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First-line managers' experience of their role and gender in elderly care

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ABSTRACT

The aim of the article is to examine first-line managers' experiences of their managerial role and gender in elderly care. Forty qualitative semi-structured interviews were conducted with first-line managers (35 women and five men) from four different organisations in Sweden. The findings suggest that the role of first-line managers was formed in everyday managerial work in two communities of practice: the care work community and the first-line manager community. The managers' navigation between these two communities of practice created dual memberships. These memberships differed depending on micropolitical processes which arose in relation to their position, expectations and gender stereotypes. A female norm ruled within the first-line manager community, providing middle-aged women with elderly care experience with a greater legitimacy to control the community, while men were not so easily accepted. On the other hand, the male norm was more prominent in the care work community in line with managerial ideals and male managers received more credit as being more capable as managers. The study contributes by demonstrating that the managerial role and gender manifested themselves in different ways within these two communities of practice and provided different conditions, giving women and men different benefits or unequal conditions for performing leadership.

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Introduction

The work of first-line managers is characterised by a high workload, versatile responsibilities, and tasks that are frequently interrupted (Hales 2005, 2007; Tengblad and Vie 2012), and the first-line manager role is often depicted as vulnerable since it is sandwiched between superior management and subordinates (Gjerde and Alvesson 2020). The work of first-line managers in elderly care is additionally characterised by complex challenges (Corin and Björk 2016; Meissner and Radford 2015; Wastesson

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et al. 2021), such as balancing humanistic and economic rationalities to fulfil their responsibilities (Antonsson 2013) and meeting expectations of being both compassionate and decisive towards employees (Ekholm 2012). In the Swedish elderly care sector, women hold 87 per cent of the managerial positions and 89 per cent of the total workforce consists of women (SCB 2019). The uneven gender distribution creates an image of a culturally and symbolically gendered sector as well as notions of femininity (Lill 2020; Vänje and Forssberg 2021), which implies that gender must be considered in analyses of managerial work in elderly care. In general, earlier studies have often found that expectations placed on female managers are linked to their gender, in terms of being caring and performing relationship-oriented leadership (Due Billing and Alvesson 2000; Hurst et al. 2017) or being deficient as managers in relation to a male norm in management (Wahl 2014). These studies have often had a primary focus on female managers in male-dominated organisations, and have repeatedly shown that women face gendered barriers in recruitment to and in holding managerial positions (Acker 2006, 2009; Bryans and Mavin 2003). For example, it has been found that female managers do not have the same opportunities for professional support, learning and career development (Acker 2009), and access to strategic social networks and mentors as their male colleagues in male-dominated organisations (Gustavsson and Fogelberg Eriksson 2010; Kossek et al. 2017).

Studies that have compared the working conditions for managers in female and male dominated public operations indicate that these conditions differ substantially: managers in female dominated care services have access to fewer resources and less organisational support but larger groups of subordinates than managers within male-dominated (technical) services (Björk and Härenstam 2016; Forsberg and Härenstam 2022). In studies on managerial work in elderly care, Regnö (2013) found that, in spite of the demanding working conditions, the female first-line managers had legitimacy and rarely felt questioned as managers, as a result of the female majority among managers. Turning then to studies that report on male first-line managers' conditions in the female-dominated elderly care, Keisu (2009) found that male managers could receive certain advantages due to their gender, such as having a greater chance of being promoted and recognised for their work efforts (cf. Kvande 2002). However, another study shows that male managers do not experience any special treatment due to their gender (Hagerman et al. 2015).

In light of the varying results of the above-referenced studies on managerial work in female-dominated organisations, an analysis that considers both female and male managers' experiences is required to gain a deeper understanding of managerial work in these organisations, such as elderly care. In order to understand how and why managers' experiences differ in everyday work, analyses that contextualise managers' experiences are needed. Departing from a community of practice lens, the article aims to examine first-line managers' experiences of their managerial role and gender in elderly care.

