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Discursively framing physicians as leaders: Institutional work to reconfigure medical professionalism

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ABSTRACT

Physicians are well-known for safeguarding medical professionalism by performing institutional work in their daily practices. However, this study shows how opinion-making physicians in strategic arenas (i.e. national professional bodies, conferences and high-impact journals) advocate to reform medical professionalism by discursively framing physicians as leaders. The aim of this article is to critically investigate the use of leadership discourse by these opinion-making physicians. By performing a discursive analysis of key documents produced in these strategic arenas and additional observations of national conferences, this article investigates how leadership discourse is used and to what purpose. The following key uses of medical leadership discourses were identified: (1) regaining the lead in medical professionalism, (2) disrupting 'old' professional values, and (3) constructing the 'modern' physician. The analysis reveals that physicians as 'leaders' are expected to become team-players that work across disciplinary and organizational boundaries to improve the quality and affordability of care. In comparison to management that is negatively associated with NPM reform, leadership discourse is linked to positive institutional change, such as decentralization and integration of care. Yet, it is unclear to what extent leadership discourses are actually incorporated on the work floor and to what effect. Future studies could therefore investigate the uptake of leadership discourses by rank and file physicians to investigate whether leadership discourses are used in restricting or empowering ways.

1. Introduction

Scholars have extensively described how managerial discourse and associated practices, such as standardization, regulation, performance indicators and audits, have entered the medical field (Muzio et al., 2011; Noordegraaf, 2015; Numerato et al., 2012). Physicians, who are well known for safeguarding medical professionalism, often feel 'threatened' by these changes and argue that these changes are imposed upon them by managers, the state or civil servants. These imposed changes are said to hamper physicians from performing the primary function of their work, i.e., caring for patients (Numerato et al., 2012). However, in contrast to 'imposed' managerial discourses, the recent development of *medical leadership discourses* shows that physicians increasingly deploy 'business-like' discourses to reform medical professionalism. Physicians are encouraged (Berghout et al., 2017; Porter and Teisberg, 2007; Swanwick and McKimm, 2011; Warren and Carnall, 2011) to 'get back in the lead' and *pro-actively* change their attitude, practices, education and field to meet societal and clinical challenges, such as increasing healthcare costs and chronic patients.

According to Martin and Learmonth (2012), this recent shift from 'management' to 'leadership' discourses is due to its presumably positive associations, that 'predominant terms such as management now lack' (Martin and Learmonth (2012):281). As such, leadership discourse is said to have change potential to reimagine public services and construct medical identities in new ways (Learmonth, 2017; Martin and Learmonth, 2012). Yet, it is unclear exactly how leadership discourse has become part of institutional work of physicians and to what purpose it is being employed.

Drawing upon both critical leadership studies (Alvesson and Spicer, 2012) and institutional work theory (Lawrence and Suddaby, 2006), this study investigates how opinion-making physicians in strategic arenas, i.e. national professional bodies, conferences and high-impact journals, use leadership discourse to perform institutional work in order to reconfigure medical professionalism. So far, existing studies have shown that physicians perform institutional work, i.e., 'purposive actions performed by individuals to maintain, disrupt or create an institution' (Lawrence and Suddaby, 2006:215), to protect medical professionalism from managerial 'encroachment' (Currie et al., 2012;

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Kitchener, 2000; Kitchener and Mertz, 2012; McGivern et al., 2015). These studies only provide examples of *re*active deeds performed by physicians in order to restore disrupted professional arrangements. This study demonstrates how physicians in strategic arenas attempt to *pro-actively* change the medical field by framing physicians as leaders that work across disciplinary and organizational boundaries.

Following the recommendations by Alvesson and Spicer (2012), who noted that leadership should be studied more *critically*, we look at what the leadership concept *does (i.e. performativity of language) in terms of discursively constituting medical professionalism in new ways,* instead of assuming beforehand that medical leadership 'exists' as an empirical phenomenon (Learmonth, 2017; Martin and Learmonth, 2012). A critical investigation can potentially reveal the profession-building processes of physicians that cannot be seen through other approaches. In doing so, we aim to increase our understanding of how opinion making physicians deal with contemporary challenges facing healthcare that supposedly require institutional change in the medical field. Our *research question* is as follows: How do opinion making physicians in strategic arenas use the discourse of medical leadership in their institutional work and for what purposes? By answering this question, we contribute to new insights into the potential reconfiguration of medical professionalism.

2. Institutional work and professionals

The concept of institutional work is rooted in both institutional theory and the sociology of practice. Lawrence and Suddaby (2006), who introduced the concept, describe that institutional studies have transitioned from studying the effects of institutions on organizational actors to studying the 'the effects of individual and organizational action on institutions' (Lawrence and Suddaby (2006):216). In turn, studies investigating institutional change have shifted their focus to the actual *processes* of actors as they 'cope with and attempt to respond to the demands of their everyday lives' (Lawrence and Suddaby (2006) and Jarzabkowski et al., 2009). Hence, institutional work entails the acts performed by actors to maintain, create or disrupt institutions.

