridisation</p>

Continue

1 ST ORDER CONCEPT EXAMPLES	2 ND ORDER THEMES	AGGREGATED CATEGORIES
<p><i>I had been directly involved with the university hospital administration. I was support director; I was deputy head for four years and director general between 1996-2000 [PSI-06].</i></p> <p><i>For two years I was the head of the state central laboratory and later I was head of the university hospital laboratory for ten years [PSI-07].</i></p> <p><i>I've been actively participating in the Department of Ophthalmology, engaging in undergraduate lessons and management. [...] For a long time I've been assisting in management because I'm very close to it [PSI-04].</i></p> <p><i>For example, the director general of the university hospital earns more than the university's rector. So there's a mismatch, really [PSI-03].</i></p> <p><i>Such a system of excessive rewards, as it has been implemented, can certainly create distortions [PSI-06].</i></p> <p><i>Doctors who perform patient care must be there [in the hospital] and often they end up assuming management, because they're more involved with the hospital and EBSEH as well. Now, with the recent admittance of doctors hired by EBSEH, doctors [employed by the university] usually have stronger voice [PSI-04].</i></p>	<p>Cumulative Experience</p> <p>Financial Rewards</p> <p>Political Influence</p>	
<p><i>Management is an activity that hinders the academic career, it really does. It's very difficult to reconcile them very well [PSI-01].</i></p> <p><i>[For many people] if you don't practice clinic then you're not a doctor [PSI-02].</i></p> <p><i>A professor who assumes management roles is, let's say, a bit frowned upon. 'This guy is pro-rector, department head, clinical director, chief of service... What's he doing there?' He's not esteemed at all. In my point of view, he's underappreciated. This is bad, I think it's bad [PSI-06].</i></p> <p><i>The hospital needs to define who is the engine. [...] So, obviously, this implies recriminations from those who are not directly involved and feel, eventually quite rightly, that their projects should be further appreciated [PSI-01].</i></p> <p><i>Indeed, personal hostilities occur, not too much. But, as I always say, when you're in a management position people look at you in a different way [PSI-06].</i></p> <p><i>There are still difficulties in health assistance, as there's high turnover among EBSEH's personnel. [...] As their positions are regulated by CLT, people who are not pleased with the workplace just quit. So, there's a turnover [PSI-03].</i></p> <p><i>Of course! This is obvious. With these new labour rules, new forms of work contracts, everything gets much easier: kick them out! Over and done [PSI-07].</i></p> <p><i>[...] creating conditions to substantially improve management standards, with the adoption of advanced tools of result control and transparency for the society (EMI nº 00383/2010/MP/MEC).</i></p> <p><i>EBSEH exerts greater control over doctors, differently from the university's structure, in which they would have more autonomy [PSI-03].</i></p> <p><i>Everything is controlled these days. So one has really to enjoy being there [in the hospital] [PSI-04].</i></p>	<p>Underprivileged Status</p> <p>Hostility</p> <p>Weak Professional Retention</p> <p>New Forms of Control</p>	
		Managerial Dehybridisation

Continue

1 ST ORDER CONCEPT EXAMPLES	2 ND ORDER THEMES	AGGREGATED CATEGORIES
<p><i>I still see a difficult in terms of centralisation there [EBSERH]. It seems that things come top-down, like “you’re going to receive eight ophthalmologists”. We have no voice about defining the people and functions we want [PSI-04].</i></p> <p><i>I think here’s the issue: centralisation of resources and decision-making and loss of university autonomy [PSI-05].</i></p>	Centralisation	
<p><i>I would say that hybridisation is a process which is being superseded, although still very meaningful [PSI-01].</i></p> <p><i>Professors no longer want to take responsibility for the hospital. They want to give their master lessons, to be due in complex surgeries, to decide on their own schedule, to see an X number of patients while teaching; but sometimes they don’t want to be in [management] [PSI-04].</i></p> <p><i>The absence of professors in the hospital’s administration impairs the university hospital’s role. I agree with that, and I think this is happening right now [PSI-06].</i></p>	Reluctance to Take Responsibility	
<p><i>I think doctors are a key figure. He’s gonna keep this huge prestige until things change, if they change [PSI-01].</i></p> <p><i>A doctor-professor brings with him a differential status, no doubt about it. He has greater market value, let’s say [PSI-06].</i></p> <p><i>Working in a university hospital gives you a status in society and within the [professional] category [PSI-05].</i></p>	Academic Status	Academic Hybridisation
<p><i>Most doctors had values in which I don’t believe. They were more interested in leaving [the university hospital] to make money with minimal effort. The population’s health was not a priority for them [PSI-02].</i></p> <p><i>That [university hospital] was a place where I imagined myself working in and I liked the federal university and all ideas around it [PSI-04].</i></p>	Subjective Links	
<p><i>I had the perspective of being a university professor [PSI-01].</i></p> <p><i>I always had interest in being professor, even with no idea about what being a professor means [PSI-07].</i></p> <p><i>I have many colleagues who are working in lecturing because they still believe that they can make a difference by transforming health professionals’ formation [PSI-02].</i></p>	Inclination to Academic Career	
<p><i>During on-call times, we used to host residents and students. So, they used to stay on duty with us. We were responsible for teaching in service, as we call it [PSI-02].</i></p> <p><i>[...] Because any doctor working in a university hospital is a prospective professor [PSI-06].</i></p>	Teaching-Learning Processes	
<p><i>Professors are the ones who campaign to elect the candidate they want there [in the hospital general directorate]. How many times has a non-academic doctor been elected? None [PSI-07].</i></p> <p><i>Doctors are influent within the institutions in which they work because they create a demand that is often hard to refuse. So, I have the impression that they’re valorised as medical professionals, especially in the case of universities where doctors have valorisation due to their academic status too [PSI-01].</i></p>	Power Retention	