The study was carried out in four Swedish elderly care organisations and is based on 40 interviews with first-line managers, 35 women and five men. By starting from a community of practice lens, we can contextualise the managers' experiences of the managerial role and gender by analysing communities of practice in which first-line managers see themselves as members. Through learning and participating in a community of practice different forms of memberships can be shaped that define different members' abilities – both in terms of legitimacy and possibilities, to engage in activities and establish social

relationships (Wenger 1998, 2010). As suggested by Farnsworth, Kleanthous and Wenger-Trayner (2016) theories of power such as gender can be 'plugged in' to the theory of community of practice. In this regard, inspired by Paechter's (2003) approach we add notions of femininities and masculinities as communities of practice to capture the gender dimension.

The outline of the article is as follows. The following section introduces the theoretical framework based on Wenger's (1998; see also Lave and Wenger 1991) theory of communities of practice and Paechter's (2003) approach to capture the gender dimension in communities of practice. Thereafter, the next section provides a brief overview of the Swedish elderly care sector and the research method. The subsequent section presents the findings. A discussion and some conclusions end the article.

Theoretical framework

The concept of community of practice, derived from the conceptual framework of situated learning (Lave and Wenger 1991), provides a useful theoretical lens for analysing how people become part of a shared domain of interests or expertise. In a community of practice, the members share joint activities and a repertoire of resources, such as tools, methods and stories, that have been developed in close and trusting relationships between the members (Wenger 1998, 2010). Being a member of a community of practice implies a commitment, but being granted membership must be earned. A prerequisite is that there must be a desire to become an established member, which means having a passion for doing something and learning to do it better (Wenger 2010). Deserving membership implies legitimacy to participate in the joint work practice, to learn what matters and to use the repertoire of resources in an appropriate way together with other members (Wenger 2010, 180). Membership also brings access to a wide range of activities, the tools in use and interactions in everyday practice (Lave 2019; Wenger 2010). By inviting themselves to take part in work activities and problem-solving, members can gain access to participation in activities for joint learning and collaboration (Akre and Ludvigsen 1997). However, gaining access to participation is often dependent on being offered access, in terms of receiving invitations from established members who have specific knowledge and a unique position that gives legitimacy to dictate the conditions for learning (Akre and Ludvigsen 1997). Therefore, membership is also dependent on established members' willingness to include a member in the community of practice, as they have the authority (formally and informally) to decide who has access to what in practice (Lave and Wenger 1991). When newcomers propose a different opinion than that, which is known or accepted by established members, participation can change in practice (Lave 2019). This implies that the relationship between established members and those who are about to enter (newcomers) or those who gain no acceptance in the community of practice reflects an inherent micropolitical dimension of membership, which reproduces power structures including who holds the mandate to control the community of practice. Wenger (2010) suggests that there are signs of power in the notion of negotiation and in power axes such as gender and class, which are parts of membership and thus the identity.

However, Wenger's (1998, 2010) theory of community of practice does not explicitly incorporate a gender dimension, but as suggested, a power theory such as gender can be

included in the community of practice theory (Farnsworth et al. 2016). Therefore, the theory of community of practice is accompanied by a gender theoretical lens to capture the gender dimension in communities of practice. In this regard, we find inspiration in Paechter's (2003) suggestion that social and relational constructions of femininities and masculinities can be considered as two communities of practice associated with different norms and ideals of participation for women and men. This implies that gender itself can constitute a form of membership. Different gender memberships are shaped, depending on what it means to be a woman or a man in the overall community of practice that members find themselves in. Consequently, gender membership does not mean the same thing at all times, or for every person. Identifying oneself as a woman or a man can be expressed through different manners or ways of dressing (Paechter 2003). Membership is not self-evident, because it may require efforts to renegotiate the practices to fit into the community (Wenger 2010). When gender stereotypical expectations of how women and men should behave are anchored within a community of practice (Salminen-Karlsson 2006; Wenger 2010), different conditions for membership are created for men and women. For example, men and women who are members of the same occupation are likely to have different jobs, tasks and expectations to fulfil (Acker 2006). In line with conventional gender stereotypes, female managers are expected to work quietly and keep things running, while male managers may adopt offensive positions as heroic leaders. Female managers who exercise power and apply the same manners as male managers may risk being classified in pejorative ways (Acker 2006). Seemingly neutral assessment criteria, for example in promotion or recruitment, often involve gender-biased judgments and a devaluation of women's work efforts (Acker 2006; Bryans and Mavin 2003; Salminen-Karlsson 2006). From a gender theoretical point of view, gender is hence an aspect in all communities of practice, and can affect female and male members in different ways (Contu and Willmott 2003; Lave and Wenger 1991; Salminen-Karlsson 2006).