Increasingly, professions are considered the 'key drivers of field-level institutional change' (Suddaby and Viale, 2011:424; Kitchener and Mertz, 2012; Lockett et al., 2012; Scott, 2008). Suddaby and Viale (2011) explain institutional change as a result of institutional work carried out 'as an inherent part of the process of professionalization'. 'Professionalization projects' as they name it (ibid.), reflect the efforts of professionals to protect their autonomy and domain from exogenous institutions. According to Suddaby and Viale (2011), these efforts are 'inherently associated with projects of institutionalization' as the existence of professions is characterized by constant negotiation and struggles with other professions, managers, the state, and clients.

Studies of institutional work performed by *physicians* show their acts to safeguard medical professionalism in response to external influences, often resulting in the reorganization of clinical practices (Currie et al., 2012; Kitchener, 2000; Levay and Waks, 2009; McGivern et al., 2015; Sheaff et al., 2013; Wallenburg et al., 2016; Waring, 2007; Waring and Currie, 2009). This stream of literature shows how professionals, through their acts to protect medical professionalism, in fact become increasingly managerialised. McGivern et al. (2015) even demonstrated how professional-managers, whom they name 'willing hybrids' challenge and disrupt medical professionalism in reaction to increased managerialist ideas in healthcare. These hybrids promote managerial targets, auditing and regulation by arguing that these actually benefit patient care, thereby integrating professional and managerial identities.

However, still scarce are studies that investigate how physicians pro-actively aim to reform the medical field rather than merely repairing the status-quo. Moreover, institutional work performed by physicians operating in strategic arenas is relatively under-studied. Yet, we argue that studying physicians as institutional agents in strategic arenas is important due to their potential ability to influence the public debate and set the agenda regarding future change in the medical field.

Our focus on discourse is underpinned by increasing evidence that shows how professionals (Suddaby and Viale, 2011:435) use language to shape institutional change presumably due to their strong social and discursive skills (Green, 2004; Heracleous and Barrett, 2001; Lawrence and Suddaby, 2006; Suddaby and Greenwood, 2005). These studies reveal that language in institutional work is not neutral and should be researched in its own right. In the following section, we briefly discuss the linguistic turn in leadership studies that guides our investigation of the use of medical leadership discourses and its potential performativity in terms of discursively constituting medical professionalism in new ways.

3. Leadership as performative discourse

In line with an earlier 'linguistic turn' in organizational studies (Alvesson and Karreman, 2000), leadership scholars have recently turned towards 'discursive leadership' (Alvesson and Spicer, 2012; Collinson, 2005; Fairhurst and Grant, 2010; Kelly, 2008; Learmonth, 2005; Martin and Learmonth, 2012). Studying leadership as a discursive phenomenon is considered a response to dissatisfying results obtained using dominant positivistic approaches to leadership in which leadership is considered an objective, free-of-power phenomenon that can be pinned down and measured (Alvesson and Spicer, 2012). In contrast, critical leadership studies investigate how actors use the discourse of leadership to construct new identities and to steer behavior in new directions, thereby constituting reality in new ways (Alvesson and Spicer, 2012; Fairhurst and Grant, 2010).

In this reading of discourse, discourse can be understood as "co-constituting what appears to be social reality" (Gond et al., 2016:441) and not merely a description of reality. In other words, discourse can be considered *performative*. The notion of 'the performative utterance' was introduced by John Austin in his 1962 book *'How to Do Things with Words'*. In this work he argued that not all language is merely descriptive. Rather, some utterances are performative in that they 'do' what they 'say' (Austin, 1962). In this light, discourse can be considered *as doing* something to reality by "constructing a person's subjectivity and framing his action" (Alvesson and Karreman, 2000:1138), and this framing is thus in itself *performative*.

Several discursive studies have shown how leadership vocabulary is used to construct the identities of professionals who are 'in the lead'. In a Foucauldian analysis of 'nurse leadership' in the US between the 1950s and 1970s, Davis and Cushing (1999) argue that the concept of leadership in the nursing profession has evolved as a response to increased hospital bureaucratization and the urge to strengthen their professionalization. As such, nurse leaders were portrayed as strong leaders who possess 'special' personality characteristics and are able to safeguard the nursing positions at hospitals. In this way, the authors argue, leadership discourse offered the nurses an ideal identity to strive for (Davis and Cushing (1999):17). Similarly, Ford (2006) showed how local governments seduced managers in the UK public sector into desired ways of working by defining the expected leadership practices and thereby in fact constructing their identities.

More recent studies have demonstrated how the leadership discourse is used to steer the behavior and practices of a much broader range of actors than merely the ones who are formally 'in the lead', including frontline professionals and patients (Ford, 2006; Learmonth, 2005; Martin and Learmonth, 2012; O'Reilly and Reed, 2010). In their study of the discursive appearance of 'leadership' in NHS policies, Martin and Learmonth (2012) show how the notion of leadership is