MATHILDE AYA BERGHOUT

MEDICAL LEADER-SHIP

TRANSFORMING **PROFESSIONAL PRACTICE** AND **IDENTITY**

Medical Leadership

Transforming Professional Practice and Identity

Mathilde Berghout

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General introduction

Medical leadership: an advocacy for the reconfiguration of medical professionalism

> *"Through medical leadership you can improve and ensure the quality and safety of care as a physician. It's thus not only about providing medical care, but also about organizing, collaborating, acting cost-efficient, transparency and self-management. Not only knowledge and skills are important. A positive attitude towards these organizational responsibilities are of equal importance. Medical leadership must be seen as part of the job of all physicians." (Platform Medisch Leiderschap 2016)*

> *"For the position of medical professionals it is important to show more leadership. Many physicians feel that they are losing control over their own domain. Within the profession there is a lot of frustration concerning increasing regulatory pressure and administration. Complaining doesn't help, developing leadership does. If physicians are better trained in medical leadership, they have better instruments to get more control over their own domain." (KNMG 2016)*

The above quotes from a physician-initiated platform for medical leadership (Platform Medisch Leiderschap) and the Dutch medical association (KNMG) illustrate that medical leadership is highly promoted among Dutch physicians, yet their interpretation of medical leadership differs. Physicians are either portrayed as heroic leaders who pro-actively deal with changing patient and organizational demands, or as victims who need to safeguard their medical domain from external 'intruders' causing an increasingly complex healthcare system and excessive administrative burdens. Although these two narratives of medical leadership differ in terms of how they portray medical leadership, they have in common that physicians use the term to encourage peers to transform their professional practice and identity. Apparently, what it means to be a physician in today's healthcare is at stake.

Advocates who portray medical leaders as pro-active heroes, argue that medical leadership is 'vital' to the delivery of high quality and safety of healthcare (Baker & Denis 2011; Chadi 2009; Clark et al. 2008; Coltart et al. 2012; Edmonstone 2009; Swanwick & McKimm 2011; Warren & Carnall 2011). These scholars associate medical leadership with high performing healthcare systems, better patient outcomes, cost savings, efficiency and greater staff engagement (Goodall 2011; Warren & Carnall 2011). These pleas often go hand in hand with a promise of a 'better future'. By building on narratives of an "increasingly complex world" (Brook 2010) and "uncertain times" (Dowton 2004), medical leadership is portrayed as the solution for "attacking this chaos" (Lee 2010). Specifically, an increase of chronic diseases, multi-morbidity, decentralization of care from hospitals to primary care settings, medical progress, rising healthcare costs and changing patient preferences are raised as issues that challenge our healthcare system and require physicians to deliver care in a different way (Noordegraaf et al. 2016; Warren & Carnall 2011). Proponents therefore argue that medical

leadership is a duty for *all* physicians, irrespective of title or specialty and thus "no longer an optional extra" (Clark 2012). Worldwide, medical educational competency frameworks are adding 'leadership' as an addition to medical-technical and academic skills (Dath et al. 2015). In addition, post-academic leadership development programs are on the rise (Frich et al. 2015). As leaders, physicians are expected to master a range of new skills, knowledge and tasks in addition to their clinical work, such as organizing and optimizing medical care, acting cost-efficient, initiating improvement projects, increasing multidisciplinary collaboration, being self-reflective and providing transparency into their work.

In a more defensive view of medical leadership, physicians are portrayed as victims of an increasingly complex healthcare system and are therefore encouraged to become medical leaders to take back charge and safeguard healthcare from 'external intruders' (Brook 2010; Fuijkschot et al. 2014; KNMG 2016; Porter & Teisberg 2007; Querido 2014; Slikboer 2014). These 'intruders' are for example managers, politicians, civil servants or healthcare insurance companies who are said to hamper healthcare improvement by their excessive focus on costs and administration rather than on quality of care. Critics argue that managerial demands to quantify and routinize healthcare are encroachments into physicians' clinical work and 'alien intrusions on their professional autonomy' (Olakivi & Niska 2016: 1; Fuijkschot et al. 2014). Moreover, these managerial demands would place an excessive administrative burden on physicians and distract their attention away from the core of medical work: treating patients (Bal et al. 2018; Noordegraaf et al. 2017). By employing medical leadership, advocates stimulate physicians to bring back simplicity in healthcare and to "return the practice of medicine to its appropriate focus: enabling health and effective care" (Porter & Teisberg 2007:1103). If not, Porter & Teisberg warn us that: "physicians will inevitably face ever-increasing administrative control of medicine" (p.1103).This implies that physicians perceive their traditionally dominant position in healthcare (Abbott 1988; Battilana 2011; Currie et al. 2012; Freidson 2001; Numerato et al. 2011; Waring 2007) as under threat and therefore encourage each other to get back in 'the lead'.

Despite the differences of these narratives in terms of how they portray physicians as medical leaders, advocates similarly plead for a change of medical professionalism. The first narrative advocates a pro-active attitude of physicians who transform their profession and identity to be able to adapt to changing patient, organizational and health system demands. In contrast, the second narrative reflects a more reactive view that interprets physicians as victims and encourages them to regain 'the lead' and safeguard their profession from external administrative and managerial pressures. Indeed, in literature, physicians are well-known for protecting their elite identity and autonomous position in healthcare, which shows similarity to the second narrative (Abbott 1988; Broom et al. 2009; Currie et al. 2012; Doolin 2001; Freidson 2001; Griffiths & Hughes 2000; McDonald 2009; Pratt et al. 2006; Suddaby & Viale 2011; Waring 2007). Yet, the first narrative shows a partly different view. By pleading for medical leadership, physicians are not only aspiring to 'regain' the lead in healthcare. More importantly, they are in fact actively pleading for a reconfiguration of medical professionalism:

the core of professional work, the medical professional identity and the content of educational curricula (Abbott 1988; Freidson 2001; Evetts 2011; 2013; Noordegraaf 2007; 2015; Wallenburg 2012).

Historically, the medical profession is regarded as a 'pure profession', similar to lawyers, accountants and judges (Etzioni 1969; Evetts 2011; Freidson 2001; Haas & Shaffir 1977; 1982; Tonkens 2013; Wilensky 1964). 'Pure' professions are characterized by specialized knowledge derived from long-life learning and experience, a service ideal to benefit clients over maximization of profits, professional autonomy and self-regulation. These characteristics have led to an elite and privileged status in society. Increasingly, however, scholars reject the model of pure professionalism, arguing that it does not correctly reflect daily practice (Harrison 2009; Noordegraaf 2015; Waring 2014). They state that influences of organizational and market logics, changing patient demands, increased calls from the public for transparency (Wagner & Lombarts 2015), and democratization of clinical knowledge (Voogt et al. 2016) have substantially influenced (medical) professionalism and forced professionals to adjust their practices to changing organizational and societal contexts. According to numerous scholars, this has led to an increased 'managerialization' or 'bureaucratization' of medical professionals (Kitchener 2000; Levay & Waks 2009; Sheaff et al. 2004; Waring & Currie 2009). More recently, scholars aim to illustrate the overlapping and complementary parts of managerial and professional logics, described in literature as 'hybrid professionalism' or 'organized professionalism' (McGivern et al. 2015; Opdahl Mo 2008; Noordegraaf 2007; 2015; et al. 2016; Postma et al. 2015; Spyridonidis et al. 2015). In a similar vein, medical leadership advocacies incorporate

These transitions in medical professionalism are most often described as the result of increased pressures by 'external' actors, such as the government, politicians, the public or managers (Numerato et al. 2012). Interestingly, however, is that physicians *themselves* are now actively pleading for a reconfiguration of medical professionalism by advocating medical leadership. Yet, to date, research on medical leadership has mainly focused on eliciting skills, activities or competencies and has neglected the social construction of medical leadership in practice. It remains unclear how medical leadership changes the medical profession and professional work in daily practices. Therefore, it is highly relevant to study how medical leadership is reconstructed in practice to investigate how physicians attempt to reconfigure medical professionalism in order to adapt to changing patient and organizational needs. Investigating this will reveal important insights into new interpretations of professional work and what it means to be a medical professional in contemporary healthcare.

Research aim and questions

The aim of this thesis is to critically investigate how physicians construct and attempt to enact medical leadership in practice. The central research question is:

How is medical leadership socially constructed in academic literature and daily practice and what are the implications of these constructions for the reconfiguration of medical professionalism?

Important to note is that this research does not incorporate a pre-specified definition of medical leadership when the inquiry started. Rather, the aim is to understand how physicians themselves understand and construct medical leadership and for what purposes. By exploring how physicians make sense of and practice medical leadership, the implications for medical professionalism can be investigated. This aim is translated in the following three sub-research questions:

(1) *How is medical leadership constructed in academic literature?*
Increasingly, medical leadership is a popular topic among academic scholars, yet there are many different definitions of medical leadership. Moreover, conceptualizations of medical leadership are often ambiguous or encompassing many different roles, competencies and tasks of medical leaders. An answer to this sub-question provides conceptual clarity by outlining the different conceptualizations and definitions of medical leadership.

(2) *How is medical leadership constructed in daily practice?*
Physicians increasingly participate in formal and informal leading positions, yet investigations of how physicians construct medical leadership in practice and detailed observational studies of how they attempt to perform these roles are rare. This sub-question seeks to provide insights into how physicians socially construct and enact medical leadership in daily practices.

(3) *What are the implications of medical leadership for the reconfiguration of medical professionalism?*
Given the popularity of medical leadership and the increasing participation of physicians in leadership roles in healthcare, it is important to investigate the implications for medical professionalism. This final sub-question aims to provide an understanding of the consequences of medical leadership on medical professionalism in terms of their medical professional identity, the core of medical professional work and medical educational curricula.

Investigating the social construction of medical leadership

One of the aims of this thesis is to investigate the social construction of medical leadership in practice. Interestingly, medical leadership is often portrayed as an appealing identity in

contrast to management (Dath et al. 2015; Porter & Teisberg 2007; Spurgeon et al. 2011). Proponents contrast leadership, that is positively associated with radical change, heroes and visionaries, to management that is often negatively associated with bureaucracy, administration and excessive profits. For example, the well-known CanMeds model, which informs medical curricula worldwide, changed one of the core competencies of physicians from 'manager' into 'leader' arguing that contemporary associations with leadership are more appropriate than those with management (Dath et al. 2015). Medical leadership arguably provides physicians with an attractive new sense of self which could 'save' their position in healthcare: instead of bureaucratic managers, they can now transform themselves into inspiring and clinically-focused leaders. This suggests that medical leadership is often used as a highly normative and prescriptive term: it outlines the necessary skills, competencies and tasks that future physicians *should* master. In addition, it is purposely chosen to encourage physicians to realize desirable change in their profession and organizational field.

Building on critical leadership studies, (Alvesson & Spicer 2012; Alvesson & Sveningsson 2003; Calás & Smircich 1991; Collinson 2011; Fairhurst & Grant 2010; Ford et al. 2008; Gemmill & Oakley 1992; Iliffe & Manthorpe 2019; Martin & Learmonth 2012), we argue that the prescriptive use of the term leadership should be investigated further. Medical leadership can be interpreted as a strategic discourse that is used by actors to co-create a newly envisioned future of the medical profession, thereby reconsidering the boundaries of the medical domain, the content of clinical practices and the core of medical identities. As previously illustrated, framing physicians as leaders can be a means to encourage physicians to acquire new skills and competencies, but also a means to safeguard their profession from influence by non-clinical actors. The way people talk and write about medical leadership is thus not without consequences, but can have performative effects, meaning that medical leadership discourses can co-constitute reality (Alvesson & Karreman 2000; Austin 1962; Gond et al. 2016).

By investigating how actors give meaning to medical leadership, in other words, how physicians socially construct medical leadership in practice, their values, ideals and purposes can be explored as well as its implications for the reconfiguration of medical professionalism. To guide the empirical analysis of different social constructions of medical leadership and their consequences for medical professionalism, certain sensitizing concepts derived from literature are used (Bowen 2006; Mortelmans 2013). This thesis draws on different bodies of literatures; ranging from institutional and identity theory to dramaturgical theory on the presentation of self. Institutional work literature (Currie et al. 2012; Jarzabkowski et al. 2009; Lawrence & Suddaby 2006; Wallenburg et al. 2016; 2019) is used to study how physicians aim to change medical professionalism by using medical leadership discourses. Institutional work is described as "purposive actions performed by individuals to maintain, disrupt or create an institution" (Lawrence & Suddaby, 2006:215). Framing physicians as leaders can be considered as an important part of institutional work aimed at reconfiguring the institution of the medical profession in terms of prescribing a new medical professional identity. To study

more in-depth how physicians construct leadership identities in practice and the implications of these constructions for the medical professional identity in general, identity work literature (Brown 2015; Pratt et al. 2006; Sveningsson & Alvesson 2003) is used. Identity work is part of institutional work (Lawrence and Suddaby 2006) and reveals 'the active construction of an individuals' identity' (Pratt et al. 2006: 237). This stream of literature is used to study the identity practices of physicians who are participating in a medical leadership development program. Educational programs, including the medical leadership development program under study can be viewed as 'identity workspaces' that are ideal to study how actors collectively reconstruct their identity (Carroll & Levy 2010, Nicholson & Carroll 2013, Petriglieri & Petriglieri 2010).

Finally, the work of sociologist Erving Goffman (Goffman 1959; reprint in 1978) is used to further investigate how physicians construct and make sense of medical leadership in practice. Goffman developed a dramaturgical framework based on metaphors of the theatre to analyze how actors construct and subsequently present the (newly constructed) 'self' to others. This presentation of self is, according to Goffman, aimed at convincing others – the audience – of a credible self. Using this approach, it is investigated how 'medical managers' (i.e. are hospital-based physicians who are part-time head of their clinical department (Llewellyn 2001) interpret their role as medical leader and how they perform this self towards others in daily practices. In bringing these different streams of literature together, it is possible to foreground how Dutch physicians interpret and construct medical leadership in practice. These investigations will generate new insights into the implications of medical leadership for medical professionalism in terms of reconfiguring the medical professional identity, the core of medical work and the boundaries of the medical field. This thesis will thereby increase knowledge about the evolvement of medical professionalism and in specific professional identities and practices (Abbott 1988; Freidson 2001; Kyratsis et al. 2017; McGivern et al. 2015; Muzio & Kirkpatrick 2011; Noordegraaf 2007; 2015; Noordegraaf et al. 2016; Reay et al. 2017; Spyridonidis et al. 2015; Wallenburg 2012).

Setting: the Dutch healthcare sector

This study is situated in the Dutch healthcare sector. This provides a particularly interesting setting to study medical leadership, as the rise of medical leadership in the Netherlands reflects the aim of physicians to reconfigure medical professionalism. Medical leadership is also a popular concept in other countries, for example in the US and UK (Baker & Denis 2011), however mostly initiated by policy makers to strategically draw physicians into administrative structures. In contrast, in the Netherlands, physicians themselves deploy the concept of medical leadership to advocate change. Investigating the constructions of medical leadership contributes to knowledge on how physicians react to changes in their medical field and attempt to transform their professional practices and identities accordingly (Kyratsis et al. 2017;

McGivern et al. 2015; Muzio & Kirkpatrick 2011; Noordegraaf 2007; 2015; Noordegraaf et al. 2016; Reay et al. 2017; Spyridonidis et al. 2015; Wallenburg et al. 2016). In the Netherlands, initiatives to develop medical leadership have increasingly evolved over the last past years (Denis & Van Gestel 2016; Lucardie et al., 2017; Noordegraaf et al. 2016; Voogt et al. 2016). Physicians, educational institutes, healthcare organizations and policy makers have developed new competency models for educational curricula and medical leadership development programs, and organized several conferences and seminars (Keijser et al. 2017; Platform Medisch Leiderschap 2016; Voogt et al. 2016). These initiatives encourage physicians to transform themselves from individual and highly autonomous professionals into responsible team players, who improve quality and efficiency of care (Heineman 2010; Noordegraaf et al. 2016). Likewise, Dutch physicians and medical students increasingly show interest in leadership –and organizational issues (De Geneeskundestudent 2015; Denis & Van Gestel 2016; Lucardie et al. 2017; Platform Medisch Leiderschap 2016; Voogt et al. 2016). Medical students for example argue that they lack knowledge about finance, the organization of healthcare or the Dutch healthcare system and therefore feel unprepared for their future as medical doctor in a market-oriented healthcare landscape (Platform Medisch Leiderschap 2016).

Although the Dutch healthcare sector is similar to other Western countries, in the sense that that it is steered by managerial and market logics that aim to increase cost containment and performance management (Scholten et al. 2019), it also has distinct characteristics. The Dutch healthcare sector specifically, is characterized by regulated competition since the introduction of the Health Insurance Act in 2006. Healthcare insurances negotiate with health providers over price and quality of care while the government safeguards affordability and availability of care (Denis & Van Gestel 2016). These changes have increased the role of managers, civil servants and healthcare insurance companies as they are expected to ensure the effectiveness of regulated competition. As a result, physicians are pressured to increase the efficiency and transparency of their work, resulting in regulatory and administrative pressures (Scholten et al. 2019; Tonkens 2013).

Yet, traditionally, Dutch physicians hold a relatively strong position in hospitals compared to physicians working in other European countries, which is reflected by a high amount of autonomy over their clinical work and salary. For example, more than 50% of Dutch physicians has an entrepreneurial status instead of being employed (Denis & Van Gestel 2016; Scholten & Van Der Grinten 2002). In practice, this means that because of physicians' high amount of autonomy, hospital directors and managers experience difficulties in engaging physicians in hospital management. To further support policy objectives of cost containment and performance management, the Dutch government introduced several initiatives to increase the involvement of physicians in hospital governance (Scholten et al. 2019; Scholten & Van Der Grinten 2002). In doing so, they aim to decrease physician's power in decision-making, which arguably obstructs cost-containment and performance management objectives. Different organisational models for joint responsibility for costs and quality of care, financial reforms and numerous governance codes all emphasize the need to integrate physicians in hospital

governance. A well-known example of physician's involvement in pursuing organizational objectives is the medical management role (or dual management structures) in hospitals. However, the autonomy and power in decision-making of Dutch physicians remain relatively high in Dutch hospitals (Muijsers 2016).

The above described transitions in the Dutch healthcare sector towards regulated competition and increased focus on cost-containment and performance management all affect the work of physicians. Next to providing safe and high quality of care – the core of medical work – physicians are increasingly required to deal with other values that characterize the current healthcare landscape: efficiency, shared decision making, cost-containment, integration of care and the transition of care from hospitals to primary care settings or at home. It is within this context that the rise and popularity of medical leadership in the Netherlands is explored and we argue that it is important to study how medical leadership is constructed and practiced by Dutch physician in order to determine its impact on the Dutch medical profession.

Outline of the research project: a multi-sited and multi-method approach

To study the different social constructions of medical leadership, different sites are studied, using a multi-method approach. Medical leadership is actively described, advocated and practiced at multiple sites: in the academic literature, in strategic arenas (i.e. online opinion fora and national conferences), in hospital settings and in medical leadership development programs. To be able to investigate how medical leadership is differently constructed at these different sites, this thesis adopts a multi-sited and multi-method approach (Clarke 2005; Wallenburg 2012). Multi-sited research enables researchers to investigate the multiple ontologies of – in this case medical leadership – in practice and its possible diverging consequences (Wallenburg 2012) With regards to the multi-method approach, a systematic literature review, a discourse analysis, a Q method study and two ethnographic observational studies are conducted. The added value of this multi-method approach is that it allows to study in-depth how physicians – and other actors – actively practice, write and talk about medical leadership in different sites and what its implications are for the reconfiguration of medical professionalism.

First, a *systematic review* of the scientific literature is conducted to investigate the different definitions of medical leadership outlined in **chapter 2**. Scholars worldwide actively describe and advocate medical leadership. However, despite its widespread celebration, conceptualization of medical leadership in the scientific literature is ambiguous. Either, clear definitions are not given in literature, or are all encompassing, including many different roles, competencies and tasks, thereby generating confusion. Physicians argue that more clarity about medical leadership in terms of definitions and descriptions of required skills and tasks is required to better prepare themselves for being a future 'medical leader' (Andersson 2015;

Kippist & Fitzgerald 2009). By means of conducting a systematic review of medical leadership, which is described in chapter 2, this thesis aims to increase conceptual clarity and answer sub-question 1 of this thesis (*how is medical leadership constructed in academic literature?)*

Second, a *discourse analysis* is performed of written documents produced in various media platforms (impactful medical journals, leaflets, books, website content) and field notes of observations of three national conferences on medical leadership, described in **chapter 3**. In recent years, Dutch opinion making physicians actively advocate for medical leadership using different media platforms and national conferences. These media platforms and national conferences can be considered strategic arenas that aim to reach as much physicians as possible. Advocates of medical leadership operating in these strategic arenas attempt to exert influence on future agenda setting. By performing a discourse analysis I aimed to generate insights into the social construction of medical leadership – how do physicians interpret and use the term medical leadership – and its implications in terms of reconfiguring medical professionalism. The outcomes of this study are described in chapter 4 and provide an answer to sub- question 2 (*How is medical leadership constructed in daily practice?*) and 3 (*what are the implications of medical leadership for the reconfiguration of medical professionalism?*)

Third, a *Q-method study* is conducted to investigate the different perceptions of hospital-based professionals (nurses, physicians, managers and laboratory technicians) on what is important for medical leadership in terms of skills, tasks or context-related factors, described in **chapter 4**. The systematic review shows numerous factors that are considered important for medical leaders to 'master'. Yet, these lists are continuously expanding and extremely scattered and all encompassing. Moreover, these factors are often listed by physicians themselves, neglecting other hospital-based actors such as nurses, technicians or managers. To gain more insights in the social perceptions of hospital-based professionals on the relative importance of factors related to medical leadership in hospitals, an interview study using the Q-methodology (Watts & Stenner 2005) is performed. The outcomes of this studies are described in chapter 3 and give answer to sub-question 2 (*How is medical leadership constructed in daily practice?*).

Fourth, six medical managers from six different clinical departments are shadowed during their daily work to gain more insights into how physicians construct their leadership roles in practice, described in **chapter 5**. Medical managers are physicians who are, in addition to their clinical work, part-time head of their clinical department. Shadowing is an observational technique which enables the researcher to get a close view of the complexities of daily life (Oldenhof 2015; Watson 1994). To shadow a person, the researcher follows her/him during the entire course of a working day 'wherever they are, whatever they are doing' (Arman et al. 2012: 301; Oldenhof 2015). Hence, shadowing medical managers is an appropriate technique to retrieve a more realistic and in-depth view of how physicians practice medical leadership and construct their leader 'self'. In addition to shadowing, Informal conservations are held with the medical managers and colleagues about their work or situations that appeared during the shadowing days. These 'informal interviews' provide many insights into the perceptions of

medical managers about their role and work. Finally, organizational documents are gathered and studied to get a better understanding of the study context, such as minutes of meetings or vision documents. By conducting the observational study of medical managers, which is described in chapter 5, this thesis aims to provide insights into how medical leadership is socially constructed in practice, thereby answering sub-question 2 (*How is medical leadership constructed in daily practice?*)

Fifth and finally, an *observational study* of a one-year medical leadership development program (Imagine2, instructed by the Erasmus Center of Healthcare Governance) is conducted, outlined in **chapter 6**. Following this development program, all program days and additional in-house sessions in the hospitals where participants work are observed. In addition, informal conversations with participants, teachers and guest-speakers are performed to get a deeper understanding of the participant's motives to participate, their experiences of the program and the perceptions of teachers and guest-speakers of medical leadership in general. The study allows to investigate how physicians, in interaction with others, collectively construct their understandings of themselves as being medical leaders and the implications for their medical professional identity. The outcomes of the study are described in chapter 6 and provide an answer to sub-questions 2 (*How is medical leadership constructed in daily practice?) and 3 (what are the implications of medical leadership for the reconfiguration of medical professionalism?*)

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2

Medical leaders or masters? – A systematic review of medical leadership in hospital settings

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Abstract

Medical leadership is increasingly considered as crucial for improving the quality of care and the sustainability of healthcare. However, conceptual clarity is lacking in the literature and in practice. Therefore, a systematic review of the scientific literature was conducted to reveal the different conceptualizations of medical leadership in terms of definitions, roles and activities, and personal – and context-specific features. Eight databases were systematically searched for eligible studies, including empirical studies published in peer-reviewed journals that included physicians carrying out a manager or leadership role in a hospital setting. Finally, 34 articles were included and their findings were synthesized and analyzed narratively. Medical leadership is conceptualized in literature either as physicians with formal managerial roles or physicians who act as informal `leaders' in daily practices. In both forms, medical leaders must carry out general management and leadership activities and acts to balance between management and medicine, because these physicians must accomplish both organizational and medical staff objectives. To perform effectively, credibility among medical peers appeared to be the most important factor, followed by a scattered list of fields of knowledge, skills and attitudes. Competing logics, role ambiguity and a lack of time and support were perceived as barriers. However, the extent to which physicians must master all elicited features, remains ambiguous. Furthermore, the extent to which medical leadership entails a shift or a reallocation of tasks that are at the core of medical professional work remains unclear. Future studies should implement stronger research designs in which more theory is used to study the effect of medical leadership on professional work, medical staff governance, and subsequently, the quality and efficiency of care.

Introduction

Recently, medical leadership in hospitals has received increasing attention from both scholars and practitioners. Medical leadership is considered to play an important role in improving organizational performance, including the quality of care, patient safety and cost-efficient care (Blumenthal et al. 2017; Meier 2015; Porter & Teisberg 2007; Warren & Carnall 2011). Furthermore, many argue that medical leadership is necessary for overcoming the divide between medical and managerial logics in hospitals that hampers improvement in healthcare (Noordegraaf et al. 2015; Witman et al. 2011). However, despite the popularity of this topic, the scientific conceptualization of medical leadership remains ambiguous (Spurgeon et al. 2015).