Continue

1 ST ORDER CONCEPT EXAMPLES	2 ND ORDER THEMES	AGGREGATED CATEGORIES
<p><i>Teaching professionals sometimes feel unmotivated to teach basic things to undergraduates. They are often more interested in teaching to residents and participating in surgeries, which however are not their main tasks as professors [PSI-04].</i></p> <p><i>I got disappointed. I went to a university hospital to work with graduates in cutting-edge things. But they were not [PSI-02].</i></p> <p><i>[...] the question of this career more, let's say, more based on research, teaching and extension will be lost, in fact. There wouldn't be such kinds of possibilities; the university wouldn't offer these possibilities [for EBSERH's doctors] for research and extension, for example [PSI-03].</i></p> <p><i>I've seen that, there's a few doctors in management and professors as well. That's the danger by turning the university hospital into an assistance hospital [PSI-06].</i></p> <p><i>In view of this employment regime and the way in which the [medical] career within EBSERH is structured, such precarisation of links and institutional damage tend to consolidate in the long run. I believe that those links that many of us have created with the institution [...] tend to diminish, tend to become more like an employee-employer relation; and if things are not good for the employee he can leave to another institution [PSI-06].</i></p> <p><i>[...] we had some professionals that decided to resign and gave up. So, I would say that, considering the situation and time in which they got admitted, it was somewhat less attractive [for them] compared to those positions in which people used to do fewer hours in their specific clinics [PSI-04].</i></p> <p><i>EBSERH has brought a totally unusual schedule compared to what used to exist in the university hospital [PSI-06].</i></p>	<p>Disappointment</p> <p>Less Scope for Academic Work</p> <p>Weak Professional Retention</p> <p>Centralisation</p>	<p>Academic Dehybridisation</p>

Source: Elaborated by the authors.

BOX C ACTORS AND DOCUMENTS INCLUDED IN THE ANALYSIS

PSI-01: Doctor-Professor-Manager

Positions: professor in the faculty of medicine of a federal university; head of a HUF

Region: Southeast

Interview time: 1:03:59

PSI-02: Doctor-Manager

Positions: head of the department of data analysis of a local government

Region: South

Interview time: 46:21

EMI n. 00383/2010/MP/MEC: sets out the draft bill for the creation of EBSERH. Retrieved from http://www.planalto.gov.br/ccivil_03/_ato2007-2010/2010/Exm/EMI-383-MP-MEC-MPV-520-10.htm

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Continue

PSI-03: Professor-Manager

Positions: head of the department of management of a federal university; expert on public management and federal universities

Region: South

Interview time: 37:20

PSI-04: Doctor-Professor

Positions: professor in the department of medicine of a federal university; doctor in HUF

Region: South

Interview time: 56:55

PSI-05: Doctor-Manager

Positions: finance director of a regional union of doctors

Region: North

Interview time: 44:27

PSI-06: Doctor-Professor-Manager

Positions: retired professor and doctor in a university hospital

Region: South

Interview time: 53:15

PSI-07: Pharmacologist-Professor-Manager

Positions: retired professor and pharmacist

Region: South

Interview time: 45:46

Decree n. 9637/1998: provides for the qualification of entities as social organisation; creates the National Program for Publication. Retrieved from http://www.planalto.gov.br/ccivil_03/leis/19637.htm

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Source: Elaborated by the authors.