Method

The study was carried out in the Swedish elderly care sector which, like its Scandinavian neighbours, has a public welfare commitment to ensure the health and care of elderly citizens. The responsibility for providing welfare is divided up between Sweden's 290 municipalities, which carry out the majority of elderly care services. Changes in the national legislation have made it possible for private companies to carry out tax-funded elderly care services. In 2019, private care providers were responsible for 23 per cent of all home-help services and 19 per cent of all nursing homes for the elderly in Sweden.

Selection and participants

First-line managers (henceforth called managers) in Swedish elderly care work in different contexts, therefore we selected managers from both public and private elderly care providers from metropolitan and rural areas. Four elderly care organisations, two municipalities and two private corporations, located in a region in the central-eastern part of Sweden were contacted. The executive managers in each organisation agreed to participate in the research project and forwarded the information to the managers in

the organisation. We then selected first-line managers based on the criterion that they operated at the lowest managerial level in a traditional hierarchical organisation and led non-managerial employees. Forty first-line managers, 35 women and 5 men, gave their informed consent to participate. The size of the sample of managers was large enough to reach saturation and therefore allowed for a credible analysis. The predominant proportion of the selected managers were women, and this reflects the gender distribution in Swedish elderly care as well as in the participating elderly care organisations.

The managers' ages ranged from 26 to 64 years. On average, they had worked as first-line managers for 9.5 years. Regardless of care provider, the participating first-line managers had similar duties and assignments to fulfil. All managers had financial responsibilities for a group of care workers (henceforth referred to as subordinates) that mainly consisted of assistant nurses, but also included registered nurses, physiotherapists and care workers without formal education. All managers were also responsible for the care users within the unit, and had to comply with the overall organisational, municipal and national regulations to fulfil their obligations to provide good quality care for the elderly. However, the managers' work conditions varied depending on what type of care services they oversaw, the span of control (which varied from 20 to over 100 employees) and the type and extent of administrative support they received. Some of the managers had responsibility for more than one elderly care unit and divided their working hours between different locations.

Data collection

Qualitative interviews were conducted with 40 first-line managers, using a semi-structured interview guide covering eight themes: background, managerial assignment, daily work activities, professional relationships and communication, everyday learning at work, conditions for learning, professional identity, and career development. The gender-related questions were interwoven with the other questions, with the intention to capture gender issues related to specific work situations and conditions, and to avoid 'correct' gender policy statements. Example of questions included: What do you do during a working day? Which contacts are important for you to manage your job? What expectations are placed on you as a manager? Should you act in a certain way to fit into the management team? Questions related to gender were: What is it like to work in a female-dominated organisation? Does the dominance of women in elderly care affect your work as manager? Are male and female managers treated in the same way or differently? The interviews, all of which were audio recorded, were just over an hour long and took place at the managers' workplaces.

Data analysis

The interviews were transcribed verbatim. The first author started the analysis by reading the interview transcripts for familiarisation. Descriptive labels, or shorter sentences were placed in the margin to create an overview. A qualitative content analysis, inspired by Graneheim and Lundman (2004) was carried out. After reading the transcripts, the second step involved identifying and sorting out meaningful units containing sentences and parts of the interview transcripts. The different units that made up subcategories

were then analysed in a second round and organised into eight categories. These categories concerned the managerial role, for example relationships with subordinates and other manager colleagues, and gender-related dimensions of the managers' work in elderly care, for example gendered expectations and stereotypes. In a third round of analysis, the categories were discussed by all authors to capture details and nuances in the managers' experiences of their role and gender. As a result of this discussion, it became evident that the managerial role shifted, depending on how the managers experienced the relationships with their subordinates and their manager colleagues, respectively. Gender played a significant role as well. In this stage, we turned to the theoretical lens of community of practice (Wenger 1998, 2010) and the notions of femininities and masculinities as communities of practice (Paechter 2003). In the final, more deductive analysis step, the theoretical lens guided us to further examine the categories, resulting in two distinct communities of practice, which we labelled: (1) the care work community and (2) the first-line manager community (see Appendix, for an overview of the coding scheme). These two communities of practice served as a structure for the findings section. Quotations from the interviews are used to illustrate the managers' experiences. The quotations have been translated from Swedish into English by the authors.