One stream of scientists conceptualizes medical leadership as formal management roles played by physicians. These authors refer to the administrative roles of physicians (Andersson 2015; Vinot 2014; Williams 2001; Witman et al. 2011) by using the term medical leadership interchangeably with the term medical management. This conceptualization stems from the

historical introduction of a medical manager to hospitals in many countries (USA (Betson & Pedroja 1989), UK (Buchanan et al. 1997), Australia (Dedman et al. 2011), and the Netherlands (Witman et al. 2011) as a response to difficulties in hospital governance to 'control' and 'manage' medical professionals (Hunter 1992; Thorne 2002).

Traditionally, professional and managerial logics are portrayed as intrinsically conflicting (Freidson 2001; Glouberman & Mintzberg 2001). On the one hand many scholars argue that physicians are 'infringed' by managerial logics following the rise of New Public Management (Evetts 2009) in the public sector. Due to an increase in managerialism in healthcare, professional work is increasingly standardized, regulated and specified in terms of quality indicators, which supposedly led to a decrease in professional autonomy and work satisfaction (Porter & Teisberg 2007). On the other hand, professionals are often portrayed as resistant to organizational and governmental requirements (Doolin 2002) and therefore are difficult to control.

To overcome the assumed divide between professional and managerial logics, hospitals have introduced the role of the medical manager, who ought to perform as a so-called 'linking pin' (Witman et al. 2011) between management and professionals. This was based on the idea that physicians are more influenced by their peers than by managers, due to the highly socialized character of the medical profession (Freidson 2001; Thorne 2002; Witman et al. 2011). A well-known example of this strategy is the introduction of clinical directorates, which was first achieved in the USA at John Hopkins Hospital in Baltimore, followed by the UK at Guy's Hospital, in which a clinical director was responsible for, among other things, quality and the budget in her/his directorate.

Another stream of literature represents medical leadership as an intrinsic component of physicians' daily work (Baker & Denis 2011; Edmonstone 2009; Noordegraaf et al. 2015). That is, physicians must act as 'leaders' within their clinical role, by organizing clinical work and establishing cross-departmental collaboration, thereby aiming for high-quality and cost-efficient care. As such, this leadership role is an informal role that transcends formal managerial work and thus applies to *all* physicians (Baker & Denis 2011; Blumenthal et al. 2012; Edmonstone 2009; Noordegraaf et al. 2015; Warren & Carnall 2011). Subsequently, a call for training medical doctors in managerial and leadership skills arose [Blumenthal et al. 2012; McDermott et al. 2013; Murdoch-Eaton & Whittle 2012; Stoller 2009). To prepare physicians for their leadership roles, existing competency models such as the well-known CanMEDS model (Frank 2005) added leadership skills to the medical and technical skills. Furthermore, new competency models have evolved, such as the Medical Leadership Competency Framework in the UK (NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges 2010) and the Framework Medical Leadership in the Netherlands (Platform Medisch Leiderschap 2015) that particularly focus on managerial and leadership skills.

Although a distinction can be made between the literature streams, a clear demarcation of the concept of medical leadership remains absent. Therefore, a better understanding of the concept is necessary for both research and practice. First, the lack of a conceptual understanding and commonly used terminology hampers empirical developments in research.

Second, the lack of a clear conceptualization appears to be problematic for physicians in performing their medical leadership roles in practice; their roles are poorly understood (Dwyer 2010; Ham et al. 2011) and physicians encounter identity struggles (Andersson 2015; Ham et al. 2011), experience stress (Willcocks 1995) and a lack of time (Kippist & Fitzgerald 2009) and feel unsupported (Buchanan et al. 1997) and unprepared (Ong 1998). If medical leadership is important for improving the quality of care, cost efficiency and hospital governance, it is necessary to first obtain a better understanding of the nature of medical leadership, the activities and roles performed by medical leaders carry, the skills that are necessary and the influential factors. Therefore, the aim of this systematic review is to unravel the different conceptualizations of medical leadership. In this systematic review, we aim to provide an overview of the scientific literature regarding the definitions of medical leadership, the activities and roles performed by a medical leader, the required knowledge and skills, and the influential factors.

Methods

Search strategy

The following eight databases were systematically searched for eligible studies: Embase, Medline, Web of Science, PubMed, Cochrane, CINAHL, ABI/inform and Google Scholar. The search strategy was established in collaboration with a librarian from a medical library who is a specialist in designing systematic reviews. The search included terms related to physicians, management and leadership, skills and influential factors. A preliminary exploratory literature search of our topic illustrated the diversity in the terms used to describe physicians in leadership or managerial roles. Therefore, we adopted a broad search strategy, which yielded a large number of articles. The following search terms were used: medical, clinical, physician*, clinician*, doctor* AND (combined with) lead*, manage*, executive*, director*, ceo* (see S1 appendix for an example of the full electronic search strategy for all databases). The final search was performed on January 31, 2017.

Eligibility criteria

Studies were included if they met the following inclusion criteria:

- Type of participants – Medical leaders who were defined in this study as physicians in a management or leadership role who work in a hospital setting.
- Topic – Studies should have focused on (1) definitions of medical leadership, (2) activities and roles performed by medical leaders, (3) skills supposedly required for a medical leader, or (4) influential factors that were experienced as barriers or facilitators in performing a medical leadership role.
- Type of publication – Empirical studies published in peer-reviewed journals are eligible. Medical leadership is a popular topic in the gray literature, however, an overview of em-

pirically based knowledge regarding medical leadership is lacking. Therefore, we aimed to describe the empirical knowledge of medical leadership and decided to not include the gray literature. Empirical studies could include all research designs, except for systematic reviews.

- Language – Studies should be written in English.

We did not make any restrictions for the year of publication.

Record selection

The search yielded 16,065 articles. After excluding the duplicate studies, 9,146 articles remained for screening (Fig 1). The screening process consisted of three steps. First, two researchers (MB and IF) independently screened all articles by scanning the titles and abstracts. Articles were excluded if they did not meet all inclusion criteria. If the information provided in either the title and/or the abstract was insufficient for a justified decision, the articles were included in the full-text screening phase. Although this resulted in a large number of full-text articles to review, it allowed us to be as thorough as possible during this phase. Second, 805 full-text articles were examined for eligibility. The first reviewer (MB) performed the first screening of the full texts for inclusion and excluded all articles that obviously did not meet the inclusion criteria. Both reviewers (MB and IF) independently screened the remaining articles by closely reading the full texts. Finally, a reference check of the included articles was performed, resulting in the inclusion of two additional articles.

Data analysis

To analyze the data, we conducted a narrative analysis of the review material. Due to the heterogeneity in the included records in terms of the conceptualizations of medical leadership, study aims and research designs, a meta-analysis was neither suitable nor possible. According to previous recommendations (Popay et al. 2006) for a narrative analysis in systematic reviews, we conducted the following steps: first, we created a data extraction form for each study, in which we summarized the author(s), year of publication, journal, country, methods used, definitions, activities and roles, skills, and influential factors.

The data regarding the activities and skills yielded some overlap, for example, 'influencing' was considered a skill by some, while other authors described 'influencing' as an activity. To ensure objectivity, we relied on the terms used by the author(s) while summarizing the data into the extraction form. Then, we inductively coded the data in three overarching themes. *The first theme* represented items that referred to similar activities and roles. We clustered these items into the following two broad categories: (1) general management and leadership and (2) balancing between management and medicine. *The second theme* represented items that referred to skills, which were clustered into the following three categories: (1) knowledge, which was defined as the understanding of a certain subject; (2) skills, which were defined as the ability to accomplish something; and (3) attitude, which was defined as a personal

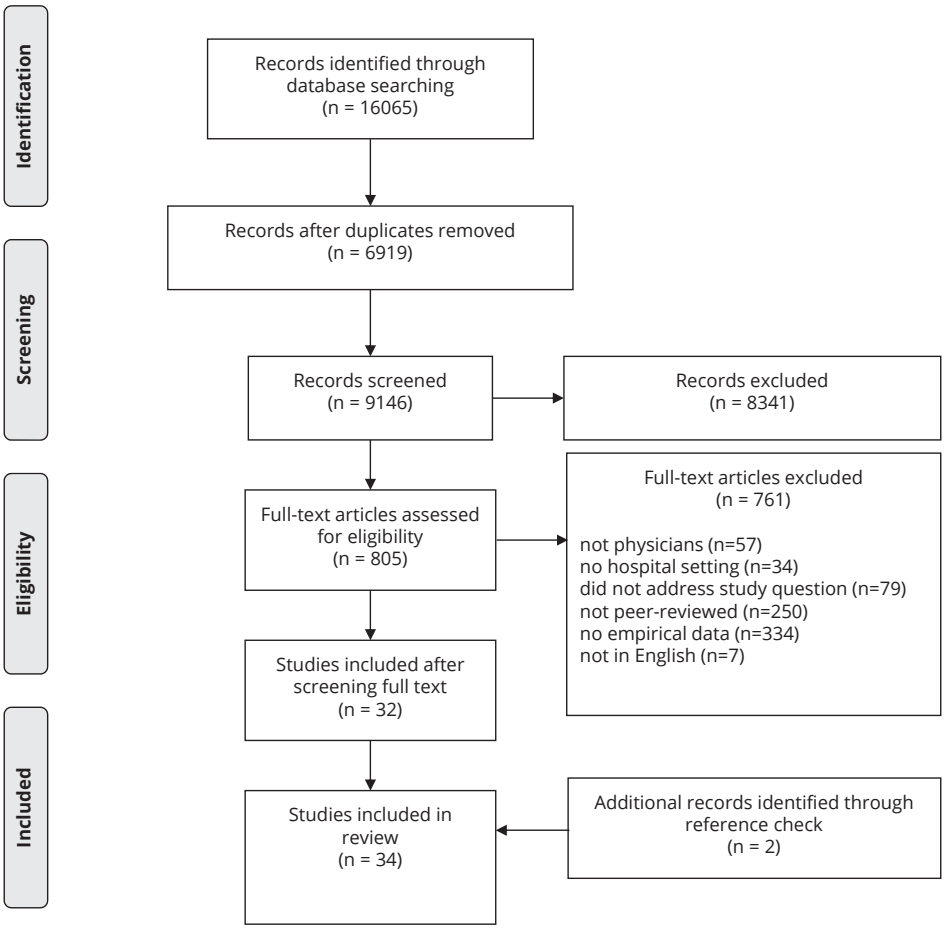

Fig 1. Flow diagram of the record selection.

characteristic. We determined the category to which each item fitted best. *The third theme* represented the data regarding influential factors. We clustered the items that referred to the same factor into the following six categories: (1) credibility, (2) experience in management, (3) competing logics, (4) role ambiguity, (5) lack of support, and (6) lack of time. After all themes were identified, we distinguished the personal from the context-specific features. These features can be either barriers or facilitators, depending on the specific person or context it relates to. At the personal level, these features refer to characteristics that are associated with a medical leader. At the context-specific level, these features refer to the cultural and institutional characteristics of the hospital in which a medical leader works. Finally, the personal features, context-specific features, and activities and roles were mapped into a comprehensive conceptual framework that will guide the results (Fig 2).

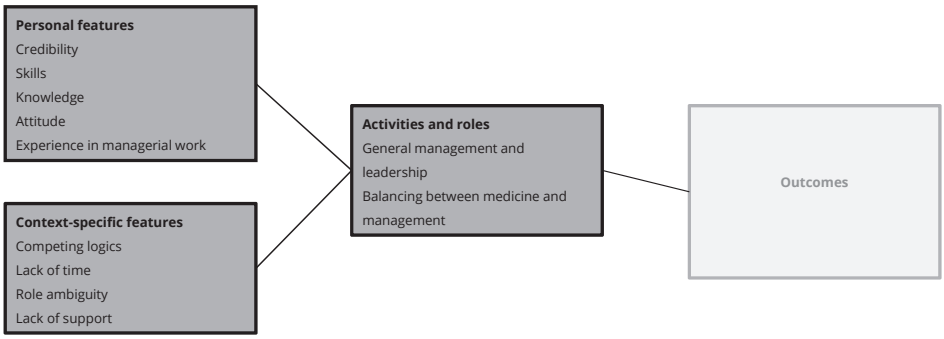

Fig 2. Conceptual framework of medical leadership in hospital settings.

Results

Research methods, journals and countries

Most studies had a qualitative research design (N=24). Of these qualitative studies, some studies relied on interviews (N=11), while the other studies used a combination of interviews, observations, document analyses or focus groups (Table 1). The remaining studies had a quantitative research approach (N=7) using self-administered surveys in which the participants listed and/or ranked task inventories or skills, or a mixed methods study design (N=3) in which the researchers used a combination of interviews and surveys. All survey studies were cross-sectional and thus contained no longitudinal data.

These studies were published in a wide array of journals ranging from purely clinical to exclusively management journals. Most studies were published in health management-related journals (N=12), followed by studies in health (care)-related journals (N=11), including leadership- and educational-associated journals. The remaining studies were published in management journals (N=6), specific medical specialty journals (N=2), an organizational journal (N=1), a public sector journal (N=1) and a human resource journal (N=1).

Most studies were conducted in the UK (N=11), followed by the USA (N=9), Australia (N=3) and Canada (N=2) (Table 1). One study was performed in different countries in North America, Europe and Asia. The remaining studies were conducted in various other Western-European countries (N=8).

Definitions

Most studies did not explicitly define the concept of medical leadership. Implicitly, these leaders were described as "champions" (Holmboe et al. 2003) "key physicians", "team-oriented" (Robinson et al. 2013), "change agents" and "visionaries" (Hopkins et al. 2015). These physicians are, "able to enact to multiple functions in addition to their clinical roles" (ibid.), "committed to hospital success" (Holmboe et al. 2003) and able to "influence and inspire their colleagues"

Table 1. Details of the studies included in this review (n=34)

Authors (year of publication)	Study aim	Methodology, participants, and setting	Country
Andersson (2015)	To analyze the identity challenges that physicians with medical leadership positions face	Interviews and observations. Participants: physicians (N=20) including physicians with a managerial role (N=10), managers (N=8) and their peers and subordinates (N=24). Observations (N=11) occurred during meetings involving physicians and managers. Setting: four hospitals	Sweden
Barrable (1988)	To explore the role of the physician manager to outline administrative performance	Surveys and interviews. Participants: physician managers (N=13) completed the survey. Interviews were held with physician managers (N=16), the chairman (N=1) and the president of the medical staff (N=1) Setting: academic hospital	Canada
Betson & Pedroja (1989)	To describe the job of physician managers in hospitals	Survey containing a task inventory. Tasks were rank-ordered according to the frequency and responsibility of the task. Participants: medical directors (N=502). Setting: hospital (N=unknown)	USA
Buchanan et al. (1997)	To explore how doctors engage in hospital management processes and consider the implications of current experiences in the next generation of clinical directors	Interviews. Participants: clinical directors (N=6) and other hospital management team members, the chief executive, non-clinical directors, business managers and senior nurse managers (N=19). Setting: general teaching hospital	UK
Dawson et al. (1995)	To examine the role of clinical directors and their increasing involvement in management and competition	Interviews and a survey. Participants: clinical directors (N=50), medical directors (N=9), executive directors (N=40), senior executives (N=45) and clinical directors who participated in a management development program (N=15). Setting: NHS trusts (N=21)	UK
Dedman et al. (2011)	To explore the perceptions of clinical directors and their roles and needed skills in clinical directorates	Interviews and document analysis. Participants: clinical directors (N=13), chief executives (N=3), nursing directors (N=12), business managers (N=9), and department heads (N=2). Setting: public teaching hospitals (N=3)	Australia
Dine et al. (2010)	To discover the characteristics associated with effective physician leadership	Focus groups. Participants: physicians (N=6), interns (N=6) residents (N=7) and nurses (N=5). Setting: academic hospital	USA
Dwyer (2010)	To document the roles, perceived skills, attributes and experience required of medical administrators	Interviews. Participants: directors of medical services (N=14). Setting: eight metropolitan public hospitals	Australia
Hallier & Forbes (2005)	To understand how organizational professionals perceive the introduction of managerialism and the incorporation of managing into specialist roles	Interviews. Participants: clinical directors (N=18). Setting: NHS acute/district general hospitals (N=unknown)	Scotland
Holmboe et al. (2003)	To investigate the characteristics and skills of physicians involved in improving quality	Interviews. Participants: key physicians, nurses, and quality management and administrative staff (N=45). Setting: eight hospitals	USA
Hopkins et al. (2015)	To determine the particular competencies demonstrated by effective physician leaders	Interviews. Participants: physicians who participated in a leadership development program (N=28). Setting: academic hospital	USA
Kindig & Lastirir-Quiros (1989)	To understand the nature of the administrative roles currently performed by physician executives and their perceptions of changes in these roles in the future	Survey. A task inventory was used to rank 33 tasks according to importance. Participants: physician executives (N=159). Setting: different hospitals	USA
Kippist & Fitzgerald (2009)	To examine the tensions between hybrid clinical managers' professional values and health care organizations' management objectives	Interviews and observations. Participants: physician-managers who participate in a clinical leadership development program (N=7), their staff (N=3), the clinical leadership development facilitator (N=1) and senior managers (N=3). Observations of interactions between team members at several team meetings. Setting: large teaching hospital	Australia

Table 1. Details of the studies included in this review (n=34) (*continued*)

Authors (year of publication)	Study aim	Methodology, participants, and setting	Country
Kuhlmann et al. (2016)	To explore the gaps and organizational weaknesses that may constrain new forms of more integrated (or hybrid) clinical management	Interviews. "Participants: physicians without a management position (N=6) and physicians with a management position (N=6) Setting: four departments at one urban hospital and three different hospitals	Sweden
Leigh & Newman (1997)	To describe the tasks of medical directors and the problems associated with their new role	Survey. Participants: medical managers (N=236) including 14 mini case-studies of current job holders and a broad outline of the responsibilities of medical managers. Setting: hospital (N=unknown)	UK
Llewellyn (2001)	To understand the aspirations and activities of clinical directors	Interviews. Participants: clinical directors (N=16). Setting: three hospitals	UK
Meier (2015)	To explore how leadership is practiced across four different hospital units	Interviews, observations and document analysis. Participants: physicians (N=5), nurses (N=4), and a physiotherapist (N=1). Setting: four hospital units, in two different hospitals	Denmark
Opdahl Mo (2008)	To determine the role of physician-managers after unitary management reforms	Interviews. Participants: medical managers (N=10). Setting: university hospital	Norway
Ong (1998)	To examine the way in which clinicians and their clinical teams are developing their understanding of the new role	Interviews. Participants: clinical directors (N=2), their managing pairs (N=unknown) and the executive team (N=unknown). Setting: two directorates in a general hospital	UK
Palmer at al. (2009)	To explore the perceptions of junior doctors of the most important leadership competencies	Survey. One on competencies and one on leadership styles (ranking). Participants: year-2 physicians (N=196). Setting: nine hospitals	UK
Quinn & Perelli (2016)	To understand how physician leaders construe their roles	Interviews. Participants: full-time physician administrators (N=6), physicians who are either department chairs or presidents of staff (N=12) and physician leaders without a formal leadership role (N=6). Setting: four hospitals	USA
Pepermans et al. (2001)	To determine the job tasks of medical directors and head nurses in intensive care units	Interviews, observations and focus groups. Participants: medical directors (N=unknown), observational units of activities (N=235), focus groups (N=unknown) and medical directors and head nurses (N=3-6) Setting: six hospital IC units	Belgium, Denmark, Portugal, Switzerland, Netherlands
Robinson et al. (2013)	To determine the personal and professional characteristics of medical leaders in urology compared to other specialties	Survey (listing of duties and skills). Participants: program directors and department heads of urology (N= 13) and other specialties (N=88). Setting: hospital (N=unknown)	Canada
Rotar et al. (2016)	To explore the formal managerial roles of doctor managers in hospitals and to determine the association between the level of their involvement in hospital management and the level of implementation of quality management systems	Survey and interviews. Participants: (1) country experts (N=19) in the OECD's health care quality indicator program and (2) physicians that have a formal or informal leading role (N=1,670). Setting: 188 hospitals	Europe, Israel, Japan, Singapore, South Korea, Turkey
Spehar et al. (2015)	To investigate how clinicians' professional background influences their transition into the managerial role and identity as clinical managers	Interviews and observations. Participants: physicians (N=13), nurses (N=16) and a clinician with another healthcare background (N=1). Setting: four public hospitals	Norway
Spyridonidis et al. (2015)	To understand how physicians assume a 'hybrid' role and identity processes as they take on managerial responsibilities	Interviews pre -and post, observations and document analysis. Participants: physician managers (N=62), pre -and post project (total N=124 interviews), and CLAHRC senior members (total N=210 interviews). Setting: hospital (N=unknown)	UK

Table 1. Details of the studies included in this review (n=34) (*continued*)

Authors (year of publication)	Study aim	Methodology, participants, and setting	Country
Taylor et al. (2008)	To explore the required leadership qualities, knowledge and skills among medical leaders in an academic hospital setting	Interviews. Participants: physicians who followed a leadership program (N=10) and course and clerkship directors, program directors and department chairs (N=8), and division directors and academic deans (N=7). Setting: academic hospital	USA
Thorne (1997a)	To discover how clinicians became clinical directors, how they perceived and enacted their role and its impact on themselves and others	Interviews and observations. Participants: clinical directors (N=unknown). Observations at management board meetings and 'being around' in both formal and informal settings. Setting: Large provincial teaching hospitals trust	UK
Thorne (1997b)	To identify the perspectives of doctors in management and managers of the clinical director role	Interviews and observations. Participants: clinical directors (N=14). Setting: 14 directorates within one NHS trust	UK
Vinot (2014)	To explore the managerial roles of doctors after major hospital management reforms	Interviews and document analysis. Participants: At each hospital two interviews were held: one with a hospital director and one with a medical manager (total N=10). Setting: three public and two university hospitals	France
Willcocks (1995)	To suggest a possible framework for examining the effectiveness of individual directors	Interviews and document analysis. Participants: clinical directors and managers (N=unknown). Setting: NHS trust hospital	UK
Williams (2001)	To indentify the skills and knowledge required for effective medical leadership	Survey containing a list of skills and knowledge, which was rank-ordered. Participants: physicians in executive or senior management positions (N=111). Setting: hospital (N=unknown)	USA
Williams & Ewell (1996)	To assess hospital medical staff governance and leadership characteristics	Survey (3 types). Participants: Two surveys were completed by the medical staff specialists, office managers or coordinators, and one by the chiefs of staff. Setting: 65 hospitals	USA
Witman et al. (2011)	To obtain insights regarding the day-to-day practices of medical leaders	Interviews, observations, focus groups in small learning groups (N=26, in 33 groups). Participants: department heads (N=6), their colleagues, residents and non-medical managers (N=23). Setting: three departments in a university hospital	NL

(Holmboe et al. 2003; Hopkins et al. 2015; Witman et al. 2011). Only two studies provided an explicit definition of medical leadership, describing it as "embodied by a practitioner who operates as an opinion-leader or even as a particular school of thought within medicine" (Vinot 2014) and "physicians in leading positions" (Andersson 2015). Although many researchers did not define medical leadership, they *did* underscore the need for a clear definition (Dine et al. 2011; Hopkins et al. 2015).

In contrast, studies reporting formal medical leadership roles, which were explicitly defined as medical management, were more straightforward regarding the definition of medical management: "(senior) doctors who have assumed management responsibilities" (Llewellyn 2001) "who may or may not retain a role in clinical work" (Spehar et al. 2015).

Types of medical leadership

Despite the lack of a common definition, as indicated in the introduction, two types of medical leadership could be identified in the literature. Type 1 includes physicians in formal managerial roles and is, described in studies as either 'medical management' or 'medical leadership'.

The participants included in these studies were, medical directors working at the executive level (Leigh and Newman 1997) or clinical directors working at the management level (Dawson et al. 1995). The nature of the medical management function differed. In some studies, these positions were full-time affiliations in which the physicians ceased to perform clinical work (Barrable 1988), whereas in other cases, the positions were considered as a part-time jobs 'on the side', meaning that they will first and foremost be a physician (Witman et al. 2011), and finally, there were studies in which both full- and part-time variants were identified (Kippist & Fitzgerald 2009; Kuhlmann et al. 2016).

Type 2 includes physicians in informal roles and is described in studies as 'medical leadership'. The included participants in these particular studies were described as physicians who act as a leader within their daily clinical work, such as physicians who were involved in quality improvement projects (Holmboe et al. 2003).

Activities and roles

Twenty-nine studies reported the activities and roles performed by medical leaders or assumed necessary for effectively performing such a role (Table 2). The resultant list included activities and roles capturing a broad range of topics. Two different types of activities and roles appeared. These two types include general management and leadership activities and balancing between management and medicine. We observed no distinction between activities specifically adhering to either formal or informal roles of medical leadership.

General management and leadership

Twenty-eight studies described 30 different activities. These activities were described as straightforward management or leadership duties, including finance (N=18), strategy (N=15), staff management (N=17), human resources (N=12), leading change (N=9), or administration (N=9) (Table 2). It is argued that these activities are performed — or should be performed —to achieve organizational and patient objectives, even when these activities conflict with personal or department goals (Taylor et al. 2008), thereby stressing that medical leadership is a rather rational profession (Thomas 2005), in which medical leaders assume more responsibility for departmental performance (N=17) in terms of outcomes (e.g., quality of care and costs) and of the functioning of individuals (e.g., medical colleagues) than 'normal' physicians. Furthermore, medical leaders should be more concerned with innovation and improvements in clinical issues (N=5) and increasing multidisciplinary collaboration to improve the quality of care (N=8). To achieve these objectives, medical leaders should, among other functions, influence (N=2) and empower peers (n=4), communicate information to medical peers as well as back and forth to management and medical practitioners (N=8), build a consensus (N=8) and resolve problems (N=3). Moreover, medical leaders should lead or attend meetings (N=8), network (N=7) within and outside the hospital, negotiate (N=6), contract (N=6) and make decisions (N=6). Additional activities that were mentioned more than twice include policy activities (N=5), research and teaching (N=5), business planning (N=4), coordination and delegation

Table 2. Activities and roles

Authors (year of publication)	General management and leadership work	Balancing between management and medicine*
Andersson (2015)	-	Influencing for multiple objectives
Barrable (1988)	Strategy, business planning, responsible for performance, finance, HR, decision making, policy, meetings	Influencing for multiple objectives
Betson & Pedroja (1989)	Staff management, consensus building, communication, strategy, responsible for performance, finance, HR, decision making, committees, research and teaching, meetings, policy, negotiation	Bridging management and medicine, dealing with tensions, representing medical staff
Buchanan et al. (1997)	Multidisciplinary collaboration, communication, staff management, responsible for performance, finance, HR, problem solving, administration, meetings	Influencing for multiple objectives, representing medical staff
Dawson et al. (1995)	Multidisciplinary collaboration, staff management, leading a team, communication, strategy, business planning, responsible for performance, leading change, finance, negotiation, contracting, HR, networking	Bridging management and medicine, representing medical staff
Dedman et al. (2011)	-	-
Dine et al. (2010)	Strategy, finance, decision making, coordination and delegation, consensus building, administration, meetings, communication, policy, feedback, empowering others	-
Dwyer (2010)	Multidisciplinary collaboration, staff management, strategy, responsible for performance, leading change, finance, clinical issues, HR, networking, research and teaching, legal issues, policy	Bridging management and medicine, influencing for multiple objectives
Hallier & Forbes (2005)	Responsible for performance, finance	-
Holmboe et al. (2003)	Committees, empowering others, multidisciplinary collaboration, consensus building, communication, feedback, responsible for performance, leading change	-
Hopkins et al. (2015)	-	-
Kindig & Lastirir-Quiros (1989)	Multidisciplinary collaboration, staff management, consensus building, communication, strategy, business planning, policy, responsible for performance, leading change, finance, clinical issues, negotiation, HR, research and teaching, legal issues, networking, risk management, representing interests	-
Kippist & Fitzgerald (2009)	-	-
Kuhlman et al. (2016)	Administration, responsible for performance, staff management	-
Leigh & Newman (1997)	Finance, contracting, strategy, networking, negotiation, responsible for performance, staff management, influencing, leading change, clinical issues, HR	Decision making, influencing for multiple objectives, bridging management and medicine
Llewellyn (2001)	Finance, consensus building, responsible for performance, risk management, negotiation	Bridging management and medicine, influencing for multiple objectives, decision making
Meier (2015)	Multidisciplinary collaboration, coordination and delegation	Negotiation, decision making
Opdahl Mo (2008)	Staff management, strategy, responsible for performance, leading change, HR, administration	Bridging management and medicine, role making
Ong (1998)	Staff management, leading a team, strategy, networking, business planning	Role making, bridging management and medicine
Palmer et al. (2009)	-	-
Pepermans et al. (2001)	Staff management, consensus building, communication, responsible for performance, coordination and delegation, problem solving, networking, administration, meetings, decision making, empowering others	-

Table 2. Activities and roles (*continued*)

Authors (year of publication)	General management and leadership work	Balancing between management and medicine*
Quinn & Perelli 2016	Administration, meetings, HR, consensus building	Bridging management and medicine, influencing for multiple objectives
Robinson et al. (2013)	Advising, finance, HR	-
Rotar et al. (2016)	Advising, HR, teaching, clinical issues, staff management, decision-making, finance	-
Spehar et al. (2015)	Finance, administration, advising, empowering others	Influencing for multiple objectives, role making
Spyridonidis et al. (2015)	Multidisciplinary collaboration, responsible for performance, leading change, research and teaching	Role making, coordination and delegation, negotiation, influencing for multiple objectives, bridging management and medicine
Taylor et al. (2008)	-	-
Thorne (1997a)	Staff management, strategy, responsible for performance, leading change, finance, contracting, meetings, negotiation	Influencing for multiple objectives, bridging management and medicine, role making, dealing with tensions
Thorne (1997b)	Leadership by example, staff management, strategy, leading change, clinical issues, finance, contracting, networking	Decision making, influencing for multiple objectives
Vinot (2014)	Multidisciplinary collaboration, staff management, strategy, responsible for performance, finance, coordination and delegation, contracting, HR, administration	Bridging management and medicine
Willcocks (1995)	Leading a team, strategy, problem solving, decision making, negotiation,	Role making, representing medical staff
Williams (2001)	Contracting, risk management, staff management, administration, strategy, finance, responsible for performance	-
Williams & Ewell (1996)	Strategy, finance, committees	Representing medical staff, decision making
Witman et al. (2010)	Staff management, feedback, advising, responsible for performance, influencing, leading by example, consensus building, meetings, communication	Bridging management and medicine, influencing for multiple objectives

* Features indicated with an asterisk indicate the unique features of medical leadership in contrast to those of general leadership

(N=4), advising (N=4), committees (N=3), leading a team (N=3), providing feedback (N=3), and risk management (N=3).

Balancing between management and medicine

Other activities and roles appeared to be more specific to the context in which the medical leaders performed their roles: namely, on the border of management and medicine (represented by 20 studies, see Table 2).

Bridging the managerial and medical worlds

First, medical leaders perform activities in which they act as liaisons, that maneuver between different objectives to bridge the managerial and medical world (N=12). Within this role, the medical leader acts as a coordinator (Vinot 2014), to create institutional linkages within and between organizations (Holmboe et al. 2003) and monitor and report information of interest back and forth between the managerial and medical worlds (Betson & Pedroja 1989; Thorne

1997b). This 'linking-pin' role is considered important for aligning the interests of both worlds (Andersson 2015). Understanding the discourses of both worlds could enable the medical leader to bridge the gap (Kippist & Fitzgerald 2009; Witman et al. 2011).

Influencing for multiple objectives

Second, many activities include methods to exert influence (N=12) to serve objectives of the 'self' and the medical staff (N=6), rather than only serving the organizational objectives. For instance, by influencing the expectations of peers and managers (Willcocks 1995) or delegating and coordinating tasks (Spyridonidis et al. 2015), medical leaders can create their own preferable roles. Furthermore, decision making (N=5), such as patient referrals, is a means of retaining professional autonomy and control over clinical issues (Thorne 1997b). Having a voice in strategy and decision making at 'higher' levels is important to guarantee that the medical staff interests are met (Dwyer 2010; Llewellyn 2001; Quinn & Perelli 2016; Spyridonidis et al. 2015). For example, financial activities may be a way to influence and control resource allocation (Llewellyn 2001). Finally, medical leaders must influence and negotiate (N=2) with, medical peers, non-medical managers, and stakeholders outside the hospital to acquiesce the changes that are necessary for organizational purposes. In the processes of negotiating or influencing, medical leaders must balance between clinical and organizational practices to safeguard both the quality *and* efficiency of care (Meier 2015; Thorne 1997a; 2002). Some even argue that the effectiveness of these processes will increase if a physician acts as a leader instead of a manager who seeks to exercise authority over others (Andersson 2015; Thorne 1997a; 2002).

Dealing with tensions

Third, to be able to balance between management and medicine, medical leaders must manage several tensions (N=2). At the intrapersonal level, medical leaders must cope with their "multiple identities" as both physicians and managers. This balance is described as role-making activities (N=6), such as sense making and identity work (Andersson 2015; Opdahl Mo 2008; Ong 1998; Spyridonidis et al. 2015; Thorn 1997b; Willcocks 1995). At the organizational level, medical leaders must deal with tensions among individuals, competing departments, the medical and managerial world and external and internal organizational demands (Thorne 1997b). Notably, many studies show that medical leaders will always prioritize their clinical identity and activities over their managerial identity and activities (Barrable 1988; Witman et al. 2011). Finally, several studies reported that some physicians believed that certain activities belonged more to managers than to medical professionals, such as performance management (Spyridonidis et al. 2015), in which a subpar performance could be a threat to the physician's clinical autonomy (Thorne 1997b), and finance (Llewellyn 2001), allowing the medical leaders to be "free from day-to-day operational financial management" [ibid].

Personal features related to medical leadership

At the personal level, features that refer to the characteristics of a medical leader were elicited (Table 3). These features include credibility (N=22), skills (N=21), knowledge (n=14), attitude (N=14), and experience in management (N=12). We observed no distinction between formal and informal medical leadership roles. In the overview of these features presented in Table 3, the features that are distinctive for medical leaders compared to those that are distinctive of general leaders are marked with an asterisk.

First, 21 studies showed the importance of *credibility* among medical peers in executing both clinical and managerial careers. Credibility is an important source of legitimacy, influence and recognition, which are required to 'get things done'. For example, the reputation of clinical excellence "has put clinical directors in a relatively strong position vis-à-vis management" (Llewellyn 2001). Moreover, credibility and maintaining a clinical identity are important for medical leaders' clinical careers, as many of these physicians hope to return to full-time clinical work 'someday'. Furthermore, the retention of a professional focus and identification was considered important in preventing isolation from medical peers not only because they do not want to be considered managers but also to convince colleagues that they did not

Table 3. Personal features

Authors (year of publication)	Credibility	Skills	Knowledge	Attitude	Experience in managerial work
Andersson (2015)	Commitment to clinical work*	-	-	-	-
Barrable (1988)	Medical excellence*, respected by peers, commitment to clinical work*	Conceptual, collaborative, empowering, lead by example, providing feedback, communication, staff management, resolve conflicts, administration, HR	Report writing, finance, IT, performance management, HR, logistics, health policy and law	Ethical and moral values, open-minded	Lack of experience in administration, need for training, concerns about performance
Betson & Pedroja (1989)	Medical excellence*	-	-	-	Need for training
Buchanan et al. (1997)	Medical excellence*, respected by peers	Vision, conceptual, teaching, time management, decision-making, self-regulation, collaborative, provide feedback, communication, listening, resolve conflicts, staff management, HR, negotiation, networking, delegation, administration, performance management, strategic, lead change, political, bridge medicine and management*, represent staff and specialty	Clinical*, leadership role, structure of the organization, health system, hospital market	Diplomatic, assertive, patience, personable, patient centered*, cooperative, motivated	Need for training
Dawson et al. (1995)	Professional credibility	-	-	-	Lack of experience in similar jobs, need for training, concerns about performance

Table 3. Personal features (*continued*)

Authors (year of publication)	Credibility	Skills	Knowledge	Attitude	Experience in managerial work
Dedman et al. (2011)	Medical excellence*, respected, authority, trusted	Self-awareness, HR, collaborative, empowering, communication, performance management, strategic management, negotiation, political, administration, staff management	Clinical*, health system, public health	Diplomatic, motivated, patient centered*, honest, open-minded	Needs training
Dine et al. (2010)	-	Vision, conceptual, time management, self-regulation, empowering, providing feedback, communication, team, resolve conflicts, performance management	Clinical	Enthusiasm for medicine*, integer, patient centered*, being visible, cooperative, quality driven, mission driven	-
Dwyer (2010)	-	Writing, decision-making, self-regulation, collaborative, empowering, communication, staff management, resolve conflicts, administration, strategic, HR, quality improvement	Clinical*, health policy and law	-	-
Hallier & Forbes (2005)	Commitment to clinical work*	-	-	-	Need for training
Holmboe et al. (2003)	Medical excellence*, objectivity, quality improvement	Empowering, communication, resolve conflicts, networking, bridge management and medicine*	IT	Innovative, assertive, quality driven, mission driven	-
Hopkins et al. (2015)	-	Conceptual, self-awareness, self-regulation, empowering, communication, team, resolve conflicts, negotiation, networking, administration, lead change	-	Self-confidence, assertive, persistent, adaptability, integer, open-minded, honest and open, empathetic, mission driven, result driven, forward thinking	-
Kindig & Lastirir-Quiros (1989)	-	-	-	-	Need for training
Kippist & Fitzgerald (2009)	-	Collaborative, performance management, political, bridge management and medicine*	Finance, performance management	-	Need for training
Kuhlmann et al. (2016)	-	-	Clinical*	-	-
Leigh & Newman (1997)	-	Communication			Concerns about financial ability
Llewellyn (2001)	Medical excellence*, commitment to clinical work*	Administration	Clinical*, finance	-	Need for financial skills

Table 3. Personal features (*continued*)

Authors (year of publication)	Credibility	Skills	Knowledge	Attitude	Experience in managerial work
Meier (2015)	Medical excellence*, medical position*	-	-	-	-
Opdahl Mo (2008)	Commitment to clinical work*	-	Clinical*	-	-
Ong (1998)	-	Strategic	-	-	Lack of experience in similar job, need for training
Palmer at al. (2009)	-	Vision, conceptual, self-awareness, collaborative, empowering, strategic, lead change	-	Self-confidence, intellect, integer, cooperative, result driven	-
Pepermans et al. (2001)	-	-	-	-	-
Quinn & Perelli (2016)	Medical excellence*	-	-	-	-
Robinson et al. (2013)	Medical excellence*, commitment to clinical work*, trusted	Collaborative, empowering	-	Personable, integer, result driven, forward thinking, cooperative	Need for training
Rotar et al. (2016)	-	-	-	-	-
Spehar et al. (2015)	Medical excellence*, commitment to clinical work*	Listening	-	Visible	-
Spyridonidis et al. (2015)	Professional autonomy	-	-	-	-
Taylor et al. (2008)	Medical excellence*	Vision, self-awareness, self-regulation, communication, listening	Clinical*, finance, IT, structure of the organization	Motivated, empathetic	-
Thorne (1997a)	Committed to clinical work*	-	-	-	Lack of experience in similar jobs, concerns about performance
Thorne (1997b)	Medical excellence*, collegial disposition, ethical and moral values	Empowering, communication, resolve conflicts, negotiation, networking, run meetings	Clinical*, structure of the organization, strategy, marketing	Motivated, contract focused	-
Vinot (2014)	Medical excellence*, ability to bridge management and medical worlds*	Team, staff management, negotiation, bridge management and medicine*, networking	-	-	-
Willcocks (1995)	Medical excellence*, respected by peers	Time management, collaborative, communication, resolve conflicts, administration, strategic, marketing	Clinical*, finance, leadership role, structure of the organization, health system and sector	Motivated, customer focused	Lack of experience, concerns about financial ability

Table 3. Personal features (*continued*)

Authors (year of publication)	Credibility	Skills	Knowledge	Attitude	Experience in managerial work
Williams (2001)	-	Conceptual, writing, time management, decision-making, vision, empowering, lead by example, build trust, communication, team, listening, resolve conflicts, negotiation, networking, HR, lead change, administration, strategic, run meetings, risk management, contracting	Clinical*, finance, IT, performance management, strategy, quality assurance, marketing, health system, policy and law, hospital market	Assertive	-
Williams & Ewell (1996)	Medical excellence*, respected by peers, experience in committees	Vision, decision-making, dealing with uncertainty, collaborative, empowering, communication, listening, resolve conflicts, negotiate, administration, lead change, political, run meetings	Strategy, marketing	Assertive, objective, stress-resistant, innovative, intellect, creative, ethical and moral values, patient centered*	-
Witman et al. (2011)	Medical excellence*, scientific disposition, respected by peers, collegial disposition, trusted	Negotiation	-	-	-

* Features indicated with an asterisk indicate the unique features of medical leadership in contrast to those of general leadership

choose the management track because they failed in their clinical careers (Opdahl Mo 2008). Credibility could be obtained in several ways. The most important sources of credibility are medical excellence (N=16), commitment to clinical work (N=4), and thereby thus "showing where their real allegiances lay" (Llewellyn 2001), respect by peers (N=6), trust by peers (N=3), and a collegial disposition (N=2).

Second, 21 studies reported on the required *skills* for medical leaders. The most cited skills include communication (N=12), empowering others (N=11), resolving conflicts (N=10), administrative skills (N=9), collaborative skills (N=9) and negotiating (N=8), followed by strategic skills (N=7), leading change (N=6), team skills (N=6), the ability to carry out a vision (N=6), networking (N=6), and conceptual skills (N=6). The arguments supporting the importance of these items differed. Some authors mentioned that these skills were required for conducting general management or leadership work (Taylor et al. 2008). Furthermore, it was argued that these skills were necessary to negotiate for or represent the interests of the entire organization (Dawson et al. 1995; Dedman et al. 2011; Taylor et al. 2008; Thorne 1997b). Other authors explicitly emphasized that these skills are necessary for balancing between medicine and management (Buchanan et al. 1997; Dwyer 2010; Kippist & Fitzgerald 2009; Holmboe et al. 2003; Vinot 2014) or negotiating for and representing the interests of the medical staff

(Llewellyn 2001; Vinot 2014; Witman et al. 2011). However, other authors did not explain why these specific items must be acquired or possessed by a medical leader (Dine et al. 2011; Willcocks 1995; Williams 2001; Williams & Ewell 1996).

Third, 14 studies reported the importance of different areas of *knowledge*. The most cited area of knowledge was clinical knowledge (N=9). Some arguments were rather straightforward, such as that clinical knowledge is crucial for making informed decisions at the departmental level (Opdahl Mo 2008) or convenient for attracting additional contracts (Llewellyn 2001). Other arguments appeared to be related to retaining power and control rather than clinical issues. In their study investigating clinical directors, Dedman et al. (2011), showed physicians argued that clinical knowledge was necessary to ensure that "decisions are based on clinical evidence", and Llewellyn (2001) that physicians that argued that, in specific areas, clinical knowledge was necessary because "managers cannot escape from the ultimate authority of doctors" (ibid.). Other areas of required knowledge that were mentioned more than twice included finance (N=6), IT (N=4), organizational structures (N=4), the health system (N=4), health policy and law (N=3), marketing (N=3) and performance management (N=3).

Fourth, 14 studies described *attitudes* (or *traits*), i.e., the innate personal qualities and characteristics that medical leaders should possess. The most cited traits were motivation (N=5), assertiveness (N=5), cooperativeness (being a team player) (N=4), patient centered (N=4), integrity (N=4), mission driven (N=3) and result driven (N=3), followed by diplomatic (N=2), personable (N=2), honest and open (N=2), visible (N=2), quality driven (N=2), innovative (N=2), self-confident (N=2), empathetic (N=2), forward thinking (N=2), and intellect (N=2). Taylor et al. (2008) questioned whether these attitudes can be learned or whether they are innate. They argue that having a mission is an innate trait, whereas areas of knowledge (such as finance) or skills (such as networking) can be learned.

Fifth, 12 studies provided evidence that physicians in formal managerial roles felt that they lacked *experience* in the 'unknown' field of management (N=5). In some cases, this lack of experience led to feelings of insecurity regarding the quality of their performance as managers (N=2) or concerns regarding their financial skills (N=2). Moreover, these physicians mentioned the difficulties in evaluating their performance because often, no formal feedback was provided by others. These difficulties could be serious issues for physicians because the physicians felt that they must always avoid public (Taylor et al. 2008) due to the importance of status and credibility. To overcome these issues, many studies reported the possibility of following learning programs to obtain specific management or leadership skills and knowledge (N=10). However, the argument to undergo training appeared to have additional objectives as follows: both as a tactic to ensure that the physicians could not get 'overruled' by management, i.e., through management jargon, and a strategy to have influence over financial or organizational issues such as resource allocation (Llewellyn 2001).

Context-specific features related to medical leadership

The following section presents the features that are related to the specific hospital-context in which a medical leader operates that may be perceived as either barriers or a facilitators (Table 4). This category includes the factors of competing logics (N=16), time (N=14), role ambiguity (N=13), and support (N=11).

First, many studies reported the issue of *competing logics* (N=16), often leading physicians to feel 'stuck' and having to choose between two worlds. While performing their hybrid role, medical managers encounter several dichotomies, such as quality of care *versus* efficiency (Buchanan et al. 1997), working autonomously *versus* being a subordinate (Andersson 2015) and engaging in clinical work *versus* managerial work (Witman et al. 2011). Notably, most experienced meaning, satisfaction and legitimacy in clinical work. For example, physicians will never identify primarily as managers (Llewellyn 2001; Ong 1998; Quinn & Perelli 2016; Spehar et al. 2015). To overcome these dichotomies, only four studies noted the importance of finding a common ground between management and medicine (Dawson et al. 1995; Llewellyn 2001; Ong 1998; Thorne 1997b).

Second, many studies emphasized *lack of time* (N=14) as a significant burden. Time issues were mostly about dividing time between clinical and managerial work (Witman et al. 2011),

Table 4. Context-specific features

Authors (year of publication)	Competing logics	Lack of time	Role ambiguity	Lack of support
Andersson (2015)	Identity struggles	-	-	-
Barrable (1988)	-	More time needed for leadership role	Lack of clarity about job content	-
Betson & Pedroja (1989)	-	-	-	-
Buchanan et al. (1997)	Management versus clinical work, different objectives	Threat to clinical work, more time needed for leadership role, work overload	Lack of clarity about job content	Lack of support
Dawson et al. (1995)	Management versus clinical work	Threat to clinical work, work overload	-	Importance of support of clinical colleagues and executives, no financial reimbursement
Dedman et al. (2011)	Different objectives	-	Lack of clarity about job content	-
Dine et al. (2010)	-	-	-	-
Dwyer (2010)	-	-	-	-
Hallier & Forbes (2005)	Management versus clinical work, distrust	-	Lack of clarity about job content	Lack of support (of executives and clinical colleagues), no formal responsibility, no financial reimbursement
Holmboe et al. (2003)	-	-	-	-
Hopkins et al. (2015)	-	-	-	-
Kindig & Lastirir-Quiros (1989)	-	-	-	-

Table 4. Context-specific features (*continued*)

Authors (year of publication)	Competing logics	Lack of time	Role ambiguity	Lack of support
Kippist & Fitzgerald (2009)	-	Management versus clinical work, more time needed for leadership role, work overload	Lack of clarity about job content, lack of job description, opportunity for role making	Lack of formal responsibility
Kuhlman et al. 2016	Identity struggles	-	Lack of clarity about job content	Lack of organizational support, lack of acceptance within the medical field, lack of formal responsibility
Leigh & Newman (1997)	Tensions	Time consuming	-	No support (of secretaries and assistants), no financial reimbursement
Llewellyn (2001)	Distrust, different objectives	Threat to clinical work and credibility	-	-
Meier (2015)	-	-	-	-
Opdahl Mo (2008)	Distrust, different objectives	Threat to clinical work	-	-
Ong (1998)	Tensions, different objectives	More time needed for leadership role	No role models, lack of clarity about job content, no role recognition, opportunity for role making	No support (by executives and clinical colleagues), isolation
Palmer et al. (2009)	-	-	-	-
Pepermans et al. (2001)	-	-	-	-
Quinn & Perelli 2016	Identity struggles, tensions	Time consuming, threat to clinical work and credibility	Lack of clarity about job content	No financial reimbursement
Robinson et al. (2013)	-	Lack of time	Lack of job description	-
Rotar et al. 2016	-	-	-	-
Spehar et al. (2015)	Identity struggles, management versus clinical work	More time needed for leadership role, work overload	-	-
Spyridonidis et al. (2015)	-	-	Opportunity for role making	Support as interference
Taylor et al. (2008)	-	-	-	-
Thorne (1997a)	Management versus clinical work	-	No role models	Trust of colleagues needed
Thorne (1997b)	Identity struggles, tensions, distrust	Work overload	Lack of job description, lack of clarity about job content, opportunity for role making	Lack of support (of executives and clinical colleagues)
Vinot (2014)	-	-	-	-
Willcocks (1995)	Identity struggles, management versus clinical work	Threat to clinical work	Lack of clarity about job content	-
Williams (2001)	-	-	-	-
Williams & Ewell (1996)	-		-	-
Witman et al. (2011)	Different objectives	Management versus clinical work, threat to clinical work and credibility	-	-

as many physicians only performed managerial activities part-time. Moreover, regarding the importance of credibility, the physicians did not want to spend too much time on managerial work because they feared losing credibility among their medical peers (Llewellyn 2001) and it is not considered a career step (Kippist & Fitzgerald 2009). Consequently, many physicians experienced that managerial work came 'on top' of or 'alongside' their clinical work, resulting in overtime work, stress, exhaustion and dissatisfaction.

Third, several studies described *role ambiguity* (N=13) as an influential factor in performing medical leadership roles. Medical leaders perceived this role ambiguity as either negative or positive. The lack of a well-defined role description, such as a description including activities and formal responsibilities, was experienced as a barrier that resulted in stress (Thorne 1997b), concerns (Willcocks 1995) and frustration (Dedman et al. 2011). Moreover, the new role led to unwanted tasks, such as managing medical colleagues—who may have been previously ignored —and addressing conflicts and resistance. Furthermore, the responsibility for the performance of medical peers could pose a threat to their clinical autonomy (Thorne 1997b). These tensions were a source of frustration and often led to stress and uncertainty. However, for some, the lack of a role definition provided opportunities as the role became "more fluid and open for interpretation" (Spyridonidis et al. 2015). Notably, managers often describe the role as a way to 'control physicians', while physicians describe the role as 'protecting' physicians from management (Thorne 1997b).