Findings

The findings presented are viewed from the experiences of managers, 35 women and 5 men, in elderly care. The findings shed light on two different communities of practice: the care work community and the first-line manager community, in which the first-line managers saw themselves as members. Depending on the community of practice in which the managers were involved, they experienced their managerial role and gender, as well as how these were intertwined, differently. However, a common characteristic of these communities of practice was that they involved a variety of activities, repertoires, and relationships, all of which influenced the managers' membership in terms of their legitimacy as well as their ability to learn, engage, and build social relationships in managerial work. As will be further elaborated in the discussion, the managers navigated between these two communities of practice, and this duality shaped different experiences of the managerial role and gender in elderly care.

The care work community

Within the care work community, the managers had superior positions and statuses compared to their subordinates, who were mainly women employed as assistant nurses. Their joint activity was to provide care services for the elderly residents who lived at one of the care provider's units. The managers led the units' operations and staff, which included organising work, scheduling, recruitment and determining salaries, while the subordinates carried out the daily routine care work at the units. Despite differences in main tasks between the managers and their subordinates, their mutual endeavour was to find a common ground and overcome difficulties in fulfilling the care assignment – to take care of the elderly residents' individual needs. The shared repertoire included standard procedures and work methods, dealing with equipment such as bicycles, cars and telephones, and managing work schedules, IT systems and

documentation about the care users, as well as a shared professional language including abbreviations and nicknames.

Although they all were members of the care work community, the managers said that they sometimes had different opinions to their subordinates about what was important for the joint activity, and the managers therefore sometimes had to deal with disagreements. According to the managers, disagreements occurred in the care work community when the subordinates did not understand the extent and significance of the administrative work the managers had to do, which was a large part of their managerial role. The managers further described that there was a great variety of attitudes towards the joint activity among the subordinates, ranging from those who had a passionate work attitude to those who were only there for the money, and who made as little effort as possible. The managers had to deal with this in their role within the care community by compromising and making careful judgements about the subordinates' attitudes and skills. However, the managers' opinions of the complexity of the joint activity varied, as some thought that carrying out care work was no more difficult than running a household, while other managers believed that the care work was based on systematic work methods.

Another important part of the managers' role in the care community was to work in close relationships with their subordinates to provide the expected level of care for the elderly. The managers said that they spent a large part of their working hours building relationships and talking to subordinates and care users, and that these conversations were appreciated because they made it easier to perform the managerial work. The mutual engagement between the managers and subordinates was based on helping each other and keeping things going, participating in problem-solving, gossiping, establishing friendships and showing an interest in each other's private lives. Within these close working relationships, the managers described how subordinates valued their care experience, and in this respect younger or newly hired managers felt that they could be perceived as less worthy in the eyes of their subordinates. A few managers without care work experience did not think it mattered as much, because it was not their main work obligation to participate 'hands-on' in the care work.

Sometimes, disagreements arose within the community among subordinates, and managers felt that dealing with these situations could be tiring. Some managers avoided making generalisations, but others put it bluntly that conflicts were a common feature among female staff in female-dominated workplaces, and even more common in female-dominated workplaces than in male-dominated workplaces. The managers thought that disagreements among staff created a great deal of gossip and drama, and that female care workers tended to engage in things that were none of their concern, for example meddling in other people's interpersonal conflicts. At times, the managers had to stop the gossip and remind subordinates not to talk behind each other's backs, and instead to engage in professional communication that was not ruled by emotions. The managers said that they tried to distance themselves from their subordinates' gossip-oriented conversations as much as possible, but they also felt that their subordinates intentionally excluded them from certain conversations to withhold information.