Fourth, many authors mentioned the importance of *support* (N=11) in becoming an effective medical manager. The importance of support and trust is two-fold. On the one hand, medical managers need 'backing' from their medical colleagues, as they (the medical managers) must 'protect' them (the medical staff) from the management world. On the other hand, physicians must gain support and trust from the management world to obtain authority and responsibility and prevent exclusion from key decisions and strategy. In conclusion, support and trust form an important component of a medical manager's power base (Dawson et al. 1995) and are needed not only to become effective but also to prevent stress and working in isolation (Kuhlmann et al. 2016). Paradoxical, a few authors (Spyridonidis et al. 2015; Thorne 1997b) mentioned that in some cases, physicians explicitly did not want support because sharing their problems could lead to public failure and the loss of credibility and status.

Discussion

In this study, we presented a systematic overview of the literature on medical leadership in hospital settings to improve the empirical knowledge and conceptualization of the subject. Accordingly, we analyzed the included records in terms of (1) definitions, (2) activities and roles, (3), skills, and (4) influential factors. We provide a comprehensive framework, including an overview of the features that are related to medical leadership at the personal, context-specific and role-related levels.

Based on our findings, we can distinguish between two types of medical leadership conceptualizations. Type 1 medical leadership includes physicians working in formal leadership roles who are mostly defined as medical managers who work at either the management or executive level at a hospital in addition to or instead of their clinical practice. Type 2 medical leadership includes physicians working in informal leadership roles at the clinical level, i.e., these physicians act as leaders within their daily clinical practice.

Regardless of the type of role a medical leader performs, this role appears to be twofold. On the one hand, this role entails broad range of general management and leadership activities on the other hand, this role entails activities to balance between the management and medical worlds. These activities must be performed not only to achieve and represent organizational objectives but also to negotiate for and represent the interests of the medical staff. To pursue these interests, the included studies revealed a multiplicity of general management and leadership skills, knowledge and attitudes, specific skills, and knowledge and attitudes specific to balance between management and medicine.

Although most elicited activities, skills, knowledge and attitudes were not different from those identified by well-established researchers in the field of general leadership (Northouse 2013) – and could thus be applicable to leaders with other backgrounds– our findings showed that *medical* leadership differs from general leadership. An important facet of a medical leadership role includes balancing between management and medicine, which forces medical leaders to constantly maneuver between clinical and organizational objectives to safeguard both the quality *and* efficiency of care. A medical background appeared to be crucial for conducting these boundary-spanning roles. Our study revealed the importance of two personal features – perceived as either barriers or facilitators – that appeared to specifically apply to a leader with a *medical background*, namely credibility and clinical knowledge. Credibility, in terms of medical excellence, a medical position within a hospital, an ability to bridge the management and medicine worlds and a commitment to clinical work is considered important for effectively performing a medical leader role. Clinical knowledge is considered important and distinctive for an effective medical leader in comparison to a general leader without a clinical background because, clinical knowledge cannot be easily acquired by a leader without a medical background, whereas in other fields, knowledge may be more easily acquired (Llewellyn 2001). Considering the specific hospital setting in which a medical leader operates, we found four features that are related to the specific context in which a medical leader performs her/his role, namely, the existence of competing logics in hospitals, role ambiguity, and (the lack of) support and time.

Although our systematic review provides conceptual clarity, a few issues remain unaddressed. The definitional issues, the number and diversity of the elicited activities, the personal and context-specific features, the role ambiguity and the lack of time, support and experience show the lack of standardization and institutionalization of medical leadership in practice and the lack of conceptual clarity in the literature. Moreover, we did not observe a clear distinction between formal and informal medical leadership roles or among the levels at

which a medical leader could be active (i.e., executive, management or clinical) in terms of activities and the personal- and context-specific features. This finding raises a few fundamental questions. First, to what extent do physicians need to master *all* the elicited items and, more specifically, be involved in managerial domains? Second, what are the potential consequences on professional work and the boundaries of the professional domain? In our findings, we observed a distinction between soft skills, such as communication and collaboration, and more technical skills, such as administration and finance, which raises questions regarding whether medical leadership entails a *shift* or a *reallocation* of tasks. Subsequently, this finding leads to the question of the extent to which medical leaders should be accountable for the performance of these 'new' activities. Third, what are the potential consequences for medical training? In practice, competency models for physicians have recently changed 'management' to 'leadership' as an important component of current professional work (Noordegraaf et al. 2016). However, an increased understanding of the exact content of this concept is necessary to improve medical training.

Furthermore, our findings show the difficulty of 'simply' involving physicians in leadership or managerial positions to improve medical governance and overcome the divide between the managerial and medical world. Medical leaders often create their own roles and subsequently use their hybrid role to exert an influence on organizational issues and serve not only the organizational objectives but also their own or the medical staff's objectives. In the literature, this is also known as *restratification*, which was proposed by Freidson (1994), who described this phenomenon as a means of maintaining professional authority in healthcare (Hoff 2000). Restratification questions whether the competing logics could disappear by incorporating organizational work into the physicians' daily practices.

Regarding future research, we have several empirical and theoretical recommendations. To further increase conceptual clarity, more in-depth studies implementing stronger research designs are needed. For example, in all quantitative studies, a survey was used to rank predefined lists of either skills or activities. Although this offers insights into the participants' views regarding the importance of the particular activities or skills, it does not show the *relative* importance of these items for effective medical leadership. Investigating which items are of relatively higher importance for effective medical leadership could further increase the conceptual clarity because the outcomes of this review and the multiplicity of the activities and personal –and context-specific features, question whether medical leaders need to master *all specific* items. Furthermore, future studies can use the framework of medical leadership in hospital settings (Fig 2) in which we point out possible directions for future research. Future studies can elaborate on the framework to investigate the extent to which the features relate to each other and the effectiveness of these features in relation to outcomes such as quality, efficiency or safety of care in hospital settings. In doing so, future studies can develop an evidence-based framework for medical leaders in hospital settings which can be used for further research or leadership development purposes. Finally, and arguably a limitation of this review, it is currently unclear whether the elicited activities and the personal and context-

specific features are of equal importance for different medical specialties and for physicians working outside a hospital setting, such as general practitioners.

Another methodological suggestion concerns the predominant literature focus on the formal roles of medical leadership. Therefore, a better understanding of the informal roles of medical leadership is necessary to increase our knowledge of the changing nature of the medical profession and *how* physicians can incorporate organizational work into their daily practices, thereby acting as 'leaders'. Ethnography is a fruitful method for obtaining insight into daily leadership practices in organizations (in this case, hospitals). Sutherland (2016) argues that ethnography remains an underrepresented method of studying leadership, although it offers important knowledge regarding the subtle processes of leadership, such as meaning making, argumentation and negotiation. The use of ethnography could improve our understanding of *how* medical leadership originates in practice and is therefore a welcomed addition to our current knowledge regarding medical leadership.

Finally, we have two theoretical suggestions for future studies. First, more knowledge is required regarding the *identity and institutional work* performed by medical leaders perform and their consequences, because this review revealed that many medical leaders struggle with their new identity and the fact that the new role they must perform is not well formalized and institutionalized. The use of institutional and identity theories (McGivern et al. 2015) to investigate these issues may be helpful. Second, it would be fruitful to study how medical leaders perform *boundary work* (Chreim et al. 2013) and how this affects the quality and efficiency of care because our study showed that medical leaders are often 'caught up' in boundary work, and they must balance between and, more importantly, link managerial and medical logics. As Ong (1998) suggests, it is important to search for common ground as shared objectives, and maybe even more fundamentally, mutual understanding may help to eliminate dichotomization in hospitals.

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3

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.

Introduction

Scholars have extensively described how managerial discourse and associated practices, such as standardization, regulation, performance indicators and audits, have entered the medical field (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 (ibid.). 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 & Teisberg 2007; Swanwick & McKimm 2011; Warren & 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' (ibid.: 281). As such, leadership discourse is said to have change potential to reimagine public services and construct medical identities in new ways (Lear-

month 2017; Martin & 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 & Spicer 2012) and institutional work theory (Lawrence & 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 & Suddaby 2006:215), to protect medical professionalism from managerial 'encroachment' (Currie et al. 2012; Kitchener 2000; Kitchener & 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 & 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 & 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.

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' (ibid.: 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' (ibid. 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 & Viale 2011:424; Kitchener & 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 & Waks 2013; McGivern et al. 2015; Sheaff et al. 2013; Wallenburg et al. 2016; Waring 2007; Waring & 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 & Viale 2011:435) use language to shape institutional change presumably due to their strong social and discursive skills (Green 2004; Heracleous & Barett 2001; Lawrence & Suddaby 2006; Suddaby & 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.

Leadership as performative discourse

In line with an earlier 'linguistic turn' in organizational studies (Alvesson & Karreman 2000), leadership scholars have recently turned towards 'discursive leadership' (Alvesson & Spicer 2012; Collinson 2005; Fairhurst & Grant 2010; Kelly 2008; Learmonth 2005; Martin & 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 & 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 & Spicer 2012; Fairhurst & 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 & 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 & 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 (ibid.: 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 & Learmonth 2012; O'Reilly & 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 used to encourage frontline clinicians and even patients to be in the lead in new policy initiatives. In this way, the authors argue (ibid.: 281), policy initiatives are made everyone's responsibility, and moreover, 'everyone's common aim'. Similarly, O'Reilly and Reed (2010) argue that leadership discourse is a normative mechanism used by the UK public sector to justify innovations and envisaged change by framing managers, professionals and citizens as 'leaders'. According to the authors (ibid.), leadership discourse becomes a means to achieve public service reform objectives in support of new public management and governance practices.

Interestingly, the leadership discourse, in contrast to 'management', appears to be chosen purposefully (for example: Alvesson & Spicer 2012; Martin & Learmonth 2012; O'Reilly & Reed 2010) because frontline professionals tend to negatively associate management with bureaucracy, profits and administration (Martin & Learmonth 2012). Historical analyses of the use of managerial discourses in healthcare (NHS: Learmonth 2017; Martin & Learmonth 2012; O'Reilly & Reed 2010) showed that nowadays "calling activities leadership does more

than calling them management" (Learmonth 2017:552) in terms of its change potential to re-imagine public services and construct a 'new' sense of self. By framing clinicians as leaders they come to understand themselves as key-drivers of change that promote decentralization objectives such as improving healthcare's quality and efficiency.

As the examples show, leadership discourses do not only mirror reality but could also frame reality in a performative way (Alvesson & Spicer 2012). In this study, we investigate how physicians use the discourse of leadership and we look at the potential performativity in terms of discursively constituting reality in new ways by framing and agenda setting.

Methods

We conducted a discourse analysis of documents and field notes of observations in strategic arenas in the Netherlands to study how institutional agents use the discourse of medical leadership and for what purposes. Instead of relying on the predefined notions of leadership, we focus on the social construction of leadership by professional actors and extract its meaning in specific circumstances (Alvesson & Spicer 2012; Martin & Learmonth 2012). In this line of argumentation, we understand discourse *as doing* something to reality by "constructing a person's subjectivity and framing his action" (Alvesson & Karreman 2000:1138). Whether the performative utterances of the agents we study are 'successful', i.e. if rank and file physicians will 'cite' leadership discourses and will act in ways leadership discourses suggest they should act, remains however outside the scope of this study.

The Netherlands is a particularly interesting setting to study medical leadership because policy– and educational initiatives to develop medical leadership in the Netherlands have increased rapidly (Denis & van Gestel 2016; Lucardie et al. 2017). These initiatives aim to 'transform' physicians into responsible actors that for example lead teams, enhance multi-disciplinary collaboration, improve quality –and safety and efficiently organize medical work. (Noordegraaf et al. 2016). The Dutch healthcare can be characterized by the specific entrepreneurial status of physicians, the introduction of regulated market competition that increased the role of government and healthcare insurance companies, and current policies for decentralization and integration of care (Denis & van Gestel 2016). These developments have pressured physicians to increase transparency, efficiency and teamwork across disciplinary and organizational boundaries (ibid.). It is within this context that we can understand the current popularity of leadership discourses.

The term 'medical leadership' has been recently deployed by various institutional agents, i.e., 'medical frontrunners', who operate in strategic arenas in the Netherlands using various media platforms. These frontrunners are both influential Dutch physicians holding strategic positions, such as hospital directors, chairmen of medical (student) associations or board members of medical professional bodies, and young, less powerful, physicians who conjoined as advocates of medical leadership by establishing platforms and foundations that aim to

educate and stimulate other young physicians regarding their involvement in organizational issues. The sites at which these agents perform their institutional work expand the boundaries of the organizations to which they are formally attached to and can be described as the '*strategic arena*' of the medical professional field: i.e. national professional bodies, large-scale conferences and impactful widely read journals. We consider these arenas strategic because they provide the actors with the means to exert influence over a broad range of physicians in the Netherlands and establish the agenda for future changes within the medical field.

Our empirical data were retrieved from these strategic arenas and consist of 21 documents (including opinion papers published in medical journals (12), position papers (5), leaflets (1), research reports (1), and books (2)), the content of two websites, an online course for young physicians and observations at three large conferences focusing on medical leadership. All the data were in Dutch and the quotes used in this study were translated to English. Although different nuances and cultural resonances of the term 'leadership' exist between different languages, the connotation with 'leadership' is comparable in the Dutch and English language, i.e. 'transformational', 'interpersonal' and 'coaching' (Brodbeck et al. 2000).

The search strategy used to localize the data was developed in three steps. First, we screened the two most popular Dutch medical journals (in terms of online reads) using the search term 'medical leadership'. We did not restrict the year of publication and thus considered all the material that was published in these journals. Second, we searched the websites of professional bodies (the Royal Dutch Medical Association, the Federation of Medical Specialists, the Dutch General Practitioners Society and the Academy of Medical Specialists) and the website of the Dutch Platform of Medical Leadership for documents related to medical leadership. Third, using a 'snowball effect', other sources were located. During the first two steps, we found the conferences, websites and online course that were included as data sites in this study. Data were included into this study when it informed the audience about medical leadership or when it advocated for medical leadership. Data were excluded if they were not initiated by (former) physicians and did not primarily focus on physicians.

The website-based data were retrieved from a website representing the Dutch medical leadership competency framework, a website developed by young physicians to advocate medical leadership education and practices, and an online course on medical leadership offered by the Dutch Medical association. Finally, we conducted observations at the following three conferences focusing on medical leadership: one conference was organized by a teaching academy for physicians, one conference was organized by the federation of medical specialists, and the final conference was organized by a physician-initiated platform that advocates medical leadership. These conferences were relevant sites to study as these allowed us to observe how medical leadership was socially constructed in interaction between leadership advocates, (e.g. key note speakers) and regular physicians (e.g. participants attending the conferences). These particular conferences were selected because they were well-visited by physicians. All data were collected between December 2015 and May 2017.

On account of this study's purposes, we analyzed our data specifically in terms of language references to leadership. We did not only look for direct linkages to the word 'leadership', but also for possible proxies such as 'leader', 'in the lead' or 'medical excellence'. While analyzing our data, we had four questions in mind: how do medical leadership advocates interpret the term leadership? What do medical leadership advocates want physicians to do and for what purpose; and how do medical leadership advocates facilitate physicians to act upon these purposes? First, we inductively coded our data into sub-clusters representing specific forms of medical leadership discourse, which aim at maintaining, disrupting or constructing medical professionalism. Specifically, we analyzed how medical leadership was constructed in our data, which led to the identification of the following three overarching aims of leadership discourse: (1) regaining the lead in medical professionalism, (2) disrupting 'old' professional values, and (3) constructing the 'modern' physician. Second, we deductively coded the clusters using Lawrence and Suddaby's taxonomy of institutional work (2006) to illustrate how the

Table 1. Documents analyzed

Year	Title	Publication details
Opinion papers		
2014a	Take control	Medical Contact
2014b	The art of medical leadership	Medical Contact
2015a	Platform Medical leadership: An update of our activities	Medical Contact
2015b	Physicians and leadership: 'Speak up, dear!'	Medical Contact
2015c	Physicians and leadership: the end of power	Medical Contact
2015d	Future physicians have to take responsibility in a changing society	Medical Contact
2015e	Medical leadership for dummies	Medical Contact
2015f	Take your role and shape the future	Medical Contact
2015	Interview chairmen Platform Medical Leadership	National General Practitioner Association
2015	Unraveling medical leadership	Dutch Journal of Medicine
2016	CanMEDS 2015: even better physicians?	Dutch Journal of Medicine
2016	More than being a physician	Medical contact
Position papers		
2012	Medical Specialist 2015	Federation Medical Specialists
2015	Framework Medical Leadership	Platform Medical Leadership
2016	Medical Leadership: Start with the Basics!	Platform Medical Leadership
2016	Medical Leadership during residency	Federation Medical Specialists
2017	Medical Specialist 2025	Federation Medical Specialists
Leaflets		
2016	Medical Excellence: the professional and the system	Academy for Medical Specialists
Research reports		
2015	Research report Medical Leadership	The Medical Student Association
Books		
2016	Physicians with knowledge – Medical Leadership, Finance and healthcare organization	Medical Business Foundation
2016	The physician and the money	Individual medical director

institutional agents in our data attempt to influence the medical field. Although an analysis of the effects of these framing efforts on practice is beyond the scope of this study, we do point out the how institutional agents shape reality in new ways by framing doctors as leaders. By doing so, they set the agenda for changing medical professionalism to meet today's challenges and create possibilities for rank and file physicians to act upon the advocated changes.

The types of institutional work identified in our data were *valorizing and demonizing* (defining the normative foundations of institutions by providing the public positive and negative examples of desired behavior), *undermining prevailing beliefs and assumptions* (disrupting what has always been taken for granted), *theorizing* (naming new concepts and describing its chains of causes and effects), *embedding and routinizing* (providing resources, that enable the participants to integrate the normative foundations of the institution into their daily practices), *defining* (demarcating membership within a field), *constructing new identities* (constructing identities that represent the new institution) and *educating* (educating actors in new skills and knowledge necessary to support the new institution). The combination of inductive and deductive coding allowed us to develop a theoretically refined analysis of the data while at the same time leaving sufficient room for bottom-up findings.

Regaining the lead in medical professionalism

Medical leadership advocates often encourage physicians to act as 'leaders' and to 'take back charge' because healthcare is currently facing a number of challenges and threats, such as increasing healthcare costs and changing care demands. These threats are said to hamper physicians from performing the primary function of their work, i.e. caring for patients. This framing suggests that physicians are no longer considered dominant actors within the medical field and have to get back into 'the lead' to regain professional dominance. Advocates argue that 'the system', which is represented by managers, the government and healthcare insurers, is too complex and distanced from the professionals' life world. It is in light of these discussions that medical leadership is often depicted as a solution to the threats provoked by the system as is clearly illustrated in the following two examples:

A conference flyer about medical leadership published by the Dutch Academy of Medical Specialists states the following:

> *"The physician and the healthcare system are having a difficult relationship. The professional needs the system to function properly but does not want to be occupied by the system. However, the system is imposed on the professional and threatens to take over the professional. [...] Professionals have no choice other than to get back in control. [...] The need for medical leadership can thus be understood as a call for help". (Flyer conference medical leadership, 11-11-2016)*

During this conference, a keynote speaker, who is a well-known hospital director, further elaborates why medical leadership is needed:

> *"Medical leadership is needed to bring back simplicity to the complex system of healthcare. Healthcare is becoming more and more complex. More people interfere in healthcare. We have to adhere to more rules, more laws, and more things. I believe that the doctor, unlike anyone else, is able to bring back simplicity to healthcare by connecting to the patient because the patient is the essence of care. And with everything we do, we should ask ourselves 'is the patient getting any better from this?'" (Conference medical leadership, 11-11-2016)*

By discursively constructing a risk, i.e. the colonization of the life world of physicians by system logics, medical leadership is subsequently *theorized* as a solution to overcome this colonization. In this way, the privileged position of physicians within the professional field can be enhanced, and the boundaries of membership within the medical professional field are *redefined*. In performative terms, this could be interpreted as an 'exercise of power' (Learmonth 2017) over who is 'in charge' of healthcare governance. Furthermore, by framing physicians as 'leaders' who need to step up, leadership advocates are co-constituting new roles for physicians in contemporary healthcare.

As part of theorizing, the concept of medical leadership is defined by underscoring what it is *not*. Advocates emphasize that leadership is highly distinct from management because it can overcome the negative associations with 'the system'. The distinction between management and leadership is achieved by illustrating the various differences between the two. For example, management is associated with coordination, stabilization and bureaucracy, whereas leadership is related to empowering others, establishing change and carrying out a vision. In an online course offered by the Dutch medical association that educates professionals on medical leadership, the chairman of the association further elucidates this distinction by highlighting that management is replaced by leadership in the well-known canMEDS model (Frank 2005):

> *"The 2005 CANMEDs model proves that medical leadership is no fashion fad term: management is replaced by leadership. It, thus, remains a matter of time before this will be changed in the Netherlands too. Clearly, this makes the importance of medical leadership for all physicians official". (Online course medical leadership, 2016)*

This illustrates how leadership is framed as more than an act performed by the individuals who are formally 'in the lead'. In fact, advocates often emphasize that *all* physicians can and, even more compulsory, should become a medical leader.

In conclusion, naming the concept of medical leadership, describing its chains of causes and effects, highlighting its urgency and defining all physicians as possible medical leaders could altogether be considered as *theorizing*, which is a critical first step in letting the concept of leadership become part of the cognitive map of the medical field.

Disrupting 'old' professional values

Using medical leadership discourses, advocates challenge the prevailing beliefs and assumptions regarding the meaning of a 'good' physician by denouncing 'old' virtues, such as hierarchy, autonomy and strong socialization processes, that are deeply rooted within medical professionalism because these virtues could hamper collaboration and the quality and efficiency of care. In this way, old institutions are disrupted to allow for the introduction of a new medical identity, which is an important part of institutional work. In an online course on medical leadership, the chairman of the Dutch medical association emphasizes that merely caring for a patient is not enough anymore by publicly *valorizing and demonizing* virtues that should and should not be part of the modern physician:

> *"Undesirable types of physicians: those who lack interest because they think they do not have to because they are powerful and influential enough in their daily practices." (Online course medical leadership, 2016)*

> *"Leaders who are needed in healthcare: those who are aware of the strong socialization process and culture among physicians and who distance themselves hereof, and moreover, who are able to change this process: no more heroes!" (Online course medical leadership, 2016)*

In an opinion paper on medical leadership, the same chairmen further emphasizes that physicians can no longer afford to ignore costs, quality of care or changing care demands:

> *"Their once highly protected world has become a peepshow. Performance indicators are being published. Remuneration structures are discussed. The E-revolution results in better-informed, critical patients, who, in addition to your medical excellence, expect enjoyable communication and an equivalent relationship. They share their reviews on the internet. In sum: your functioning is not unquestionable anymore just because you are a physician." (Medical Contact, 2015c)*

The speaker in these quotes is thus deploying the leadership term to challenge the secluded bubble in which physicians are disconnected from the outside world.

In addition to challenging 'old' professional values and work settings, advocates use the medical leadership discourse to disrupt the boundaries of the medical field. While physicians

used to work undisturbed, autonomously and often independently within the borders of their own specialty, 'medical leaders' are discursively positioned as transparent team players who engage in multidisciplinary collaborations and cross borders between primary and hospital care. Moreover, medical leaders are expected to collaborate with other actors, such as patients, managers, health insurance companies and technicians. Thus, leadership discourse is mobilized to expand the boundaries of medical professional work, which are represented as outdated as argued by a former chairman of the Dutch medical association in a medical opinion paper:

> *"Strong medical leadership is needed to safeguard healthcare in close collaboration with the patient. In some ways, our healthcare reminds me of the religious landscape thirty years ago. The fences between primary, hospital and specialist care seem to be holy, which is not beneficially to the patient. We need a master plan to link all these little islands together. That transition is necessary, and medical leadership therefore, is essential." (Medical Contact, 2014b)*

Finally, advocates use the medical leadership discourse to draw attention to the lack of skills and knowledge of physicians that are necessary to address the threats currently faced by healthcare. In a book on medical leadership, a group of physicians argue that merely mastering medical-technical skills is no longer sufficient:

> *"Fifty years ago, the skills and knowledge acquired during medical school seemed sufficient for the entire lasting career of a physician. However, the exponential growth in knowledge and techniques, as well as both horizontal and vertical task reallocation to other healthcare professionals, have changed this significantly." (Medical Business, 2016)*

Additionally, medical students use medical leadership discourse to criticize current medical curricula because they fall short in preparing medical students for 'the future'. To support their argument, these students established a workgroup of 'national advocates of medical students' and conducted a survey amongst medical students to investigate the need for medical leadership. The findings demonstrate that most medical students feel that they lack medical leadership skills (Research report Medical Leadership 2015). These survey findings are strategically cited by leadership advocates to disrupt the 'old' curricula and to reconstruct a new curriculum that supports the *development of a new professional* institutional logic. The discursive deployment of leadership in these examples is performative in that it challenges what was once 'reality' in order to shape and steer a 'new reality' of medical professionalism.

Constructing the 'modern' physician

In the strategic arenas, advocates frequently refer to medical leadership to define the *'modern' physician as leader, thereby attempting to constitute a new medical identity*. The constitution of this

new identity is invoked by all kinds of action: i.e. the organization of leadership conferences, the development of new educational materials about leadership skills, such as competency models and the writing of leadership visions and books. It is through these material actions, that the identity of the modern physician as 'leader' discursively comes into being, thereby showing the performativity of leadership discourse.

Physicians are mobilized through the organization of various large-scale conferences on medical leadership. During a conference on the 'future physician' (the Netherlands, 14 March 2016), the Dutch medical federation presented a vision document on the 'physician 2025'. In this vision, advocates urge physicians to undertake actions outside the consultation room, hospital or healthcare organization, thereby expanding professional work and the professional field. The authors remind the physicians of their responsibility to society: physicians should be involved in societal debates concerning reconfigurations of the Dutch health care system, care purchasing with health insurance companies, price negotiations of expensive or orphan drugs and the development of quality indicators. In these matters, their medical expertise would be crucial for safeguarding patients' interests. Furthermore, leadership advocates encourage physicians to form alliances and share knowledge with 'others', e.g. professionals, managers, and healthcare organizations. Here, the authors use the leadership term to re-present what is supposedly at the core of medical work. Framing these actions can be understood as a performative act as it re-constitutes medical work.

By *becoming medical leaders*, advocates argue, physicians could 'bridge the gap' between the before-mentioned system and life world. During a conference organized by the Platform Medical Leadership a conference speaker asks participants to reflect upon what leadership means to them. A young physician answers:

> *"We are here mainly to broaden our view. To look further than just the clinical, the medical, with what we are occupied daily. I want to know how I can increase my role in quality improvement."*

This quote demonstrates that this physician apparently feels addressed by the leadership discourse and that it performatively shapes her interpretation of her own role as a physician being more than merely medical. Although the uptake of leadership discourse formally falls outside the scope of our study, this finding is an indication that leadership discourse is potentially shaping a different sense of self.

In addition, advocates use medical leadership discourses to emphasize the need for *educating* physicians in new skills and knowledge. Advocates developed new learning materials, such as the competency framework developed by the Dutch medical leadership platform, (online) leadership courses, conferences and seminars, and books regarding medical leadership knowledge thereby in fact *(re)constructing medical education* in support of the 'new' institution. Several workgroups were established; certain groups were supported by official bodies, such as the Dutch medical federation, while other groups were initiated voluntarily

by a conjoined group of physicians. Similarly, medical students wish to change the content of medical training and, moreover, be in charge of this process. A group of students established a workgroup and developed a vision document in which they use leadership discourses to request the incorporation of other skills, such as personal development or organizational and financial knowledge, in medical curricula. These materials are not only performative in that they constitute a new curricula that is needed to construct the 'modern physician', moreover they offer templates or frameworks to physicians that provide them with an outline for action, thereby enabling physicians to act upon the new institution.

To ensure that *all* physicians can change their identity and field, or as advocates argue, *become a medical leader*, advocates often emphasize that changing behavior or adopting new practices does not require difficult or intensive educational programs, but can be easily achieved in daily practices, as exemplified by the following quote:

> *"To facilitate medical students in leadership, not much extra has to be organized. In fact, there are a number of 'low-hanging fruit'. In a hospital, for example, there are a lot of committees from which to learn as a medical student. Imagine the input you could provide as a physician to a committee that is concerned with the reconstruction of a department, or to the committee of quality and safety, or the DRG-committee (Diagnostic-Related-Group) where you can learn about the hospitals' financial structures. You will need all of that knowledge to demonstrate leadership, and this can be best learned in practice." (Medical Contact, 2014b)*

In several opinion papers, advocates provide numerous 'simple' examples to adopt if physicians want to become medical leaders, such as taking initiatives in the municipality, organizing an education evening, collaborating with a physician-assistant and starting a conversation with informal caregivers or patients' families (Medical Contact 2015; National General Practitioner Association 2015).

These examples show that leadership discourses are not only descriptive but also performative as they frame medical work –and identities in new ways, which can be considered an important component of the *construction* of the 'modern' physician. Moreover, these acts could also evoke action and potentially influence new work practices. Through the provision of numerous examples of actions that are in support of the 'new' identity, advocates enable physicians to *embed and routinize* the normative foundations of the new institution into daily practices.

Discussion and conclusion

This study investigated how opinion making physicians operating in strategic arenas in the Netherlands use the discourse of medical leadership to conduct institutional work with the

aim of reconfiguring medical professionalism. Using the concept of institutional work (Lawrence & Suddaby 2006), we described the following three uses of the medical leadership discourse: (1) regaining the lead in medical professionalism, (2) disrupting 'old' professional values, and (3) constructing the 'modern' physician.

The empirical analysis revealed that medical leadership is not a neutral concept describing inherent skills or behavior. Rather, medical leadership should be viewed as a performative discourse in terms of constituting medical professionalism in new ways through framing doctors as leaders and setting the agenda for field-level change. Institutional agents use leadership discourses to regain professional dominance by discursively placing the professional in the lead and framing the representatives of the 'system' e.g. managers, policy makers or state officials, as unable to construct 'good' systems. The mobilization of dichotomized representations of managerial and medical logics could be interpreted as an 'exercise of power' (Learmonth 2017) over 'who is in charge' of healthcare governance.

Furthermore, advocates use medical leadership discourses to challenge the prevailing beliefs and assumptions regarding the definition of a 'good' physician by denouncing traditional professional values, such as hierarchy and autonomy. By subsequently *re*-presenting medical work as leadership work and framing physicians as leaders who need to step up, leadership advocates are co-constructing new identities of physicians as team-players who work across disciplinary and organizational boundaries to improve the quality and affordability of care. Finally, advocates set an agenda for field-level change by organizing conferences and seminars about medical leadership, establishing workgroups, and developing new learning materials, online courses and competency models. Hence, these material actions can be considered as performative in terms of materially constituting a 'new' medical professionalism.

Although the leadership discourse is presented as having clear, sharp boundaries and distinguished from the discourse of management, it is questionable to what extent this discursive distinction between leadership and management is entirely adequate. The leadership advocates for example associate 'transparency', 'efficiency' or 'responsibility' with leadership, which are terms that have been previously associated with management and NPM reforms (Learmonth 2017; O'Reilly and Reed 2010). This poses the question to what extent leadership discourse is old wine in new bottles. If this is the case, 'old' NPM reform may be re-introduced under the guise of 'new' leadership discourse, potentially co-opting physicians into implementing reform that is at the same critiqued under the label of management. We however need further research to investigate whether the discursive move to distance leadership discourse form management is backed up by empirical practices.

Our study also contributes to the literature on institutional work and the sociology of professions. Existing studies on the influence of managerialism on professions primarily highlight the re-active work that actors perform to *maintain* (Currie et al. 2012; Kitchener 2000; Kitchener & Mertz 2012; Levay & Waks 2009; Sheaff et al. 2003; Waring 2007; Waring & Currie 2009) or *challenge* (McGivern et al. 2015) professional dominance. However, our findings show that professionals are in fact pro-actively aiming for *new* professional institutions. We

are however attentive to the fact that leadership discourse is not solely coined by the Dutch physicians we studied, but rather is the outcome of a dynamic mediation between external (i.e. 'outside' the medical field) and internal challenges within the broader institutional context. In Dutch healthcare, regulated competition and political pressures for more efficiency and transparency have increased the role of government and healthcare insurance companies and have stimulated physicians to increase their accountability (Denis & van Gestel 2016). Other recent policy changes such as the decentralizations of care to municipalities and the transition of less acute care from hospitals to primary care stimulate physicians to enhance interdisciplinary teamwork and increase their responsibility for efficiency and quality of care (ibid.; Noordegraaf et al. 2016). It is within this context that we interpreted physicians' advocacy of leadership discourses as a means to not only remain and *possibly enlarge* their leading position within healthcare, but also to change the role of physicians from autonomous individualists to inter-disciplinary team workers.

The final important contribution of our study is that we demonstrate how physicians perform institutional work in strategic arenas, such as national professional bodies and conference venues. In general, studies investigating institutional work of physicians focus on the work floor in hospital settings (Currie et al. 2012; Waring 2007; Waring & Currie 2009). However, our analysis demonstrates the importance of studying other areas in addition to the work floor to understand the profession-building processes of physicians that potentially lead to institutional change. The findings further illustrate that in addition to influential agents in the medical field, young, less powerful physicians can also perform institutional work that potentially triggers institutional change. Apparently, the strategic arena offers young, less powerful agents an important platform to raise their voice and exert influence over a broader group of actors in the medical field.

Our study has two important limitations. First, an investigation of the question whether the performative leadership discourses are successful on a work floor practice-level, i.e. if rank and file physicians will 'cite' leadership discourses and will act accordingly, was outside the scope of our study. However, there is an increasing number of studies that show how physicians and medical students enact leadership discourse and adopt new identities as leaders by regularly invoking the term. This empirical evidence suggests the gradual uptake of leadership discourses in daily practices (the Netherlands: Lucardie et al. 2017; Noordegraaf et al. 2016, NHS: Gordon et al. 2015; Learmonth 2017; Martin & Learmonth 2012). The extent to which the deployment of leadership discourses ultimately leads to institutional change on the work floor is an important gap that must be investigated in future studies.

Second, we only investigated the Dutch context, which could limit the generalizability of our findings to other contexts. While we observed similar developments of medical leadership in other Western countries (for example in the NHS: Swanwick & McKimm 2011, or USA: Porter & Teisberg 2007), considering contextual differences in generalizing our findings to different settings is important. For example, the Dutch reimbursement system significantly differs from contexts, such as the NHS or the USA. Healthcare insurance companies in the Netherlands

purchase hospital care through negotiations regarding costs and quality. To achieve a fair price during these negotiations, hospitals, and specifically physicians 'in the lead' must provide insight into quality of care and develop negotiating skills to achieve a good business deal. However, despite these particularities in the use of leadership discourses, we also note the generalizability of certain findings beyond the Dutch context: across contexts, leadership discourses are considered the answer to addressing the increase in chronic patients -leading to an increased need for multidisciplinary collaboration- and healthcare costs leading to an increased need for cost-efficiency (Porter & Teisberg 2007; Swanwick & McKimm 201; Warren & Carnall 2011).

Consistent with a recent call to focus on the actual, day-to-day, processes of institutional work in which actors 'try to address daily life' (Lawrence et al. 2013; Wallenburg et al. 2016), we encourage studies that investigate the extent to which physicians incorporate leadership discourses into daily work practices and how this affects the relational dynamics between peer professionals, managers and other actors. To obtain an in-depth understanding of the messy day-to-day institutional work, ethnography can be a very fruitful method (Lawrence 2013). Particularly the technique of shadowing rank-and-file physicians in their daily work could be helpful to study how the advocated changes turn out in practice.

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4

What makes an ideal hospital-based medical leader? Three views of healthcare professionals and managers: A case study

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Abstract

Medical leadership is an increasingly important aspect of hospital management. By engaging physicians in leadership roles, hospitals aim to improve their clinical and financial performances. Research has revealed numerous factors that are regarded as necessary for 'medical leaders' to master, however we lack insights into their relative importance. This study investigates the views of healthcare professionals and managers on what they consider the most important factors for medical leadership. Physicians (n=11), nurses (n=10), laboratory technicians (n=4) and managers (n=14) were interviewed using Q methodology. Participants ranked 34 statements on factors elicited from the scientific literature, including personal features, context-specific features, activities and roles. By-person factor analysis revealed three distinct views of medical leadership. The first view represents a strategic leader who prioritizes the interests of the hospital by participating in hospital strategy and decision making. The second view describes a social leader with strong collaboration and communication skills. The third view reflects an accepted leader among peers that is guided by a clear job description. Despite these differences, all respondents agreed upon the importance of personal skills in collaboration and communication, and having integrity and a clear vision. We find no differences in views related to particular healthcare professionals, managers, or departments as all views were defined by a mixture of departments and participants. The findings contribute to increased calls from both practice and literature to increase conceptual clarity by eliciting the relative importance of medical leadership-related factors. Hospitals that wish to increase the engagement of physicians in improving clinical and financial performances through medical leadership should focus on selecting and developing leaders who are strong strategists, socially skilled and accepted by clinical peers.

Introduction

Medical leadership is an increasingly important topic in both literature and practice, because of the anticipated positive effect that physicians in leadership positions have on quality of care, patient safety and cost efficiency (Blumenthal et al. 2012; Spurgeon et al. 2017; Warren & Carnall 2011; Witman et al. 2011). Research shows that hospitals perform better when led by physicians (Clay-Williams et al. 2017; Goodall 2011; Veronesi et al. 2013; West et al. 2015). Moreover, physicians are said to have more influence over clinical peers in contrast to non-clinical hospital professionals (Bresnen et al. 2018; Kitchener 2000; Llewellyn 2001; McGivern et al. 2015; Witman et al. 2011). By engaging in leadership roles, physicians could play an important role in encouraging fellow clinicians in achieving contemporary clinical and organizational objectives.

The importance of and need for medical leadership is reflected in both practice and the literature. Internationally, medical curricula are increasingly adjusting their programs to include

leadership competencies, for example the well-known CanMEDS model (Frank et al. 2015). Medical students would like more management and leadership training at medical school as now they feel partially unprepared for a future career that is moving beyond clinical boundaries (Abbas et al. 2011; Blumenthal et al. 2012; Rouhani et al. 2018; Saravo et al. 2017; Stoller 2009; Voogt et al. 2016). Likewise, educational institutes increasingly offer medical leadership development programs to medical specialists, which physicians value highly (Frich et al. 2015). The popularity of medical leadership is also reflected in the scientific literature. The amount of research on the subject is rapidly increasing, mainly yielding insights into the factors, e.g. skills, knowledge, institutional characteristics, activities, that are required for the development of medical leaders and leadership (Dedman et al. 2011; Dine et al. 2011; Holmboe et al. 2004; Hopkins et al. 2015; Palmer et al. 2008; Robinson et al. 2013; Taylor et al. 2008; Williams 2001). Although both practice and research embrace and plead for the development of medical leadership, there remains a lack of conceptual clarity on the relative importance of factors associated with effective leadership (Berghout et al. 2017; West et al. 2015).

In response to the fast-growing but scattered literature on what effective medical leadership entails and the skills and knowledge medical leaders should possess, Berghout et al. (2017) conducted a systematic literature review. This revealed two broad definitions: a formal managerial role, with a specific appointment, and an informal role, where leadership is inherently part of physicians' daily work. Irrespective of whether the role is formal or informal, the review elicited three main areas of factors that medical leaders should master: personal features, context-specific features, and activities and roles (ibid.). Personal features concern the skills, attitude, knowledge, experience in management and credibility a medical leader should have, and include a wide range of character traits, such as communication skills, motivation and clinical knowledge. Secondly, context-specific features refer to management experience, role ambiguity, support and time, and include a variety of institutional and cultural characteristics of the hospital where a medical leader works related to an assumed dichotomy between the managerial and medical world. Finally, the third area consists of the activities and roles required to carry out the role of medical leader, such as strategy and decision making, networking and responsibility for the performance of the department. The long and diverse list of factors is in line with the outcomes of similar literature reviews on medical leadership (Abbas et al. 2011; Gillmartin & D'Aunno 2007; Hartley et al. 2008). This raises the question to what extent a medical leader could, or should, master all the factors and thus of their relative importance.

The diversity of factors could be explained by the potential views of various professionals (e.g. physicians, nurses, laboratory technicians and managers) on what is most important for effective medical leadership. The aim of this study is to provide insight into what healthcare professionals and managers in a specific hospital think is important for effective hospital-based medical leadership. The results of this study could help hospitals to reflect on what type of leadership they aspire to in comparison to the kind of medical leaders they currently have in place. Moreover, hospitals and current medical leaders could use the findings to gain insight into necessary or desirable improvements to enhance the effectiveness of medical

leadership. This study could contribute to the development of future medical leaders, by incorporating the factors that are considered important in medical curricula.

Methods

Q methodology was used to explore healthcare professionals and managers' views on factors in the areas of personal features, context-specific features, and activities and roles that are thought of as most important for effective medical leadership in a hospital setting. Q methodology combines qualitative and quantitative research techniques to provide a foundation for the systematic study of subjectivity, such as a person's view or opinion (McKeown & Thomas 2013; Watts & Stenner 2018). In conducting a Q-study, researchers present respondents with a comprehensive set of statements about the subject of study, which they are asked to rank according to their view on the subject, and to explain their ranking. By-person factor analysis is used to identify subgroups of respondents who rank the statements in a similar way, resulting in a limited number of distinct composite rankings that can be interpreted and described as the principal shared views on the subject of study. Finally, the qualitative data elicited from the interviews, during which respondents explain their ranking of the most and least important statements, is used to check and refine the interpretation of the quantitative data, and to enrich the description with citations.

This study fell outside the scope of the Netherlands' Medical Research Involving Human Subjects Act (WMO) and therefore no formal ethical approval was needed. Although our research was conducted in a medical setting, it met none of the WMO criteria (http://www.ccmo.nl/en/your-research-does-it-fall-under-thewmo). First, no patients were involved. Second, the study content and methodology did not constitute an infringement of the physical and/or psychological integrity of the participants. This study was part of an overarching research project on medical leadership, which was evaluated by the IRB who confirmed that no ethical approval was required (MEC-2017-409).

Statement set

The respondents ranked a set of 34 statements about medical leadership. This set derived from an initial set of 37 statements culled from a systematic review of the literature about medical leadership in a hospital setting (Berghout et al. 2017) that provided an overview of factors held important, categorized into three main areas: personal features, context-specific features, and activities and roles. All statements were based on the systematic review of Berghout et al. (2017) and additional literature on medical leadership (Abbas et al. 2011; Gillmartin & D'Aunno 2007; Hartley et al. 2008) revealed no further factors that would have complemented the statement set. To test the comprehensiveness of the set and the comprehensibility of the statements, a pilot study was conducted among six healthcare professionals (two medical students, a nurse and two physicians) and one quality manager. The total set

was reviewed and eventually 11 statements were revised: four statements were combined into two statements because they addressed the same factor, two statements were removed because they were considered irrelevant to the study context, one statement was split into two statements as it addressed potentially separate factors, and four statements were re-formulated for clarity. The final set of 34 statements used in the interviews appropriately represented the scientific literature on medical leadership (Table 1).

Table 1. Statement set including 34 statements on effective medical leadership (derived from Berghout et al. (2017)).

Area	Dimension	Statements
Personal features	Skills	1. Have good communication skills
		2. Be able to enthuse and motivate others
		3. Be able to resolve conflicts
		4. Have the skills to manage a team
		5. Have the skills to manage a department
		6. Be able to collaborate
		7. Have good negotiation skills
	Attitude	8. Be assertive
		9. Be a team player
		10. Have integrity
		11. Have an eye for quality and costs and the balance between them
		12. Have a clear vision and be able to convey it to others
		13. Be patient centered
	Knowledge	14. Be excellent in their medical discipline
		15. Knowledge of hospital finances
		16. Knowledge of the structure and processes of the hospital
		17. Knowledge of the Dutch healthcare system
	Experience in management	18. Have experience in leadership
		19. Be trained in leadership
	Credibility	20. Be held in high esteem by fellow physicians
		21. Consider themselves primarily a physician
		22. Being a practicing physician
Context-specific features	Competing logics	23. Able to connect the clinical and the management domains
		24. Focus on the interests of the hospital as a whole
		25. Focus on the interests of the clinical departments
	Role ambiguity	26. Have a clear job description of medical leadership
	Support	27. Be accepted as a medical leader
	Time	28. Have sufficient time to execute the leadership role and all associated tasks
Activities and roles		29. Be involved in strategy development at the hospital level
		30. Be responsible for the performance of the employees in their department
		31. Be able to initiate improvements
		32. Network and make alliances outside the hospital
		33. Be responsible for the performance of their department
		34. Be able to initiate and maintain cross-department collaborations

Respondents

In a Q methodology study, participants are selected purposively in order to maximize the possibility of discovering a diversity of views on the subject of study (Watts & Stenner 2018). Since the aim is to explore different views on a specific subject and not the prevalence of these views in the larger population, a relatively small sample is sufficient (ibid.).

The study was conducted at a general district hospital in the Netherlands. This hospital is committed to developing medical leadership and therefore offers a leadership program for physicians. As this hospital has been intrinsically interested in medical leadership for 10 years at least, it offered a useful setting to study the matter. It was possible to gain access to three departments and obtain the cooperation of all kinds of healthcare professionals and managers. Although the study was conducted in only one hospital, the ability to include such a variety of departments and professionals enabled this study to provide a broad representation of views on medical leadership. A total of 39 healthcare professionals and managers from the departments of radiology, internal medicine and surgery were asked to participate. These departments were selected because they represent three large overarching units committed to different types of care delivery. Therefore, the healthcare professionals and managers working at these departments were expected to represent a variety of views on what is important for medical leadership across the broader hospital setting. To maximize the possibility of finding the principal views on this subject, four kinds of professionals were interviewed: managers (n=14), physicians (n=11), and nurses (n=10) or laboratory technicians (n=4) (Table 2). Managers include six business managers and seven team heads, who hold a background in nursing. The category of 'physicians' also includes five physicians who manage their clinical departments part-time. As the department of radiology does not employ nurses, laboratory technicians were asked to participate. The professionals were approached by the secretary of each department and selected on availability.

Table 2. Background characteristics of total sample.

Characteristic	Surgical (n=13)	Radiology (n=13)	Internal medicine (n=13)	Total (n=39)
Sex (% female)	69%	46%	69%	62%
Mean age (years)	43	44	44	44
Profession				
Manager	4	5	5	14
Physician	4	4	3	11
Nurse	5	0	5	10
Laboratory technician	0	4	0	4
Fulltime/part-time (% fulltime)	86%	86%	71%	81%
Mean years employed in current function	7	9	6	7
Mean years employed in this hospital	13	16	14	14
Management school or cursus (% yes)	62%	64%	46%	57%

Data collection

Quantitative and qualitative data were collected through semi-structured interviews, during which the respondents ranked the 34 statements according to importance for medical leadership. On finishing the ranking exercise, they answered questions to clarify their ranking. All interviews were conducted in April 2017 and lasted between 20 to 45 minutes. To ensure that the respondents were well informed, medical leadership was first briefly defined: a medical leader is always a physician, but the role of a medical leader can be either formal or informal.

After the introduction, respondents were handed the statement set, printed on cards and randomly ordered, and a sorting grid (Fig 1). The respondents were asked to read all the statements and divide them into three piles: (1) important, (2) neutral and (3) unimportant for effective medical leadership. Next, the respondents were instructed to read all the statements from each pile again, consecutively, and to rank them on the grid. After finishing the ranking exercise, respondents were asked to check their ranking by reading all statements again and adjust the ranking, if needed. Subsequently, the respondents were asked to explain the placement of the statements in the most important and least important columns. All respondents were able to sort their statements into the shape of the Q sort shown in figure 1 (Fig 1). At the end of the interview, respondents answered questions about a number of background characteristics, which are listed in Table 2. Finally, the respondents were asked whether they felt the statement set was complete or if there were any factors lacking. A minority of the respondents (N=14) mentioned approachability of a medical leader, remuneration for the

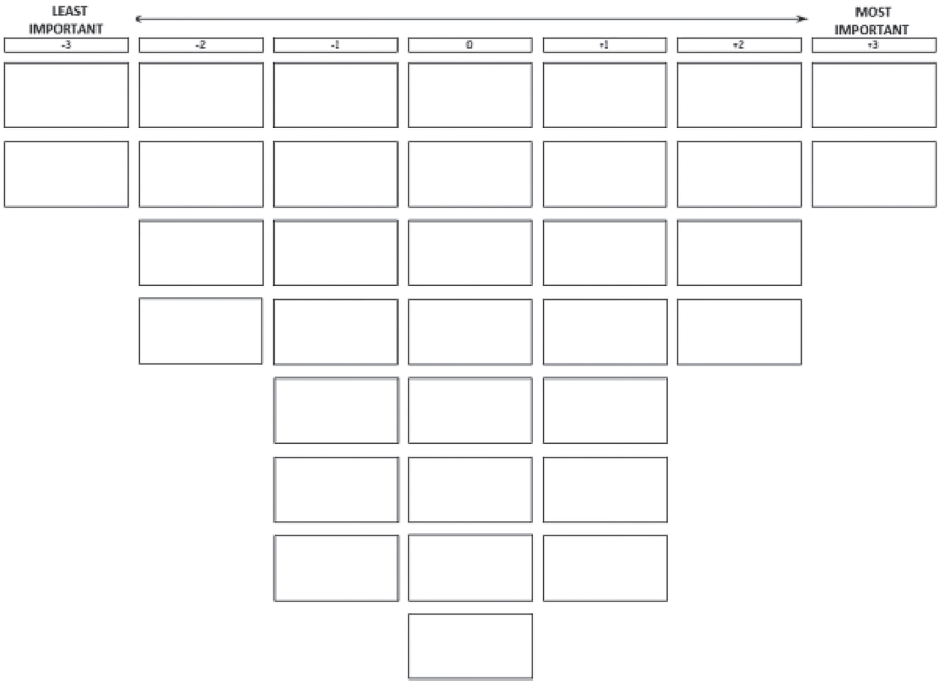

Fig 1. Score sheet.

time a medical leader spends on additional tasks and listening to others as factors related to medical leadership. During the initial development of the statement set these factors were not included as they were not or scarcely mentioned in literature [28], neither were they mentioned during the pilot study. All interviews were recorded and transcribed with the permission of the respondent.

Analysis

To analyze the rankings, we used PQMethode 2.11 software (Schmolck 2014). We conducted by-person factor analysis with centroid factor extraction and varimax rotation, resulting in a three-factor solution that explained 44% of the variance in ranking data. An idealized ranking of 34 statements was computed, based on the rankings of the respondents that were associated with that factor (Table 3). These idealized rankings were interpreted as distinct views on what is important for effective medical leadership, focusing on the statements that characterize each of the factors (i.e., those ranked in the outer columns of the idealized ranking of the factor) and those that distinguish between factors (i.e., with a statistically significantly different rank score in a factor as compared to the other factors). The first interpretations of the three factors based on the quantitative data were further refined using the qualitative data retrieved from the semi-structured interviews. Some explanations from respondents associated with a factor are cited for illustration of the interpretation of that factor.