> So this, I mean it's really easy to say "Well, I don't like our boss, he/she is horrible", something like that is easy to say. Or when you enter the room during a coffee break and it falls

> totally silent, then you know that they were talking about me … and then you need to understand as a manager that people almost always talk about their boss. Even if you are really nice, really support everything your staff say, this is not always the right thing, because then you are seen as a wimp. And if you say no to everything, then you are seen as very inflexible, so you must be … how can I put it? Something in between; try to understand how they think, but still be tough and put your foot down and say "No, this is how it's going to be". (Female manager, private care provider)

Whilst the managers thought that staff should distance themselves from their feelings, the atmosphere in the community was expected to be imbued with inclusion and empathy towards both members and care users. The managers said that this required considerable expertise in the managerial role, striking a balance between showing compassion and at the same time demonstrating decisive leadership. In this regard, gender differences were articulated by the managers since some of the female managers stated that they were expected to be more compassionate than their male colleagues, for example by showing an interest in their subordinates' family situation and knowing the names of their children. One manager said that her subordinates preferred talking to her about private matters rather than to her male colleague. Other female managers were worried about being perceived as harsh, as they believed that this would reduce their subordinates' trust and willingness to cooperate. At times, both female and male managers recognised that it was an advantage to be a man, because subordinates tended to take male managers more seriously, and did not question male managers' decisions as much as decisions made by female managers.

> It's easier for a guy to – sometimes, maybe not always – well, yes, I think that there is a difference. I have had several others too, and several of my former colleagues have said that you notice when there is a guy, they favour him. It's easier for a guy to say "This is how it's going to be" than for a girl, it's like, they respect a guy a little more, I think. Not that I don't think they respect me, but sometimes I think it works that way. (Female manager, private care provider)

On the one hand, the male managers expressed that their gender could give them more authority and that some subordinates accordingly 'upped their game'.

> Well I'll soon be forty, middle aged, and maybe some of these 48 women are doing a better job than they would otherwise do, because I'm a guy. Maybe, some of them do the opposite as they don't really want to take orders from me. If it's an older assistant nurse who knows how things have been done here for many years, and then a young bloke comes to boss them around. (Male manager, municipality)

On the other hand, the male managers felt that older, experienced subordinates could be more hesitant about allowing a male manager to supervise the care work community. For example, two of the men had felt resistance from subordinates, which they thought was due to subordinates perceiving them as unfamiliar with elderly care work. Regardless of gender, the managers thought that resistance to change among their subordinates was generally difficult to handle due to the community's limited resources for work improvements and low-skilled subordinates, who were more difficult to persuade to make changes in the workplace. The managers also saw the slow pace of change as a typically feminine characteristic that differed from male workplaces. At the same time, the perception was that there was less prestige and more willingness to cooperate in female-

dominated communities than male-dominated communities, which made it easier to deal with the physically and mentally demanding care work.

The first-line manager community

The community of first-line managers brought first-line managers from the care provider's various units together in a way that allowed joint activities to develop along with a professional camaraderie that led to a sense of cohesion within the community. Joint activities involved interpreting the managerial assignment from the superior management (decision-makers) and the requirements for the role of first-line manager, which included leadership responsibility for the subordinates at the unit. The managers shared a repertoire in terms of professional language, scheduled meetings and IT systems for administration relating to staff and care users. In addition, as members of the community the managers had access to the same support functions (which were not available to subordinates) and had to comply with the same organisation-specific policies and guidelines.

Meetings were arranged regularly by the employer, bringing all managers together for collaborative discussions on common topics. Between these meetings, the managers sometimes contacted other managers within the community for advice on work-related difficulties. Common topics within the first-line manager community included work environment responsibilities, rehabilitation matters, wage setting, staffing, change initiatives and solving conflicts among subordinates. The managers supported each other by jointly offering tangible suggestions or applying joint problem-solving methods. Support from other managers was considered important to fulfil obligations such as implementing directives from higher managerial levels.

Despite mutual engagement, the managers acknowledged that it could be difficult to trust other managers who lacked knowledge, even if no open conflicts or competition situations were obvious in the community. However, members of the community had different expectations which the managers had to adapt to, in order to gain acceptance. One such expectation was to work overtime regularly – up to 60 h a week – and to be available 24 h a day, seven days a week. Despite this, not everyone registered their overtime or talked openly about it, due to the fear of being perceived as incompetent and inadequate as a manager by other managers in the community. Some managers felt that they were assessed by the other managers in terms of how well they succeeded in fulfilling their joint duties, for example sticking to budgets, being available, including staff in decision-making activities and delivering good quality care. However, the managers rarely had a specific idea about what was considered a 'good manager' within the first-line manager community. Some managers considered the managerial role to be an impossible mission under the prevailing conditions, or even a suicide mission. Others thought that there was too much whining in the community, and some felt that if anyone thought it was too burdensome, they should not be a manager at all.