Results

Thirty-nine respondents participated in the study, 13 from each of the departments (Table 2). The analysis revealed three main shared views on what is important for effective medical leadership in a hospital setting, with 36 (92%) respondents associating statistically significantly with one of the factors. The views are described below with reference to the placement of statements in the idealized ranking of the factor (Table 3).

View 1: the strategic leader

This view contains two main aspects that the respondents find important for a medical leader. The first aspect relates to the respondents' concerns about lack of unity in the hospital. Respondents argued that every department favors its own interests over hospital-broad objectives resulting in a culture of 'conflicting islands' that in turn could jeopardize the quality of care delivery. Therefore, they want a medical leader capable of forging unity between and beyond clinical departments by participating in hospital strategy and decision making [statement (st.) 29, scored as +3**]. According to the respondents, a medical leader needs to transcend professional boundaries, connect the clinical and management domains (st. 23, 2) and pursue the interests of the hospital instead of merely the departments (st. 25, +2).

Table 3. Idealized ranking per view of the 34 statements on effective medical leadership for the full sample.

Statements	View 1 Strategic leader	View 2 Social leader	View 3 Accepted leader
Personal features			
1. Have good communication skills	1**	3*	2*
2. Be able to enthuse and motivate others	2	1	3
3. Be able to resolve conflicts	1	2**	0
4. Have the skills to manage a team	0*	1	1
5. Have the skills to manage a department	-1*	3**	0*
6. Be able to collaborate	1**	3	2
7. Have good negotiation skills	-1	1**	0
8. Be assertive	0**	1**	-1**
9. Be a team player	0**	1	1
10. Have integrity	2	2	2
11. Have an eye for quality and costs and the balance between them	1**	0	0
12. Have a clear vision and be able to convey it to others	3**	2	2
13. Be patient centered	3*	2	1
14. Be excellent in their medical discipline	-1	-1	-3**
15. Knowledge of hospital finances	0	-1	-2**
16. Knowledge of the structure and processes of the hospital	0	0	1**
17. Knowledge of the Dutch healthcare system	-1*	-2**	0*
18. Have experience in leadership	-2	0**	-2
19. Be trained in leadership	-1	1**	-1
20. Be held in high esteem by fellow physicians	-2	-3	-2
21. Consider themselves primarily a physician	-3	-2	-1**
22. Be a practicing physician	-1**	-2**	1**
Context-specific features			
23. Be able to connect the clinical and the management domains	2*	0	1
24. Focus on the interests of the hospital as a whole	2**	0**	-2**
25. Focus on the interests of the clinical departments	-2	0	-1
26. Have a clear job description of medical leadership	-2**	-1**	3**
27. Be accepted as a medical leader	-1**	-2**	3**
28. Have sufficient time to execute the leadership role and all associated tasks	1	0	1*
Activities and roles			
29. Be involved in strategy development at the hospital level	3**	-1	-1
30. Be responsible for the performance of the employees in his/her department	0	-1	-1
31. Be able to initiate improvements	1	1	0**
32. Network and make alliances outside the hospital	0*	-1	-1
33. Be responsible for the performance of their department	0	0	0
34. Be able to initiate and maintain cross-department collaborations	1**	-1**	0**

"After the hospital renovations, clinical departments turned into little islands, not hearing or seeing each other anymore. That used to be different. [...] We don't help each other out so much anymore nor do we know what is happening in other clinical departments. [...] I think this comes at the expense of being a unity as a hospital." (Surgery nurse 2)

Respondents argued that improving unity within the hospital and increasing collaboration between healthcare professionals and non-clinicians (e.g. managers, support staff, and directors) would eventually have a positive effect on the clinical departments too. Having a clear vision for a clinical department that is in line with the hospital's strategy and being able to convey it to others was therefore ranked as most important (st. 12, +3**) (st. 24, +2**). In this view the patient should always be the main priority (st. 13, +3*), although many respondents argued that this should be obvious and thus unnecessary to mention explicitly.

> *"I think that as a medical leader you should be involved in decision making and determining the strategy of the hospital. Only then can you defend and convey these choices to your department, which in turn is only possible when you have taken part in these discussions."* (Internal medicine manager 3)

The second aspect deemed important for medical leadership in this view is the importance of having strong personal skills. Most of all, a medical leader should have integrity (st. 10, +2) and be able to motivate and enthuse others (st. 2, +2). Integrity was perceived as important for gaining trust and respect. Although not ranked as the relatively most important, communication and collaboration skills were often underscored as necessary to create unity and engage others in executing their vision (st. 1, +1**) (st. 6, +1**). In contrast, the respondents ranked "be held in high esteem by fellow physicians" (st. 20, -2) as relatively less important for effective medical leadership. Respondents stated that popularity does not immediately turn someone into a good medical leader, while integrity was argued as essential for medical leaders to get things done:

> *"For example, look at Mark Rutte (Dutch prime minister). I don't think everyone admires him, but I think he's a good leader. So, respect is not connected to how you do your work. That a medical leader brings in important things for the patient or for the hospital is more important than how popular that medical leader is at work."* (Surgery nurse 4)

Respondents perceived training (st. 19, -1), work experience (st. 18, -2) and a clear job description (st. 26, -2**) as relatively unimportant for medical leadership. Respondents argued that being a medical leader is either part of your personality or not and can therefore not be taught. They stated that education or job descriptions could support a medical leader, but that strong personal skills such as being able to convey a vision to others are more important for a medical leader to possess. Additionally, professional identity in terms of a medical leader considering themselves primarily a physician (st. 21, -3) was ranked relatively unimportant for effective medical leadership. Participants felt that leadership activities and clinical work are equally important. Some even questioned whether a medical leader has to be a physician or if other healthcare professionals can execute leadership roles as well:

"A medical leader can also be someone who has not necessarily specialized as a physician." (Surgical nurse 2)

In conclusion, this view represents a strategic leader, who prioritizes the interests of the hospital over clinical department-specific interests by participating in hospital strategy and decision making. A strategic leader has a personality that reflects integrity and is not subject to status or experience. This view is represented by managers (n=8), physicians (n=5), nurses (n=3) and laboratory technicians (n=1) and explained 21% of the variance in rankings.

View 2: the social leader

The second view represents a social leader. Holders of this view regard personal skills, specifically strong communication and collaboration skills, as most important for medical leadership (st. 1, +3*) (st. 6, +3). Respondents argued that these skills enable a medical leader to manage a department effectively (st. 5, +3**) and resolve conflicts (st. 3, +2**) among department members. Moreover, by participants considered communication skills and the ability to collaborate necessary to convey a clear vision to others (st. 12, +2) and to engage others in executing their vision:

"Decision making must be transparent to all. Occasionally you have to explain very clearly why you are making a certain decision, because then people will be more likely to follow you, not always, but far more." (Surgery physician 1)

Respondents explained, however, that in terms of a formal type of medical leadership, medical managers were often not chosen for these skills but for more practical reasons, such as their availability or motivation. Consequently, medical department leaders did not always have social skills. Respondents argued that having strong ties with all the staff and knowing "what's going on" is important in preventing friction among staff and improving decision making.

The holders of this second view implied that it is more important for a medical leader to possess leadership skills than medical excellence or being a practicing physician. Respondents argued that medical leadership can only be effective when physicians fully commit to the responsibility of being a leader. In contrast to the first view – that a medical leader should balance between being a medical leader and a physician – the second view reflects a medical leader who does not consider themselves primarily a physician (st. 21, -2). According to the respondents, being a practicing physician may even stand in the way of being a good medical leader (st. 22, -2**) as it could increase the chance of favoring clinical issues, which might not benefit long-term objectives. Likewise, acceptance and being held in high esteem were considered less important in this view, as respondents believed that neither one is a premise for effective medical leadership (st. 20, -3) (st. 27, -2**):

"I think that being held in high esteem by fellow physicians has little to do with whether you are a good medical leader or not. There are also physicians who are held less high in esteem, but are very good at managing." (Surgery physician 3)

Having a medical background, however was considered a prerequisite for being a medical leader or head of a clinical department as is enables the leader to correctly interpret issues and set the right goals for the department. Yet, the respondents argued that a medical leader does not need to master specific managerial knowledge. For example specific knowledge of the Dutch health system was perceived as least important for effective medical leadership (st. 17, -2**). When a medical leader has strong social skills and can collaborate with others, any financial or policy-related information can easily be obtained if required from (non-clinical) colleagues:

"I think that basic knowledge is enough. A medical leader must of course know something about the system, must know something about finance, but it's not the most important thing in the role of medical leader. If you have the skills to listen and trust others, then you don't have to have that knowledge yourself." (Internal medicine manager 3)

In conclusion, the second view represents a social medical leader, who is known for strong collaboration and communication skills instead of medical excellence. These social skills increase the capability of the medical leader to convey their vision clearly to others. This view is held by managers (n=3), physicians (n=3) and laboratory technicians (n=3) and explained 11% of the rankings variance.

View 3: the accepted leader

The third view reflects a medical leader who is guided by a clear job description and is accepted by others in their medical leadership role (st. 27, +3**) (st. 26, +3**). Respondents holding this view felt that they, and fellow clinicians, were not always well informed about the tasks and duties of a medical leader. Ambiguity regarding the medical leadership was seen as a cause of occasional confusion and frustration inside a clinical department. Respondents said that having a clear job description of medical leadership allows the medical leader to execute tasks more efficiently and improves expectation management among clinical peers.

Again, respondents emphasized the importance of communication skills (st. 1, 2*) and the ability to enthuse and motivate others (st. 2, 3). These skills were deemed necessary to create clarity about the responsibilities of the medical leader, but even more to keep all staff informed about and engaged in (proposed) changes in department processes and care delivery. In turn, respondents argued that clarity leads to the good working atmosphere that favors staff well-being and the quality of care. Acceptance of a medical leader was said to be highly important to engage fellow clinicians (physicians and nurses) in future changes or developments. At the same time, respondents argued that physicians play a big role in

decision making and therefore peers perceived their credibility as a medical leader as key to effective leadership. Fir a medical leaders to create acceptance among clinical peers, being able to collaborate (st. 6, +2), having a clear vision and being able to convey it to others (st. 12, +2) were considered relatively important:

> *"Working together is a core value in healthcare. The medical manager happens to be the head of the department, but we all have to pull together. Otherwise you lack acceptance as a leader…You may want to go in a certain direction, but if your colleagues are not behind you, it will be hard to convey your vision."* (Internal medicine manager 2)

Similar to the second view, being held in high esteem by fellow physicians (st. 20, -2) and being excellent in their medical discipline (st. 14, -3**) were not regarded as important factors.

> *"I don't care about respect or peers holding someone in high esteem. I personally don't think it's important. I'd like everyone to treat each other with respect, regardless of whether I'm a medical manager or a radiologist."* (Radiology physician 2)
> *"You have to be good at your medical discipline and understand what others are doing. Make that you behave well. But it doesn't mean you have to be excellent. I think being a leader has a higher priority than being excellent in your discipline."* (Internal medicine nurse 4)

Likewise, leadership experience (st. 18, -2) was not considered a precondition for effective medical leadership. Rather, holders of this view perceive leadership as an innate characteristic which does not come with experience or education:

> *"Some people are just born leaders. I think you can function as an informal leader without experience. You can learn a lot, but you have to have certain personality traits if you want to be a leader. You can't learn it all; some people are no good at it by nature."* (Internal medicine nurse 2)

In a similar vein respondents argued that a medical leader should not have to possess specific knowledge that can easily be obtained from others, for example, on hospital finance (st. 15, -2**). Rather, a medical leader needs to know where they can find the required knowledge and should be able to establish valuable cooperation with others:

> *"The specific knowledge is present in the hospital, so that doesn't mean that you need to know it all yourself straight away. You can also check and review things. I think that's more like the ability to find the right people in the right place."* (Radiology manager 5)

Finally, the respondents of this view ranked "focus on the interests of the hospital as whole" (st. 24, -2**) as least important in medical leadership. This finding is in contrast to the first and second views that both made prioritizing hospital objectives as a characteristic of good medical leadership. The respondents of this third view, however, argued that a medical leader should focus on the quality and efficiency of one clinical department first:

> *"If your own field does not function properly, the entire hospital cannot function properly either."* (Internal medicine nurse 4)

In conclusion, the third view represents a medical leader who is accepted among peers. The proper execution of medical leadership requires a clear job description. This view is represented by managers (n=2), physicians (n=2) and nurses (n=5) and explained 12% of the variance in rankings.

Differences and similarities between the three views

We observed three remarkable differences between the three views. The first distinction concerns the prioritization of either hospital or department interests. The medical leader in view 1 conveys a hospital-wide vision to overcome fragmentation and increase unity while the medical leader in view 3 prioritizes the interests of their own clinical department, arguing that the performance of individual clinical departments is a premise for the performance of a hospital as a whole. Second, the importance of peer acceptance was perceived differently. In view 3, respondents argued that peer acceptance is key for medical leadership as without acceptance a medical leader would be unable to engage others in executing their vision. In contrast, in view 2 respondents interpreted peer acceptance as a basic principle of collegiality, related to trust and respect, and was not regarded as a guarantee for successful leadership. Third, view 2 states that a medical leader should prioritize the duties of leadership over clinical work, while view 1 values leadership and clinical responsibilities equally. Similarly, being a practicing physician was ranked as relatively unimportant in view 2, whereas respondents in views 1 and 3 were more neutral toward this statement.

All three views ranked personal features as relatively important for medical leadership. Specifically, strong communication skills, collaboration skills, integrity and having a vision and being able to convey this to others were ranked as most important for a medical leader to possess. There were small differences for other personal features as relatively important. Views 1 and 3 prioritized being able to enthuse and motivate others, while view 2 perceived resolving conflicts and possessing management skills as more important. With regard to what respondents perceived as relatively unimportant, all interviewees agreed that being held in high esteem by fellow physicians, leadership experience, considering yourself primarily a physician and mastering specific managerial knowledge were the least important factors. All views stated that peer approval, or popularity, does not immediately turn a physician into a good medical leader and was thus not regarded as a premise for medical leadership.

Concerning leadership experience, the respondents argued that being a good leader is often an innate part of your character and does not come from years of experience. Considering yourself primarily a physician was perceived as unimportant in all three views. However, the interpretation of the statement differed between the first two views. Whereas view 1 felt that a medical leader should balance between being a leader and a physician, view 2 stated that a medical leader can only be effective when prioritizing leadership-related work. All respondents ranked possessing managerial knowledge as relatively unimportant because this could easily be obtained from (non-clinical) colleagues. Finally, we found no differences in views between different professionals or departments as all views were defined by a mixture of the departments and healthcare professionals and managers.

Discussion

This study distinguished three views of healthcare professionals and managers on what is most important for medical leadership in a hospital. The first view represents a strategic leader who prioritizes the interests of the hospital by participating in hospital strategy and decision making. Holders of this view argue that this type of leadership is needed in hospitals to create more unity between clinicians and non-clinicians in favor of quality and efficiency of care. The second view describes a social leader who has strong collaborative and communication skills. Respondents holding this view state that social skills are a premise for efficiently leading a clinical department and engaging all staff in creating a shared vision. The third view reflects an accepted leader who is guided by a clear job description. Peer acceptance and clarity concerning the responsibilities of a medical leader were considered necessary to engage fellow staff in decision making and change processes. Despite their differences, all participants agreed upon the importance of personal skills, specifically communication skills, collaboration skills, integrity and having a vision and being able to convey this to others. All interviewees perceived being held in high esteem by fellow physicians, leadership experience, considering yourself primarily a physician and mastering specific managerial knowledge the least important factors for medical leadership.

The findings are in line with previous studies on medical leadership. In specific, scholars often underscore the importance of communication skills (Buchanan et al. 1997; Dawson et al. 1995; Dedman et al. 2011; Dine et al. 2011; Holmboe et al. 2003; Hopkins et al. 2015; Taylor et al. 2008; Thorne 1997; Williams 2001; Witman et al. 2011) and collaboration skills (Buchanan et al. 1997; Dawson et al. 1995; Dedman et al. 2011; Holmboe et al. 2003; Kippist & Fitzgerald 2009; Palmer et al. 2008; Robinson et al. 2013). Having a clear vision (Buchanan et al. 1997; Dine et al. 2011; Palmer et al. 2008; Taylor et al. 2008; Williams 2001) and integrity (Dine et al. 2011; Hopkins et al. 2015; Palmer et al. 2008; Robinson et al. 2013) were also emphasized as important in literature, however, mentioned less often. Statements that were ranked as important by participants, but were not statistically significant were nonetheless

found in literature to be important: connecting the clinical and management domain (view 1: Buchanan et al. 1997; Dawson et al. 1995; Holmboe et al. 2003; Kippist and Fitzgerald 2009; Llewellyn 2001; Opdahl Mo 2008; Thorne 1997; Witman et al. 2011) pursuing the interests of the hospital (view 1: Dawson et al. 1995; Dedman et al. 2011; Taylor et al. 2008; Thorne 1997) and being able to motivate and enthuse others (view 1 and 3: Dedman et al. 2011; Dine et al. 2011; Holmboe et al. 2003; Hopkins et al. 2015; Palmer et al. 2008; Robinson et al. 2013; Thorne 1997; Williams 2001).

Our findings are furthermore in line with a recent stream of literature that shows that professionals are increasingly engaged in healthcare improvement and organizational issues (Evetts 2009; McGivern et al. 2015; Noordegraaf 2007; et al. 2011; Voogt et al. 2016). Adhering to the notion of 'organized professionalism', social scientists are moving beyond the assumption that professionalism and managerialism are intrinsically conflicting and argue instead that these can co-exist (Evetts 2009; Noordegraaf 2007; et al. 2011; 2016; Olakivi & Niska 2016; Postma et al. 2014). In a similar vein, medical leadership is seen as a key element in dealing simultaneously with pressures for increasing efficiency and quality of care (Noordegraaf et al. 2016; West et al. 2015). Likewise, our findings showed that healthcare professionals and managers support the involvement of physicians, and arguably other healthcare professionals, in leadership roles and managerial activities. The respondents, both clinical professionals and managers, underscored the necessity of transcending clinical and departmental borders [view 1] to stimulate hospital unity and multidisciplinary collaboration between (non) clinicians [view 1, 2 and 3]. To what extent physicians should prioritize leadership-related duties over clinical work was, however, perceived differently by the respondents. View 1 stated that clinical work and medical leadership are of equal importance, while view 2 argued that medical leadership can only be effective when the physician fully commits themselves to the responsibilities of being a leader. View 3 was represented by respondents who were less familiar with medical leadership and therefore perceived clarity about the role as relatively most important.

Previous studies show that being held in high esteem by fellow physicians and identifying as primarily a physician are significant for being a medical leader (Andersson 2015; Buchanan et al. 1997; Dedman et al. 2011; Llewellyn 2001; Opdahl Mo 2008; Thorne 1997; Witman et al. 2011). Scholars have shown that this is important to prevent peers from interpreting medical leaders as 'agents of government to control the expert power of the professional' (Oni 1995). Interestingly, the results of our study suggest the opposite, as healthcare professionals and managers rated both features as relatively unimportant. Instead, respondents representing the first view argued that a medical leader should create unity between physicians and managers and prioritize hospital-wide objectives over department-specific ones. The second view even argued that a medical leader should fully commit to leadership-related duties to decrease the chance of favoring clinical issues, which not always benefits the long-term objectives. In conclusion, all respondents stated that popularity does not immediately turn someone into a good medical leader, while integrity (view 1), prioritization of leadership (view 2) and acceptance (3) were argued as necessary for medical leaders in order to get things

done. Although these findings are contrary to previous studies on medical leadership and management, recent studies on the topic show similar results. Studies among both mid-career physicians and medical students show the increasing willingness of physicians to engage in healthcare improvement and organizational issues through medical leadership (Berghout et al. 2018; Gordon et al. 2015; Kyratsis et al. 2017; McGivern et al. 2015; Noordegraaf et al. 2016; Reay et al. 2017; Stoller 2009; Voogt et al. 2016).

The final remarkable outcome of our study was the low ranking of facilitating factors such as leadership experience and training. Previous research has, however, extensively described the need for training and experience in medical leadership among medical physicians and students (Berghout et al. 2017; Blumenthal et al. 2012; Dawson et al. 1995). Current physicians in leadership argue that lack of training and experience lead to insecurity, stress, and frustration and hinder them from performing their role effectively (Andersson 2015; Berghout et al. 2017; Kippist & Fitzgerald 2009; Sonsale & Bharamgoudar 2017). Likewise, medical students advocate for the incorporation of leadership and management training in medical curricula as they feel that their current training program does not prepare them properly for their future medical careers (Blumenthal et al. 2012; Gordon et al. 2015; Saravo et al. 2017; Stoller 2009). Our distinctive finding could be explained by the fact that our respondents argued that effective medical leadership is innate and depends on a person's character and not on experience and training. Important to note here is the fact that these features were ranked least important in this study does not mean that the respondents felt they had no value whatsoever. The design of the study required the respondents to arrange the factors in order of relative importance.

We found no differences in views between different professionals or departments as all views were defined by a mixture of the departments, healthcare professionals and managers. Based on our findings, we suggest that what healthcare professionals and managers deem important for medical leadership is not determined by their professional background or specialism. However, most of the nurses we interviewed argued that medical leaders do not have to be a physician per se, as long as they have a medical background. This argument is underlined by several scholars, who plead for nursing leadership by showing its importance (Manojlovich 2005; Murray et al. 2018; Scully 2015) and the ability of nurses to fulfill similar leadership roles (Wong and Cummings 2007).

Limitations

This study has four limitations. First, the set of statements was developed from English literature reviews and translated into Dutch. A previous study showed that English and Dutch speakers vary in how strongly they use various syntactic cues to interpret sentences, like prepositions or word order (McDonald 1987). Therefore it can be argued that statements could be interpreted differently in various settings, for example "be held in high esteem by fellow physicians" and "be accepted as a medical leader". However, we believe that this limitation is restricted as the pilot study did not show reason for doubt. Second, the perceptions of

medical leadership can be influenced by the short introduction to medical leadership before the ranking. The role of medical leader was explained in two ways, as an informal or a formal role. As the clinical departments of the hospital where our inquiry took place are guided by medical managers (formal medical leadership role) it is not clear whether the respondents interpreted medical leaders as formal leaders, their medical manager, or informal leaders, which could be any physician. Third, our sample came from three departments of one general hospital that is already focused on medical leadership and provides training in medical leadership, which possibly makes our findings not generalizable to other clinical departments or hospitals. Although we found no specific differences in views on medical leadership among the three clinical departments, it could be that certain departments encounter different medical and organizational issues that ask for a different medical leader as suggested in a study by Meretoja et al. (2004). We thus recommend replication of this study among healthcare professionals and managers in different settings to confirm if these views are applicable to other clinical departments (e.g. gynecology, oncology), types of hospitals (e.g. teaching hospitals) or even other countries. Finally, during the data collection the respondents were asked whether they felt the statement set was complete or if there were any factors lacking. A minority of the respondents mentioned a few additional factors, which they linked to medical leadership: approachability of a medical leader, remuneration for the time a medical leader spends on additional tasks, and listening to others. During the initial development of the statement set we did not include these factors as they were not or scarcely mentioned in literature (Berghout et al. 2017), neither were they mentioned during the pilot study. We do not claim that the statement set includes all factors related to medical leadership. The factors most often mentioned in literature are however represented in the statement set.

Implications

Our findings translate into one scientific and two practical implications. The scientific implication is that this study increases conceptual clarity about medical leadership by investigating the relative importance of factors that are related to it. We thereby respond to increased callings in literature and practice for more conceptual clarity (Andersson 2015; Berghout et al. 2017; Blumenthal et al. 2012). Future studies could examine how current or future medical leaders develop themselves as one, or a mixture, of these types of leaders (strategic, social, or accepted) and how these types of leadership influence quality and efficiency of care. The first practical implication is that our findings can be used to improve medical education and leadership programs. Based on our findings, medical curricula, hospital training for medical managers and leaders and medical leadership development programs should focus more on personal development, specifically communication skills, collaboration skills, having a clear vision and being able to convey it to others, and resolving conflicts. These factors are deemed more important than, for example, merely focusing on financial and management skills or knowledge of healthcare systems (Chen 2018; Dath & Chan 2015). This outcome is also emphasized in the well-known CanMEDS framework that recently replaced the physician's core

value 'manager' with 'leader' (Dath & Chan 2015). The second practical implication is that the results of this study could contribute to the professionalization of recruiting medical managers (or 'clinical directors') in hospitals. In selecting medical managers, hospitals should move the focus from physicians who are held in high esteem by peers or are known for their medical excellence, to physicians with strong interpersonal skills in communication and collaboration, and who have a strong vision and are able to convey it to others. This could arguably lead to increased effective medical leadership as the respondents of this study argue that current medical leaders, in this case medical managers, do not always seem 'fit for the job'.

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5

Performing the medical manager-self: balancing credibility

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Abstract

Hospital-based physicians increasingly participate in management roles in addition to clinical practice. Credibility among medical peers is perceived most important to perform effectively, yet how medical managers aim to construct a credible performance in the eye of others remains unknown. Informed by Erving Goffman's work on the 'presentation of self' we investigated in this study how medical managers construct and perform their manager-self and balance credibility towards others. Using ethnographic methods, six physician-medical managers were shadowed in their daily work. The results show that the medical managers constructed four distinctive performances of the self in interaction with others: a comfortable self, an uncertain self, a political self, and a mediator self. Credibility was not merely achieved by showing commitment to clinical work, as previous studies suggest. Instead, credibility was increasingly based on their ability to represent departmental interests, acquire approval for business cases, reason from cost-effectiveness arguments and align to hospital governance objectives. The results imply that sources of credibility and the audience of their performances have shifted substantially, which require medical managers to acquire different skills and knowledge. Finally, we contribute an alternative understanding of credibility: as a state of doing - 'credibility work' - instead of being.

Introduction

Hospital-based physicians increasingly participate in formal management roles as 'medical manager', 'medical director' or clinical director' in addition to their clinical work (Kirkpatrick et al. 2005). These roles are developed worldwide in an effort to engage physicians in contemporary policy objectives of cost containment and performance management. Medical managers[1] can be defined as physicians who are assigned with managerial responsibilities on top of their clinical work, for example, as head of clinical units or departments. Scholars often conceptualize medical managers as spatially situated in-between 'management' and 'medicine'. As such, medical managers are expected to think and act from both managerial and clinical perspectives in order to align managerial (e.g. performance targets and cost-efficiency) and clinical (e.g. quality of care and patient-centeredness) values (Llewellyn 2001; Witman et al. 2011). Physicians are said to be the ideal boundary-spanners as they, rather than non-clinical managers, would be able to steer fellow peers in adapting to the 'new' hospital objectives (Snell et al. 2011). Despite these high expectations, in practice, medical managers often experience their new role as a struggle (Berghout et al. 2017; Bresnen et al. 2019; Correia & Denis 2016; Numerato et al. 2012; Sartirana et al. 2018).

1 We will use the term medical managers throughout the article to denote physicians in formal management roles as head of their medical department

First, many physicians perceive medical management as an undesired role, causing extensive stress and frustration, a 'duty' that 'someone has to do' or even as a threat to their medical career (Kippist & Fitzgerald 2009; Llewellyn 2001). Second, medical managers experience significant difficulties in balancing managerial and professional objectives (e.g. quality versus efficiency) (Witman et al. 2011). Third, medical managers have often used their role to influence decision making in favor of their own purposes (e.g. safeguarding departmental budgets) over broader hospital objectives (Llewellyn 2001; Spyridonidis et al. 2015; Quinn & Perelli 2016). Fourth, assigning physicians with managerial responsibilities, was primarily underpinned by the assumption that physicians are better able to influence their peers than non-clinicians based on their medical background and exclusive membership of 'the clan' (Andersson 2015). However, medical managers often perceive influencing their peers as extremely difficult due to a lack of formal power (over peers) (Berghout et al. 2017; Kitchener 2000; Llewellyn 2001; Thorne 1997; Witman et al. 2011).

One of the most important factors described in literature for medical managers to perform effectively – that is having influence in decision making, and being able to serve multiple interests such as quality, efficiency and safety of care – is their ability to construct a *credible self* in the eye of their medical peers (Andersson 2015; Berghout et al. 2017; Llewellyn 2001; Witman et al 2011). Credibility is said to be derived from being an 'excellent doctor': i.e. full dedication to patient care, collegial disposition and showing peers that they prioritize clinical objectives over 'managerial' objectives (Berghout et al. 2017; Llewellyn 2001; Witman et al. 2011). Constructing a credible self is said to be important for medical managers because they need to show their peers that they can be believed and trusted. Many studies argue that if medical managers are able to construct a credible self, it would enable them to fully enact their new role and have influence in decision making (Andersson 2015; Witman et al. 2011).

Yet, so far we lack detailed insights into how medical managers interpret and construct their performance as a medical manager. To better grasp the complexity of daily hospital management and understand physician's responses to their medical manager role, it is important to investigate *how* medical managers aim to construct a credible performance of the self. We build on Irving Goffman's work on 'the presentation of self' (1956, reprint 1978) to investigate medical manager performances and the resources that constitute these credible performances. For the purpose of this study, we performed an ethnographic study by shadowing six hospital-based medical managers. Most evidence on medical managers stems from interview-data (a notable exception is Witman et al. 2011), yet shadowing offers a unique opportunity to study the complexities of every day (organizational) life, thereby enabling us to study the daily practices of medical managers in-depth.

The medical manager performance: beyond hybridity

Research investigating physicians in managerial roles, and likewise the influence of management on medical professionalism, can be broadly divided into three phases. Initially, scholars have repeatedly underscored the dualism and conflict between management and profession-

alism (Doolin 2002; Fitzgerald 1994; Hunter 1992; Kitchener 2000; Llewellyn 2001). Embarking on this assumption of an existing 'divide', scholars have shown how medical managers used their role to increase their power and influence in decision making to favor clinical rather than managerial objectives. Having a voice in finance for example, could enable medical managers to steer and control resource allocation (Llewellyn 2001). Likewise, involvement in hospital strategy and decision making can be a way to safeguard medical staff's interests (Quinn & Perelli 2016; Spyridonidis et al. 2015). These studies have demonstrated that medical manager's power is derived from their ability to construct a credible *self* as medical manager in the eyes of their medical peers. Credibility, in turn, is said to be obtained through medical excellence, commitment to clinical work, collegial disposition and preventing to act too '*managerial*' (Andersson 2015; Berghout et al. 2017; Llewellyn 2001; Spehar et al. 2015; Witman et al. 2011).

By introducing the notion of 'hybridity', scholars have tended to move beyond dualistic notions of professionals versus managers by showing how professionals are increasingly becoming more *managerialized* (Denis et al. 2015; McGivern et al. 2015; Noordegraaf 2007; Numerato et al. 2012). In their acts to protect medicine from managerial interference, professionals in fact renegotiate jurisdictional boundaries and reorganize clinical work by using managerial discourse and incorporating managerial approaches in daily practices (Iedema et al. 2004; Numerato et al. 2012; Waring 2007). Some have even shown how professionals willingly engage in hybrid roles in order to challenge 'old' professional values (such as hierarchy and strong socialization) (McGivern et al. 2015). These hybrids encourage their peers to involve themselves in standardization, regulation, or audits as they argue they improve rather than harm quality of care (ibid.). This stream of literature thus aimed to show that professionals engaged in 'managerial' roles have developed blended roles and ways of working in which they commit to both professional and managerial objectives.

Despite different findings, both streams have in common that they remain positioned within the 'professionals versus managers' dilemma. Medical manager selves are portrayed as either against management (negative) or adaptive to (or even in favor of) management (positive). Very recent studies argue that these conceptualizations do not capture the complexity of identity processes, which physicians undergo when moving into managerial roles (Bresnen et al. 2019; Denis et al. 2015; Numerato et al. 2012; Sartirana et al. 2018). In addition to understanding professional's responses to management, these studies recommend future researchers to investigate 'agency and social interaction processes' (Denis et al. 2015: 285) that steer medical manager performances, thereby letting go of a-priori constructed 'divides' between management and professionals.

In this paper we take up these suggestions by using Goffman's dramaturgical framework of performances of the self. This framework is particularly suitable to investigate the social construction of identity. We contribute to this literature an investigation of how medical managers construct the performance of their 'managerial' self and navigate their credibility within these constructions. To do so, we shadowed medical managers in the Netherlands, a context, similar to other Western countries, of changing healthcare policy and organizational demands.

Goffman: the performance of the self

To investigate how the medical manager-self is constructed and performed in daily practices we use Erving Goffman's dramaturgical framework to investigate performances of *the self*. Using the metaphor of the theatre, Goffman analysed daily social interactions, described in his 1956 book 'The Presentation of the Self in Everyday Life'. In this book, Goffman shows that the self is not a static actor following predetermined directions, but a flexibly constructed character. The aim is to present a credible self to others. Important to note is that Goffman showed that one can construct different selves depending on the audience and issue at stake. By using the metaphors of a *back and front stage*, Goffman shows how the self, *as a performed character*, comes into being. The front stage region is where the actual performance is enacted in order to convince the audience of an idealized self. In contract, backstage is 'hidden' from the audience, enabling the performer to relax and prepare their front stage performance. The front stage performance is prepared by developing a script or 'plot' that suggests how the actor should behave or act in a certain situation and determines what to bring to the fore *and what not* in order to convince the audience. If needed, other actors are casted to join the performance or explicitly excluded from it if they do not add to a credible performance. Finally, resources can be used (i.e. symbols, materials clothing or language deemed appropriate in a certain context) in support of the performance. Hence, the performance is carefully prepared by using impression management techniques and adjusted to meet the assumed normative requirements of their roles according to the audience to avoid public failures, humiliation or losing face (Goffman 1967; see also Bourgoin & Harvey 2018). A performance, Goffman thus defines as "*all the activity of a given participant on a given occasion which serves to influence in any way any of the other participants" (1956:15).*

By analyzing how actors are aiming to construct a credible self, one can investigate how actors position themselves towards others. The construction of a credible self can thus be understood as the 'alignment of communication between the speaker and the hearer' (Marks 2012). This means that based on one's basic understanding of the self and the self in relation to the other, one chooses certain words, clothes, and ways of acting that is appropriate in an encounter with the other. Goffman argues that one adapts the way /she speaks, behaves, acts, listens etc. based on her/his understanding of the self in relation to others. People thus bring into interactions, Goffman argues, certain frames, cultural backgrounds, beliefs or behavior, which steers how someone communicates with others.

Although Goffman's perspective focuses on the construction and presentation of the *self* by an individual, it does not grant the audience the role of a passive recipient (Goffman 1956; Sinha 2010). The role of the audience is to question the presentation of the self (e.g. is it legitimate, appropriate, convincing, does it meet the demands of the audience). By doing so, the self and the audience co-construct the performance. As Sinha (2010: 191) argues: "dramatism offers a dialectic form of inquiry" and likewise "the researcher must assume an egalitarian form of interaction" (p.193). In contrast to what Goffman's distinction between back –and front stage might suggest, we agree with scholars who understand the self as

something that is shaped by individual's behavior, *and* through social interaction (Sinha 2010; Jacobsen & Kristiansen 2014:113). Selves are thus not prepared a-priori in isolation and then delivered to an audience. Rather, social performances are the sites of the construction in which others are equally part of.

The dramaturgical perspective and accompanying symbolic-interactional methodologies have provided many insights into the socialization of professionals (Bourgoin & Harvey 2018) and in specific medical students (Becker et al. 1962; Haas & Shaffir 1977; 1982). Haas and Shaffir (1982) have for example investigated how professional socialization among medical students occurs in transitioning into a physician. It is well-known that socialization and specifically credibility and 'image' is highly important among professionals, such as physicians, when they engage in new roles (Ibarra 1999). Haas and Shaffir (1977; 1982) illustrated how medical students used status symbols, i.e. surgical tools or white coats, the 'rights' medical language or imitation tactics (Bourgoin & Harvey 2018: 1632) in the process of their socialization in becoming physicians. Yet, the dramaturgical framework has – to our knowledge – not been used to investigate how physicians aim to construct credible performances when entering in new, or arguably 'threatening' roles such as medical management during later stages of their career. Medical managers are increasingly urged to collaborate with 'new' actors, i.e. other (non) clinical actors and in 'new' contexts, i.e. changing organizational and clinical demands, where 'different' behaviour and language is appropriate (Llewellyn 2001; Witman et al. 2011). This arguably requires medical managers – and physicians in general – to use other sources of credibility in addition to showing commitment to clinical work and which transcend their professional jurisdictional domain (see Abbott 1988; Becker et al. 1961; Freidson 2001; Haas & Shaffir 1982). Therefore, we argue that it is highly relevant to use the dramaturgical framework for our aim to study how medical managers construct a credible self.

Methods

Research context and setting

The study is located in a general district hospital in the Netherlands. Similar to other Western countries, the Dutch healthcare sector is increasingly guided by market and business logics aiming at cost containment and performance management (Scholten et al. 2019). In the mid 90's Dutch hospitals introduced the role of medical management. The term 'medical management' in the Netherlands refers to practicing physicians who are part-time responsible for the clinical and financial performance of their clinical department. This is similar to for example NHS 'clinical directors' (Kitchener 2000) although they are responsible for a clinical *directorate* which is usually a conglomeration of multiple similar clinical departments.

The hospital where our inquiry took place is characterized by a dual and decentralized governance structure. Medical managers work together with business managers to ensure the clinical and financial performance of the clinical departments. The role of medical manag-

ers in this specific hospital could be described as partially ambiguous as there does not exist a formal job description nor performance evaluation system. Broadly formulated, the medical manager is responsible for the departments' clinical and financial performance together with the administrative manager and team head. This setting provides a particular interesting setting to study the performances of medical managers, as a lack of clear responsibilities for medical managers allows for multiple interpretations and sense making of the medical manager self. The lack of a clear 'script' for professionals in management is reported by research conducted globally (Kippist & Fitzgerald 2009; Scholten et al. 2019; Spehar et al. 2015; Spyridonidis et al. 2015; Quinn & Perelli 2011) and therefore our case provides a representative setting to study this matter.

Data collection

We conducted an ethnographic study of hospital-based medical managers, which enabled us to study in-situ how medical managers actively constructed their medical manager-self/performance and how, in these performances and interaction with others (e.g. medical peers, directors and managers) credibility is navigated. The main data collection was shadowing, an observation technique particularly suitable for our purpose to scrutinize the social constructions of the self. In shadowing a person, following her/him everywhere s/he goes and by 'just being around' the researcher retrieves a close view on the complexities of daily organizational life including its social and material interactions (Ybema et al. 2009).

The first researcher shadowed six medical managers (three women, three men) working at the departments of geriatrics, psychiatry, internal medicine, radiology, dermatology and ear-nose-throat. These specific departments were chosen based on the following criteria: size of the department in terms of personnel, beds and patient consultations and type of care delivered (general medicine, mental healthcare, surgical, imaging). The variation in our sample was purposely chosen as it allowed us to study, if present, multiple and possibly contrasting performances and constructions of the medical manager self.

Each medical manager was shadowed for three to four days (between 6 – 10 hours per day). These were 'average' days, according to our medical managers, and consisted of both clinical work such as patient consultations and surgeries, as well as department meetings, managerial meetings with business managers or the board of directors, lunches, informal chats with colleagues, reading e-mails or making phone calls. Additional observations were conducted at meetings or gatherings that were deemed important to study, e.g. strategy meetings, as part of theoretical sampling (Bowen 2006). During shadowing informal interviews were conducted with the medical managers and their colleagues to get a deeper understanding of how they made sense of their medical manager self and to retrieve clarifications of specific interactions that had just happened during meetings or informal chats.

During shadowing and observations extensive field notes were taken using a notebook or iPad and elaborated the same day or the next day. In total, the data consists of 160 hours of observations, resulting in around 400 pages of field notes and transcripts of recorded meet-

ings or informal interviews. To ensure data triangulation, we triangulated observations and interviews with organizational documents to deepen our understanding of our study context, such as minutes of meetings, hospital vision documents or documents our medical managers created (e.g. a formal job description for medical managers). All data were collected between December 2016 and March 2018.

Data analysis

We followed a dramaturgical approach using Erving Goffman's metaphor of the theatre to analyze the daily practices of six medical managers. We started the analysis with extensive readings of all the fieldnotes. Within this phase we aimed to explore how physicians interpreted their role as medical manager and made sense of their medical manager-self. We identified four different performances of the medical manager self among the six shadowed medical managers: the performance of the comfortable self, the uncertain self, the political self and the mediator self. Each performance represented a different construction and interpretation of the medical-manager self. Important to note is that these are not behavioural types inherent to one person. Rather, one person could switch between different selves depending on the audience or issue at stake. Yet, the data showed that each medical manager holds a preferable script to which s/he is likely to stick.

During the second phase of analysis we aimed to make sense of the four different performances of 'selves' and the ongoing co-construction of these performances with others, i.e. clinical peers, financial and business managers or hospital directors. We deductively coded the interview data along Goffman's performance lines: credibility, scripting, audience, cast, resources (which we understood as discursive, material or symbolical) and credibility. The 'script' reflected the interpretation of a medical managers regarding her/his role and responsibilities as medical manager self and determined how one should behave or communicate in a given situation to convince a certain audience of a credible performance. The 'audience' reflected the actor(s) for whom the script was performed and whom had to be convinced of a credible presentation of the self. The 'cast' represented other actors that were strategically drawn into the performance to increase its credibility. 'Resources' reflected certain language, behavior or material (i.e. clothes or attributes) that contributed to the credibility of a performance. Finally, we contribute an alternative understanding of credibility as a relational, situated accomplishment that, if it is to be accomplished, happens in everyday and routine interactions.

Credibility has traditionally been approached as a psychological construct predicated on the relationship between trustworthiness and competence (Hovland et al. 1953). In such research credibility is assumed to be a characteristic or something one can possess (or not) that can be measured and co-related with other organisational dimensions such as cynicism (Kim et al. 2009) or leader effectiveness (Kouzes and Posner 2003; 2005). Our research departs from such a research tradition to explore credibility as a process co-constructed between organisational actors and situated across time and space or what Goffman termed 'the production of credibility' (Manning 2000). We would argue that approaching credibility in

such a way offers the promise of demystifying a construct that, despite its disaggregation in multi dimension and multi variable relationships, offers few handles on how to develop and enact in an active way. In typical social constructionist fashion we then approach credibility, not as a state of being, but as 'doing'.

We used two types of data to analyse the constructions of credible selves. The observational data was used to investigate in-action how actors aimed to present themselves to others and how these others (audience of the performance) reacted towards this presentation. As we did not interview 'others' on how they perceived the performances of the medical managers, the confirmation of a performance's credibility was thus determined indirectly. Yet, it is important to note that we analyzed how medical managers aimed to construct a credible self – and not to what extent others regarded them as credible. Second, the interview data – informal interviews with the medical managers – was used to further analyze how each medical managers interprets the self and aimed to construct a credible performance towards others. The results section shows how each of the four performances of the self is constructed.

Performance of a comfortable self

The first performance reflects the performance of a comfortable self as medical manager. The comfortable self reflects a visionary physician who sees it as his/her personal mission to increase the hospital's quality and efficiency of care in collaboration with others. Within this vision, medical management is considered a means to achieve these objectives and perceived as a natural and logical *mask* to wear. The performance of the medical manager self is broadly interpreted including multiple scripts for multiple plays expanding 'ordinary' responsibilities for departmental issues, such as quality of care, finance, human resources and chairing department meetings. Credibility among others comes natural and confirmation to be this self further stimulates the performance.

Although medical managers interpret medical management as a distinctive 'role' in addition to their clinical physician being, the comfortable self does not easily classify responsibilities as either managerial or clinical. 'Managerial' work is interpreted as an inherent part of being a physician and likewise management and clinical work intertwine with each other as the following fieldnotes of an observation illustrate:

> *Peter*[2] *explains that his responsibilities as a medical manager are not easily classified as either managerial or clinical. When checking his e-mail, Peter explains to me whether something is a medical management task or not. Sometimes he doubts. He would first say a task is managerial and later would say it isn't, for example his advisory role for the medical cooperation or chairing numerous committees.* [Fieldnotes 23 February 2017].

2 We used pseudonyms for study participants

The fieldnotes illustrate the fluidity of tasks, and arguably this self does not need a distinctive *mask* to carry out the performance.

The script of the comfortable self is to engage others in adopting a vision of increasing quality and efficiency of care and multi-disciplinary collaboration. The script thus expands the borders of the own medical department. The medical manager of psychiatry, for example, uses his medical manager role for a broader cause: responsibilizing physicians into pro-active team-players who feel responsible for more than 'just' clinical work, such as cost –and organizational issues. Therefore, he is developing a new leadership development program for healthcare professionals and aims to script the performance of others. The following excerpt from an observation illustrates a *frontstage* performance of the comfortable self. The observation stems from a meeting with one of the board directors and a policy officer regarding the development of a new leadership program:

> *Peter: "So we have been thinking about a new medical leadership program..... in regard of the hospital's current strategy, and also, I believe it was in a former meeting with you [director], we agreed upon broadening the program a bit."*
> *Director: "That's [strategy sessions] where leadership emerged as one of the hospital's spearheads."*
> *Peter: "Yes, yes! Well, then I think that the program could be a part of its kick-off". "Yes, yes... we do have to make that step at some point I think, you agree? [silence]"*
> *Director: "I think that it would be very good, considering the challenge to institutionalize leadership in our organization."*
> *Peter: "Yes."*
> *Director: "We could indeed put physicians central, but others as well, nurses... and."*
> *Peter: "You actually touch upon an organizational shift, I mean, you wanted to equip physicians in leadership roles, but now you are actually saying, in line with the new strategy, no, we want all employees... everyone's commitment, broadening the movement, well at least that's what I was thinking..."*
> *Director: "Yes... [...] I absolutely see the added value of a pro-active attitude from the healthcare professionals. A new leadership program should further facilitate and safeguard these aims. However, for me the question remains how to serve everyone's specific training needs."*
> *Peter: "I think it fits very well with the hospital's vision that leadership is required from everyone in this organisation."* [Observations 13 September 2017]

This performance can be seen as an act to responsibilize hospital-professionals into accountable and pro-active actors who are committed to the hospital's ambitions. By developing a new leadership program, which is inclusive for *all* employees instead of keeping it exclusive for physicians, this medical manager aims to blur professional borders *and stage* the performance of others. By embarking on the hospital's strategy, constantly checking his audience

for confirmation, using similar discourse ('movement', 'strategy') and switching from speaking in 'I' to 'we' terms, he slowly transforms his audience into co-actors of his performance/play. The performance shows a comfortable self who easily draws on the appropriate resources (language, framing). By articulating a 'rational' and presumably attractive vision of how to construct 'responsible and committed clinicians' and adapting his vision to the demands of the audience (the hospital's director) he further supports and ensures a credible and convincing performance in the eyes of the audience.

As the above shows, the performance of the medical manager is not an individualistic act. Rather, others are actively invited to join the performance and to participate. *Casting* actors is dependent on the knowledge an actor possesses that is needed for a certain performance. The medical manager of psychiatry for example, seeks help from a financial manager in writing a business case to hire a new psychiatrist, or in developing leadership and medical management training he collaborates with the hospital director and a policy officer.

Confirmation by others appeared to be an important resource for being a comfortable self, allowing for comfortability and stimulating motivation, as one medical manager argues when he explains how he became a medical manager: *"After following a leadership program in the hospital I started to fulfil more managerial roles (i.e. advisor medical staff board). I noticed that I liked it and that I received positive feedback from others: people thought I was a suitable leader, which further motivated me to move into more organizational roles."* [Informal interview 16 January 2017] His explanation shows that acknowledgement of an effective performance by others seems to motivate this medical manager to further adopt additional managerial tasks.

Performance of an uncertain self

The second performance illustrates the performance of an uncertain self, who is performing a far from fun play. This self interprets medical management as an unwanted duty which must be done nevertheless. The uncertain self has a narrow script for the medical manager role, hoping to offload or at least share some managerial responsibilities with others. Discomfort stems from a lack of perceived 'necessary' resources to perform the medical manager self: e.g. time, a clear script and financial knowledge.

The script for this performance is based on technocratic and narrow understandings of 'management': informing colleagues about attended managerial meetings, making work schedules, and writing business cases to receive more budget for personnel or materials. One medical manager describes her role as 'nothing special' and not very distinctive to what others do: *"I for example write the department's year overview, it is not really much than that actually. It is a small department and everyone has his or her own tasks and projects."* [Informal interview 19 December 2016.] As the quote shows, this medical manager is downplaying her performance, thereby constructing the uncertain self. Downplaying the medical manager performance seems a way of coping with her disappointment of being a medical manager. She explains that what she initially intended to do as medical manager failed, now hoping that she can get rid of the job sooner rather than later: *"I was really motivated you know… I hoped that*

I could structure and organize processes differently, more efficiently, because no one else does it… However, I am just too busy to do it. I'd really like to pass the job to someone else now…" [Informal interview 19 December 2016]. Discomfort and a negative 'image' of the medical management performance is further constructed by others. Peers for example confirm the 'not fun part' of the performance by arguing that they "*wouldn't like it [medical management] at all*", or that "*If you do managerial tasks you never go home early*." [Observations 20 December 2016].

The uncertain self interprets the business manager, who is financially responsible for the department, as an important *audience* of the performance. The uncertain self argues that the business manager is responsible for financial and organizational issues and needs her/his approval for business cases. The following interaction shows a *frontstage* performance of a meeting between the medical and business manager. The medical manager tries to convince the business manager of the necessity of a budget allocation to educate a new nurse. The interaction illustrates how discomfort is constructed within this performance as the medical manager fails to convince her audience because she does not mobilize the right financial resources:

> *Anna (A): "Any news on the budget for educating a new geriatrics nurse?*
> *Business manager (BM): "There is no budget at this moment."*
> *A: "We really need more people. For example at cardiology, people just don't know how to treat frail elderly and we really feel that they call us when things already have been escalated. So we want someone of us to join the multi-disciplinary meetings."*
> *BM: "And that expertise really has to come from geriatrics?*
> *A: "Look the advantage of a geriatrics nurse is that such a person is less influenced and pressured by what the specific specialist wants or capacity problems for example and can therefore better safeguard the patient's interests."*
> *BM: "You know what, I support it all, I want to organize everything, but it really is on the board of direction to make budgetary choices."*
> *A: "Yes… but… I do actually see that as your responsibility. I mean, that you tell them… I mean that's why I'm giving you these examples so that you can convince them of the benefits of such a nurse. And you could also argue that, maybe it doesn't work like that at all… but that you argue that the other departments should finance this too right…? I mean I have little knowledge about financial issues…"*
> *BM: "You know what, Anna, I think it's no discussion whether it needs to be better or not. I'm convinced it's better for the patient. However, what I want to say is that it's not always financially supported, it's just not that simple."*
> [Observations, 27 January 2017]

The excerpt illustrates how this interaction becomes a performance of a rather uncertain self. First, Anna interprets her business manager as both part of the cast of the performance *and* an important audience to be convinced through the performance. This is shown in the

excerpt when Anna says "*I do actually see that as your responsibility. I mean, that you tell them*". In saying this, she reinforces her clinical role and interests and 'delegates' any voice and participation in the budgeting, resourcing and business to the business manager. Second, Anna switches from a clinical to a financial *mask* when she changes her argument for more budget: from clinical to financial. In doing so, she tries to gain credibility and 'save' face [the performance] towards her business manager when she realizes that the business manager is not taking part in her performance but rather positions herself as an audience that needs to be convinced. The excerpt thus shows that not only the script of the medical manager is about to fail, but also that the script she had anticipated for her business manager is likely to fail.