> I never feel completely powerless, like "Oh, how should I do this?" And then it's like … in those situations, when I hear some colleagues not … really cope with it, then I think "Why did you choose to be a manager if you think it's so difficult and hard?" That's part of the game! I find myself thinking that way sometimes and I try to tone it down, because I really don't want to be perceived as a know-it-all. (Female manager, municipality)

Managers who saw themselves as a typical manager described themselves as straightforward and liked to take charge. Those who did not see themselves as typical managers said that they had a soft approach and included subordinates in decision-making. Others were ambivalent and questioned whether there was any such thing as a typical manager, referring to leadership as being based on personality, or that different situations required different leadership approaches. Due to different personalities, it was difficult to discern the ideal manager or a single way of understanding their duties as a manager to fit into the first-line manager community.

It was suggested by some managers that the spread in terms of age, gender, educational background and professional background was positive, and led to a dynamic commitment and new angles of approach to joint activities. Other managers described the community as homogeneous, in terms of members being predominantly middle-aged women with nursing experience, and those who deviated from this norm were less accepted. The explanation for a female dominance was that most managers were recruited from the female-dominated elderly care sector, and the few men who worked in the community more often had a background in healthcare. Due to this female dominance, the female managers had greater legitimacy in the community. For example, one of the male managers felt singled out when a female manager indicated that as a young man, he should show more drive and ambition in the first-line manager community.

Another aspect of gender differences was also articulated by the managers, with a plethora of expectations on how female and male managers behaved or were expected to behave in the first-line manager community. Female managers thought that men were better at bragging about their work performance, while women tended to work in silence. A female manager believed that male managers did not have the same high workload as women, since women were expected to do more care work. As a result, men were seen to have better opportunities for doing their managerial duties. Female managers said that male managers were recruited in the hope that this would reduce what they called 'female cackling'. However, both female and male managers thought it was more common for male managers to leave the community to move on to higher management positions, in order to achieve a stronger position with higher salary and status. Some female managers perceived that men recruited men, and men were therefore more privileged due to their gender and not just because of their leadership qualifications.

> There is a huge difference, what I have seen during these years about advancing in their roles. Where I used to work, they were about to reorganise and expand the number of regional managers. It can't be a coincidence that two of those positions were filled by two men who had lower scores than female colleagues in surveys on quality, co-worker satisfaction and financial results. So I think … female-dominated sectors often have a tendency to promote men, but women in male-dominated sectors are not promoted to the same extent. (Female manager, private care provider)

Although the male managers believed that the men in the community could have greater chances of career development, none of them had any ambition themselves to advance to a higher manager position. Both female and male managers who were newly employed said that even though they felt welcome in the first-line manager community, the

established managers were not always interested in their contributions to the joint activities. Difficulties with making changes within the community were due to a few established managers' negative attitudes to new ideas that could permeate the community. On the other hand, established managers believed that gendered power structures could be an impediment because the community's collective voice to demand change was perceived by higher management as whining and hassling.

> The older I get, the more aware of these power structures I become … and it can be very annoying sometimes. I sometimes feel that it has an impact, we have female majority in our management team and […] I often feel, how should I put this, that you are perceived as a bitch if you make demands and questions things. Instead, if this were taken into account, because when we dare to question things and have open minds, that's when we have very constructive discussions and that's when our work can really benefit from this. (Female manager, municipality)

As the quotation shows, it could be a balance between making demands and questioning things, while at the same time having constructive discussions, that developed the first-line manager community. Changes were feasible if the managers made well-worded statements that could be taken seriously instead of being easily dismissed.

Discussion

This article provides insights into first-line managers' experiences of their managerial role and gender in two different communities of practice: the care work community and the first-line manager community (Wenger 1998, 2010). It was obvious that these two communities of practice distinguished themselves in terms of having a significant influence on the managers' everyday work because both communities constituted a direction for their managerial role. The managerial role required the manager to learn how to navigate between the care work community and the first-line manager community to fulfil their managerial duties successfully. In both communities of practice, the managers had experiences of how gender was intertwined with their role and work. Notions of femininities and masculinities in these communities (Paechter 2003) created different expectations on how female and male managers ought to behave and carry out managerial work, and who did and did not have advantages due to their gender. These expectations provided different conditions for female and male managers, which influenced their leadership and their opportunities to learn how to become accepted members of each community (Wenger 1998, 2010).

The managers' navigation between the care work community and the first-line manager community created dual memberships, which indicates that the managers' membership in each community differed depending on micropolitical processes which arose in relation to their position, expectations from others and gender stereotypes in the community. This duality shaped different experiences of the managerial role and gender in relation to the female dominance in elderly care. If we now take a closer look at each community of practice, a deeper understanding of the intertwining of managers' role and gender can be obtained. In the care work community, the manager had an important strategic position of leading the operation and staff compared to the subordinates who executed the daily care work. Despite the managers' formal authority, they had to gain legitimacy from their subordinates by continuously adapting in line with their

expectations and maintaining trustful relationships, for example between being compassionate and being decisive (Ekholm 2012). The managers' dependence on their subordinates' willingness to allow them into the community (Lave and Wenger 1991) actualises an interesting paradox in the managerial role. In one respect, the managers did not experience their role as powerful, because their position was limited to the will of their subordinates – the other members' approval of the manager in the care work community. In that sense, their membership had to be earned (Wenger 2010), which made it necessary for female managers in particular to learn to adopt a caring leadership style within the female-dominated care work community towards their subordinates, such as knowing the subordinates' family situation and the names of their children. Being accepted as a member served as a resource for creating a trustful managerial role, and practical experience of elderly care was also a valuable resource in the managers' repertoire that made it easier to win subordinates' appreciation.

In another respect, the managers described how they distanced themselves from femininity, which was regarded as an unprofessional aspect of the provision of elderly care, indicating that the male norm was advocated as a managerial ideal for leading subordinates (Acker 2006; Bryans and Mavin 2003; Salminen-Karlsson 2006). For example, the managers avoided participating in gossip, which was seen as a female thing to do and was attributed to subordinates. In this position, the managers could maintain their legitimate mandate by downplaying what was feminine in the care work community. Creating respect maintained a hierarchy between the managers and their subordinates, but also indicates that managers have to strike a balance between gender stereotypical attributes ascribed to female and male norms, both by themselves and by others (Salminen-Karlsson 2006). Female managers tried not to be harsh to a greater extent than male managers, which implied a fear among the female managers of losing their subordinates' trustful respect. These findings are in line with other studies, showing that female managers who adopt male-coded leadership attributes are classified in pejorative ways or as less competent than their male colleagues (Acker 2006). The resistance male managers faced from subordinates could be related to the female dominance in elderly care – another dimension of membership of the care work community.

Within the first-line manager community, managers met regularly to support each other and jointly develop the skills needed to deal with their unit operations and staff. Sharing and developing knowledge about the community's joint activity was considered necessary in order to gain access to important information for performing the managerial work. The developed knowledge was an asset for the whole community, consisting of a common repertoire of working methods and leadership attitudes that strengthened their professional identity as first-line managers within the care provider. Being a member of this community was based on trust by fulfilling the same obligations for all first-line managers in a joint, appropriate and committed manner (Wenger 2010). It was expected that each manager would adhere to the rules set out in the first-line manager community, such as working overtime, being available, keeping to the budget and delivering good quality care. Beneath a harmonious surface, the managers within the community struggled not to deviate from the norm of 'how a manager should be' in order to gain acceptance in the community, or at least not to show openly if they did not follow the expected rules. Adhering to the rules was a way to earn legitimate membership, but it also required adapting to the community's female dominance (Paechter 2003) as

maintained by established female managers (Lave and Wenger 1991). If managers deviated from the norm of being a middle-aged white woman with care experience, they could be treated differently. In this regard, a female norm ruled within the community (Regnö 2013) – a manager should not only be 'female', but also have extensive managerial experience of elderly care and be 'middle-aged' since youth was perceived as involving a lack of such experience.

These expectations related to gender, but also to other qualities associated with the capacity of being a manager ('intersectional perspective' Acker 2006; or 'power axes' Wenger 2010) in this community. For example, male managers experienced how their legitimacy was obstructed by female managers, but both female and male managers shared common notions of male privilege among managers in general (Acker 2009; Heilman 2012), and even within elderly care (Keisu 2009). In addition, men were not expected to stay, but to advance to higher management positions. Judgments like these reproduced the idea that elderly care work had a low status and did not suit men as they had higher career ambitions, while women were content with less (Gustavsson and Fogelberg Eriksson 2010; Wahl 2014). Hence, the dominance of women in elderly care and gender expectations maintained general stereotypes of women and men.

Conclusions

This study contributes knowledge that increases our understanding of the managerial role in elderly care and in particular first-line managers' dual membership and their navigation between the care work community and the first-line manager community. The first-line managerial role in terms of a dual membership led us to re-consider previous research that tend to illustrate first-line managers as sandwiched between superior management and subordinates (Gjerde and Alvesson 2020; Sims 2003). As opposed to research that shows that first-line managers are squeezed, our study indicates that managers in a first-line position were able to navigate within and between the care work community and the first-line manager community. This means that managers can use their dual membership to intentionally reshape and adapt their managerial practice depending on various circumstances and conditions in their work.

Even if not all managers made categorical statements or explicit comments in relation to gender, the findings reveal that notions of gender were an inherent aspect of the managers' experiences of their managerial role. A female norm ruled within the first-line manager community, providing middle-aged women with elderly care experience with a greater legitimacy to control the community, while men were not so easily accepted. On the other hand, the male norm was more prominent in the care work community in line with managerial ideals. This suggests that male managers received more credit as being more capable as managers, while female managers who adopted the male norm by downplaying their femininity also had to balance this male norm with a feminine, caring leadership style. This means that gender manifested itself in different ways within these two communities of practice and provided different conditions, giving women and men different benefits or unequal conditions for performing leadership. However, a further and more comprehensive investigation of first-line managers' dual memberships is needed to unravel the complexity of managerial work, and what practical implications this duality may have for managers' learning and leadership development at work.

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Appendix: Coding scheme – data analysis

Subcategory	Category	Aggregate dimension
Standard procedures and work methods Daily routines care work Purchases and dealing with equipment, e.g. maintenance of vehicles Professional language, abbreviations IT systems and documentation Care work as household work	Care service (joint activities and shared repertoire)	The care work community
Organising work Scheduling Recruitments Determining salaries Resolving conflicts Improvement work Managing change initiatives Distance themselves from gossip and intrigues Building trustful relationships with subordinates Include subordinates in decision-making Female managers have heavier workload than male managers	The first-line managers' work tasks and responsibilities	
Do 'hands-on' care work Being available Problem-solving Provide expertise and personal experience in care work Show compassion versus being decisive Female managers are expected to show more compassion than male managers Male managers are taken more seriously	Subordinates' expectations on the manager	
Gossip Passion for work versus doing it for the money Meddling in others business Compassion towards care users Emotion-driven Conflicts Friendships and personal relationships Avoid gender generalisations Whining Slow pace of change Less prestige and big egos Cooperation	Conceptions about the 'typical' feminine workplace and subordinates	
Participate in meetings arranged by the employer Collective problem-solving Interpretation of managerial assignments Professional language Access to same support functions (IT, HR) Policies and guidelines Knowledge sharing Sticking to budget Work overtime if necessary	Joint activities, responsibilities and repertoire	The first-line manager community

(*Continued*)

Appendix: Continued.

Subcategory	Category	Aggregate dimension
Camaraderie	Relationships among first-line managers	
Social and collegial support		
Building relationships based on similar personal backgrounds		
Difficult to trust other managers		
No conflicts among managers		
Help each other		
No contact outside work		
Middle-aged women	Norms for the managerial role and position to influence practice	
Healthcare or care work experience		
Everyone is welcome		
Different personalities		
New managers are silenced		
Established managers have more influence on practice		
Young managers are not taken seriously versus bring new perspectives		
Keeping up appearance by working hard and not showing weakness		
Established managers are negative towards change		
Female managers have greater legitimacy than male managers		
A mission impossible		
Men leave the organisation for higher management positions	Conceptions about male and female managers	
Women generally have more experience in care work		
Female managers tend to whine		
Male mangers brag and female managers work in silence		
Men are welcome versus male managers feel singled out		
Female managers are not being taken seriously by decision makers		