The uncertain self does not have 'formal' management time. One medical manager explains how the time that she reserves for 'managerial' work keeps getting filled in by 'urging clinical work' and that she does a lot of her 'managerial work' in her spare time causing stress and frustration. A lack of a *formal script* – job description – and a lack of financial knowledge further fuels discomfort and frustration. These are perceived as crucial resources for constructing a credible performance:

> *"During a clinical meeting with the psychiatry and medical psychology department I meet Patricia, recently started as medical manager. She tells me that she is still trying to understand what the role actually entails. "I ask people what are my tasks? What do I have to do? And no one knows! Ha!" [Acts surprised and frustrated].* [Observation 23 February 2017]

> *"It makes it really hard to write a business case if you don't know anything about finance… […] It really bothers me you know."* [Informal interview 19 December 2016]

Performance of the political self

The third performance reflects the performance of a political self who interprets medical management as a political act. The performance of the political self demonstrates a construction of a self that is aiming to serve the department's quality and efficiency of care through reputation management vis-à-vis other medical departments, management and the board of directors. Actors mastering skills or knowledge that the medical manager lacks are strategically casted for the performance. In a similar vein, unwanted actors are framed as incompetent or excluded from 'the scene' to save face. To remain credible among peers, medical managers need to construct a legitimate self that strategically serves the department interests.

Reputation management is considered a significant part of the medical manager script. This includes staging the performance of the department vis-a-vis other medical departments and the board of directors [audience] to ensure an 'image' of good clinical and financial performances. The following excerpt shows how a medical managers aims to 'set the scene' of an upcoming financial meeting: i.e. a backstage preparation for a frontstage performance.

The performances of multiple medical departments are discussed with medical managers, business managers and the hospital's chief financial officer. [Excerpt from a telephone conversation between the medical manager and the department's team head.]

> *"Last time I left rather sad. It was like a tribunal. [Name director] called me afterwards, I really appreciated that. But I told him, as I did last time, and I know, it costs more time, but you have to discuss every department separately. Because they will tell you [our] outpatient clinic is doing great and the OR shit. Yes we know that. But the other departments don't have to hear that. […] If there are problems at the OR I'm not going to tell it in there."* [Observation 13 November 2017]

As the excerpt shows, the medical manager is trying to stage the department's performance in reaction to experienced threats by negotiating what to bring to the fore and what not and which actors are allowed to be on stage and which not [casting]. This 'setting the scene' could be interpreted as a way to overcome the insights of 'others' (medical peers of other disciplines) into 'bad' performance and excluding actors that form a possible threat.

Performing reputation management is not only scripted by the medical manager her/himself. Others – medical peers – explicitly request the medical manager to do so and thereby they co-construct the performance of the political self. Constructing a legitimate self that serves the department interests is an important part of this performance as it grants the medical manager with credibility among her/his peers. However, the following interaction shows that a peer deconstructs the legitimacy of the medical manager by questioning the ability of medical manager to safeguard the department's performance:

[Observations at a weekly 'board meeting' (the concerning medical manager forms a daily board with a peer in order to 'manage' the department. Peers are invited to join meetings)]

> *John [peer]: "I am worried, not so much about myself, but in particular about the group as a whole. Like oncology, concerning the shared night/weekend shifts […]. People shouldn't arrange things themselves… Look, the board is very important. It must be clear to all of us that you are the main point of contact, end of discussion. And if you want to change things, or if you want to work less, that you take the lead in that."*
> *Erik [medical manager]: "Well not only via us, but we will try that our ideas… like a roadmap, in the end the department must…"*
> *John: "That's all fine, but you are the main point of contact, and you share the plans with the entire group. […] And now we hear stuff afterwards"*
> *Erik: "But that doesn't have to do with fragmentation though, more with logistics."*
> *John: "You need to make sure it stays a whole. And you need to ensure that you keep in charge of the club. And not that everyone as a crazy group of wild frogs arrange everything themselves."*

> *Erik: "Sure, exactly like that. The daypart shifts are a new phenomenon for which we need to make rules right away. And it's not like things were done afterwards or anything, but it has been a bit unclear about how it works. But we will pick it up and in the future it needs to proceed via a standardized procedure."* [Observations 6 March 2017]

The excerpt shows how the medical manager tries to 'save face' frontstage towards his *audience* (peers). At first, he presents himself not not as 'formal manager making final decisions' and discursively shifts responsibility back to the group ("in the end the department must…"). He then tries to undermine the acquisition by shifting the source of the problem ("has to do more with logistics"). In a final attempt to save face after another acquisition of his peer, he ensures him that they will create standardized procedures and formalizing rules. This can be interpreted as a way to show his peer that he will have 'control' over the group.

When his peer has left the board meeting, the meeting continues between the medical manager and his co-board member. The following excerpt shows that the medical manager proposes how to present themselves towards one of their most important audience: their medical peers.

> *Erik: "So I think that we agree upon the fact that as we two sit here together, that people can join our meetings… That is how we see it and in that way we decrease work load for others, and that everyone's dayshifts will be safeguarded and that we stay informed. Their issue, was however, on trust. That not every section of our department is represented by our board."* [Observations 6 March 2017]

The interaction illustrates how the medical manager aims to *script* a legitimate performance *backstage*. By constructing a board that is 'open' for everyone to join, they aim to show peers that they are serving everyone's interests and thereby hope to increase the legitimacy of their performance.

To perform this self, others are strategically casted – drawn in or excluded from the performance –depending on the issue at stake. Medical managers for example script their role as a *shared responsibility* conducted by a collective of actors who strive for similar objectives. Or as one medical manager explains: *"I am not really good with numbers, so [name], my colleague, is minister of finance and then we have [name], who is minister of human resources and I am the prime minister of the entire cabinet"* [Informal interview 13 November 2017]. Financial knowledge is considered an importance source for an effective performance – like negotiations over budget allocations. In contrast, 'managers' are often interpreted as 'the opponent', lacking the 'right' knowledge and encroaching into daily practices. The following quote illustrates how a medical manager draws a clear boundary between clinical and managerial work, which he regards as conflicting. Hereby he obstructs non-clinical managers from taking part in the performance and thus excludes actors that form a possible 'threat':

> *"I don't plan any managerial work during my clinical practice. Professional ethics. I don't do it! Managers sending meeting invitations for 3 pm while I have patients scheduled. I refuse to cancel patients for managerial issues. […] Managers only look at numbers which threatens quality of care. Quality isn't expressible in numbers. […] They speak in terms of profits, clients, production. Awful! Look, a cow can be exploited entirely. Could deliver you 9 bottles of milk. But a 10th would be difficult. That's how it feels."* [Informal interview 13 November 2017]

As shown, peers from within and outside of the department, managers or directors, are regarded as either associates or opponents and in a similar vein, the hospital is interpreted as the political arena where the performance takes place.

Performance of the mediator self

The fourth performance represents an egalitarian/facilitative performance. The medical manager performance is interpreted as a means to facilitate peers and the department in providing efficient and high quality of care. The performance does not reflect an intrinsic need nor ambition to be a medical manager, but a neutral 'duty' that everyone has to do 'at some point'. The performance shows a construction of a self who is mediating and translating interests between different audiences (clinical peers, business managers, team heads and directors) without pursuing a strong personal vision. The presentation of the medical manager self needs to have a 'professional fit' – not making formal decisions over peers, respecting autonomy and not presenting the self as a hierarchical or formal 'manager'. Credibility among peers – and managers and directors – stems furthermore from symbolically complying with business logics, justifying collaboration with managers and reasoning from cost-effectiveness arguments.

Medical managers construct this self by reframing their role [scripting] from manager to *mediator*, who translates interests among and between peers, other departments or management as the following two excerpts illustrate:

> *"I am, together with the team head, the link between the physicians and the physician assistants. And yes, that can go two ways some times. That we have different objectives. For me that is the most challenging."* [Informal interview 23 October 2017]

> *"My only role is to listen to everyone, everyone has an opinion and comes to see me and ventilate their opinions… I have my own opinion too, of course. But in the end I am just a mediator […] in the end, physicians will make this decision themselves."* [Informal interview 10 October 2017]

The audience of this performance exists of mostly medical peers. To conduct this performance, medical managers consciously present themselves as not-manager towards their peers. As

the second excerpt above shows, the performance explicitly does not include making formal decisions over clinical peers. Rather, the medical manager performance needs to fit well with professional values such as collegiality and professional autonomy. In order to remain credible in performing the medical manager self, medical managers do not hierarchically present themselves 'above', but rather among their peers:

> *"I am not a manager, come on! [laughs] I am not educated as a manager, yes you do a course about this and that, but in the end you're often clueless."* [Informal interview 10 October 2017]

Positioning the self 'in-between' peers is furthermore a means to increase the ability to translate interests and perform the desired mediator self as the medical manager of dermatology explains:

> *"I consciously chose to situate myself among the assistants during my management afternoon every Monday so I can easily communicate with them and know what happens."* [Informal interview 23 October 2017]

This example illustrates that this medical manager aims to present herself as easy to approach, by being physically present and visible *frontstage* towards her clinical peers. The performance furthermore includes translating cost-related interests back and forth between the business manager, team head, peers and the board of directors. In the following quote a medical manager explains how she needs to perform 'the mediator self' to serve two different audiences (the board of directors and her medical peers) to defend an investment quest for 3 FTE laboratory technicians:

"It is an investment which will not directly give something in return. But if you keep emphasizing that the work pressure is too high and that we [radiologists] are doing a lot of non-complex care while laboratory technicians can do that too. […] So we had to construct a sort of model why it is attractive for the board of directors to invest… So, yes you know I don't really believe in it either but you have to put SOMETHING on paper. And then they will say "oh well, we will invest." And my peers reacted really critical "why invest?! You will never earn back that money." No we are not, maybe, you don't know. But you have to defend your policy. You can't tell the board oh well just give us 6 technicians and you won't get anything in return" […] [Informal interview 7 November 2017]

The excerpt shows that in this performance, the medical manager tries to 'sell' her investments quest towards the hospital board by reasoning from cost-efficiency arguments. At the same time, she also needs to remain credible towards her peers in defending the efficiency objectives – who are critical at first – and does so by symbolically complying with business logics ("*I don't really believed in it either but you have to put SOMETHING on paper*").

The business manager and team head are important actors in the performance of the mediator self to facilitate both the smooth run of daily affairs and the development of a long-term vision including the obtainment of investments for more personnel or equipment. Yet, medical peers are not always directly convinced by the added value of this collaboration as one of the medical managers explains:

> *"We go along very well. […] But I have to justify her actions or decisions. For example, she had been writing a business case for an echo laboratory technician. And then one of my colleagues said: "but she doesn't understand a thing, she doesn't know how a hospital works…" But wait a second, she was a nurse at the intensive care, she does know how certain things work and has a clear vision so..!"* [Informal interview 7 November 2017]

The excerpt shows how a medical manager justifies collaboration with her business manager in order to remain credible among her medical peers. She does so by emphasizing her clinical background and claiming that she is knowledgeable because she is a nurse she defends involvement of the business manager in (cost)efficiency projects towards medical peers.

Discussion and conclusion

The main contribution of this article is foregrounding the social construction of medical manager selves. By shadowing the daily practices of six medical managers, we were able to study in-depth how physicians respond to their medical manager role and how they aim to construct a credible performance of the self. By using Irving Goffman's theories on 'the presentation of self' (1956 in Goffman 1978) we showed how these medical managers construct four distinctive performances of the self: a comfortable self, an uncertain self, a political self, and a mediator self. Each performance is guided by a specific script determining the acts and behavior of the medical manager, which actors should be casted to join the performance (or not) and supported by specific resources aiming at constructing a credible self in the eye of the audience.

First, our results show that medical managers construct very *distinctive* selves, fueled by different individual scripts which represent the interpretation of their medical manager-self. The comfortable self interpreted the medical-manager role as a logical and natural duty for a physician to perform and used the role as a means to engage others in increasing quality and efficiency of care and multi-disciplinary collaboration. The uncertain self interpreted the medical manager role as a time-consuming duty which obstructed clinical practices. The political self perceived the medical manager role as a means to safeguard the departmental objectives and budget vis-à-vis other departments and likewise the hospital was interpreted as a political arena. The mediator self represented a medical manager who perceived the role a as means to translate and bridge interests within and beyond the medical department.

Identity resources provided confidence to be the preferred self (e.g. confirmation by others) or were actively sought for when the script was uncomfortable or questioned by others (e.g. a clear script, knowledge, time, legitimacy among peers or presenting the self as not-manager). These constructions were co-constructed in interaction with others, e.g. clinical peers, hospital directors or managers. Confirmation, questioning, violating or engaging with these 'selves' steered how the medical managers constituted their performances.

Research on medical managers has shown the existence of different 'selves'. Yet, often these investigations positioned the role of medical managers within the traditional 'professionalism versus managerialism' dilemma (Doolin 2002; Llelwellyn 2001; McGivern et al. 2015; Numerato et al. 2012; Witman et al. 2011). Medical-manager identities were for example portrayed as in favor (positive) or in resistance (negative) of managerialism as opposed to professionalism. Likewise, medical managers were divided into 'willing' and 'incidental' hybrids (McGivern et al. 2015) or into 'adapters' and 'resisters' (Doolin 2002). Our results however show that this 'divide' does not necessarily *exist*, but is in fact socially constructed and can thus as such be perceived (or not). For example, the construction of the comfortable self, showed how one medical manager could not easily distinguish clinical from 'managerial' work. Rather, most duties, such as chairing the medical staff committee, reorganizing clinical practices or increasing multidisciplinary collaboration, were interpreted as inherent to the work of a modern physician. In contrast, the construction of the uncertain self, showed how a medical manager in interaction with a business manager abdicates herself from any responsibility of the approval of a business case by constructing a discursive divide between clinical and financial frames. Moreover, we showed how some medical managers constructed more collaborative understandings of leadership, sharing their responsibilities with others, including peers and non-clinical actors. These results thus show that the boundaries between medical professionalism and management are not pre-given but the outcome of boundary work and individual agency (Bresnen et al. 2019; Halffman 2003). Medical managers draw strategic boundaries, sometimes more strictly (i.e. 'this management task is not my responsibility') and sometimes more loosely (boundary blurring; i.e. sharing responsibilities with others), depending on one's interests and resources. This thinking is in line with other scholars (Bresnen et al. 2019; Noordegraaf 2007; Numerato et al. 2012; Olakivi & Niska 2016; Postma et al. 2014; Sartirana et al. 2018) who increasingly argue that (the relationship between) professional and managerial logics are the outcome of daily negotiations instead of a pre-given representation of how the world is structured.

Second, our results show the different ways in which medical managers aim to construct a credible self towards others. For the comfortable self, credibility among others comes natural as this self is comfortable in the medical manager role and confirmation is given by others. This self consciously aligns his/her objectives with the hospital's strategy objectives to increase credibility from hospital directors. The performance of the uncertain self is occasionally questioned by others, e.g. peers and managers, and therefore s/he aims to save face and construct credibility towards peers by downplaying the managerial role. Another attempt

to gain credibility and save face is switching between masks (e.g. clinical and financial) in supporting arguments for, for example, investment quests, when others are not directly convinced of the performance of this self. The political self is mainly concerned with constructing a legitimate self among peers as his/her performance is constantly questioned. Reputation management and not presenting the self as a formal manager making final decisions are important strategies in aiming to construct a credible self. Finally, the mediator self uses different strategies to construct credibility dependent on the audience in a performance. Among peers, the presentation of this self needs to have a 'professional fit' – respecting autonomy of peers and preventing to be seen as a hierarchical or formal 'manager'. Credibility towards directors and managers is gained by reasoning from cost-effectiveness arguments.

So far, research on medical managers has extensively shown that credibility among peers, (which is arguably needed to exert influence) is especially derived from showing commitment to *clinical work*. Medical managers had to show their peers that they are first and foremost a 'doctor' and that they would never join 'the dark side' [of management] as it provides a threat to their status and identity as a doctor (McKee et al. 1999; Llewellyn 2001; Witman et al. 2011). Although the medical managers we shadowed occasionally prioritized clinical work, overall our findings provide a different perspective. Our findings demonstrated that medical managers aimed to construct credible selves who are able to exert influence on a *variety of organizational issues* that go beyond merely clinical work. They were questioned by others or granted credibility based on for example their ability to represent department interests, acquire approval for business cases, reason from cost-effectiveness arguments, align to hospital governance objectives or their motivation to participate in hospital management. Credibility was thus not per se gained by showing that their allegiances lay with clinical work. Finally, these 'others' were not merely clinical peers but also other professionals with non-clinical backgrounds who also contribute to the construction of the self. Hence, the sources of credibility have shifted substantially as well as the audience of their performances, which will require medical managers to acquire different – organizational and leadership – skills and competencies. This is in line with current calls for medical leadership among (hospital-based) physicians worldwide (Andersson 2015; Berghout et al. 2017). These calls urge physicians to adapt their practices and professional identity to changing organizational and clinical demands, i.e. an increase of chronic patients, multi-morbidity, financial pressures. It is within these changing contexts that we can understand our finding that sources of credibility among medical managers are shifting.

Overall, our results show the complexity of these 'selves' in terms of how they come into being. Investigating these constructions in-depth was enabled by the method of shadowing (Ybema et al. 2009). Our findings contribute to our understandings of the transitions and identity processes professional undergo when they engage into managerial roles, which are so far mainly based on interviews and questionnaires. A limitation of our methodological approach, however, is that we only shadowed the subject of our study and that we did not (formally) interview peers to investigate how this 'self' is perceived through the eye of the 'other'.

When shadowing, a researcher can only indirectly derive the reactions of others towards the performance of medical managers in contrast to interviews when a reaction towards performances can be gained directly. We therefore encourage future researchers who will adapt a similar dramaturgical framework and use shadowing techniques to also (informally) interview the audiences of the performances.

We contribute an alternative understanding of credibility as a relational, situated accomplishment that, if it is to be accomplished, happens in everyday and routine interactions such as the ones presented in this article. In fact we propose that our medical manager subjects are doing a form of 'credibility work', not just in their ongoing interactions with colleagues and peers, but also in interviews with researchers such as ourselves. Such credibility work involves "dramatic realisation" (Manning, 2000, p. 7 Semantic Scholar (I note it has been properly published elsewhere) where medical managers draw on a range of resources-social, relational, professional and discursive- to pursue personal, clinical and organisational outcomes that are often entangled in complex ways. We highlight that such resources do not precede interactions but are emergent within them as social actors respond to cues offered by others, improvise with ways through or around obstacles that are presented by other actors, and seize on institutional texts, protocols and norms to forge novel connections and possibilities in the moment. Ultimately this inquiry concludes that medical or hybrid managers accomplish credibility as they become adept at a repertoire of performances that intersect their clinical, managerial and institutional selves.

Finally, our paper offers a methodological contribution to research studying identity processes or *constructions of the 'self'*. We offer an analysis of two stages – the interview and the interaction – as two different kinds of performances for very different audiences: one of course the researcher and one the medical peer or non-clinical actor that each research subjects shares a stage with. We do not attempt to differentiate one as front stage and one as back stage. We would argue both have a self-consciousness, intentionality and social script about them and given both are a stage-research and professional practice-that they are attuned to and vigilant of. This reflects a desire to unsettle the essentialism that Goffman has been accused of and any traces that some selves have the potential to escape the 'constructedness' of research (Sinha 2010). What is more, we argue, in line with Down and Reveley (2009) that studies investigating identity processes – or constructions of the 'self' – should examine both narrations *and* interactions as these co-construct the construction and performance of the self. As our research shows, Goffman's dramaturgical framework – in combination with (informal) interviews – offers an important and very useful framework for analyzing identity processes in organisations (Down & Reveley 2009; Manning 2008).

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6

From context to contexting: professional identity un/doing in a medical leadership development programme

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Abstract

Physicians are known for safeguarding their professional identities against organisational influences. However, this study shows how a medical leadership program enables the reconstruction of professional identities that work with rather than against organisational and institutional contexts to improve quality and efficiency of care. Based on an ethnographic study, the results illustrate how physicians initially construct conflicting leadership narratives – heroic (pioneer), clinical (patient's guardian) and collaborative (linking pin) leader – in reaction to changing organisational and clinical demands. Each narrative contains a particular relational-agentic view of physicians regarding the contexts of hospitals: respectively as individually shapeable; disconnected; or collectively adjustable. Interactions between teachers, participants, group discussions and in-hospital experiences led to the gradual deconstruction of the heroic –and clinical leader narrative. Collaborative leadership emerged as the desirable new professional identity. We contribute to the professional identity literature by illustrating how physicians make a gradual transition from viewing organisational and institutional contexts as pre-given to contexting, i.e. continuously adjusting the context with others. When engaged in contexting, physicians increasingly consider managers and directors as necessary partners and colleague-physicians who do not wish to change as the new 'anti-identity'.

Introduction

Physicians are well-known for safeguarding their professional and *elite* identity upon 'external threats', such as the increase of managerialism and market logics in healthcare (Numerato et al. 2012). Managerialism, resulting in increased standardization, control, auditing and administration burdens, is said to threaten physicians' professional identity as it would hamper them from performing the essence of their work: treating patients (ibid.). Contemporary healthcare in Western countries, however, does not only face 'external' pressures but also 'internal pressures', such as the expansion of chronic diseases and multi-morbid patients, cost-efficiency objectives and shifts in care delivery from hospital to primary care. (Noordegraaf 2011). Increasingly, physicians are expected to adapt their work practices accordingly and pro-actively shape organisational changes in their field. Yet critical insights in *how* professionals interpret these institutional pressures and how they reconstruct their own professional identities accordingly are still lacking.

In particular, a number of opinion-making physicians seem to embrace these requests, as is reflected by their recent pleas for *medical leadership* (Berghout et al. 2017; Swanwick & McKimm, 2011; Warren & Carnall, 2011). By framing physicians as leaders, opinion-makers stimulate other physicians to disrupt 'old' professional values, such as professional autonomy, hierarchy and socialization, in order to construct a *new medical identity*, which enables physicians to meet societal and clinical challenges (Berghout et al. 2018). In this light, various

initiatives to develop medical leadership have emerged. New competency models complement technical skills with 'leadership' skills (ibid.). In addition, educational institutes have been established by medical associations offering physicians the possibility to train themselves as 'leaders' in medical leadership development programs (MLDP) (Frich et al. 2015). These initiatives stimulate physicians to act as 'leaders' in their daily work by setting up multidisciplinary collaboration, taking care of cost-efficiency and fulfilling roles in hospital governance.

Although ideologically framed as 'the solution' for contemporary issues in healthcare (Swanwick & McKimm, 2011; Warren & Carnall, 2011), the advocacy for medical leadership reflects complex and paradoxical identity demands. First, advocates stimulate physicians to get 'back in the lead' by regaining professional dominance in healthcare while simultaneously having to denounce professional values such as autonomy and hierarchy in order to become multi-disciplinary *team players* (Berghout et al. 2018). Second, denouncing professional values such as professional autonomy, hierarchy and strong socialization processes is arguably easier said than done among highly socialized and institutionalized professionals (Freidson 2001; Reay et al. 2017). And third, medical leadership discourses presume the possibility of easily incorporating organisational demands into daily clinical practices. Although a number of scholars have shown that organisational and professional logics have become increasingly intertwined (McGivern et al. 2015; Noordegraaf 2011; Sheaff et al. 2003), many physicians still perceive these requirements as *competing* demands (Berghout et al. 2018).

In this study, we investigate the identity work – 'the active construction of an individuals' identity' (Pratt et al. 2006: 237) – that is carried out by physicians who identify themselves as 'medical leaders'. Empirically, we zoom in on a medical leadership development program (MLDP). We understand physician's participation in a MLDP as a need to reconstruct their medical identities to meet contemporary societal and clinical challenges. Investigating these identity processes in a MLDP is relevant as it provides critical insights in how professionals subjectively interpret conflicting institutional pressures and how they reconstruct their own professional identities accordingly (Bevort & Suddaby 2016; Reay et al. 2017). In the literature, MLDP's are recently considered as important identity spaces (Petriglieri & Petriglieri 2010) that enable identity work. By using the concept of *contexting* – continuously adjusting the organisational context with others (Asdal & Moser 2012; Bevort & Suddaby 2016; McGivern et al. 2015), we show how physicians aim to un*do* (Nicholson and Carroll 2013) their often-assumed stable and detached professional identity by reinterpreting a new relational-agentic view regarding organizational and institutional contexts and other (non) clinical actors.

Identity, identity work and physicians

Theoretically, we draw on social constructivist accounts of identity, specifically focusing on the construction of professional identities (e.g. Alvesson & Willmott 2002; Brown 2015; Carroll & Levy 2010; Sveningsson & Alvesson 2003; Sveningsson & Larsson 2006). Identity refers to the social construction of the self and seeks to provide answers to questions such as 'who am I (are we)?' and 'where do I (we) stand for?' (Sveningsson & Alvesson 2003: 1164). Conceptually,

a distinction can be drawn between social identities (nationality or gender) or personal identities (intelligence or height) (Brown 2015:23) and *identity* in general that refers to "the meaning that an individual attach reflexively to *'the self'*" (Brown 2015:23). Following Alvesson and Willmott (2002), we use the concept of identity as the latter form, and we understand identity thus as fluid, dynamic and socially constructed rather than stable and static. Importantly, scholars point to the fact that identities are shaped by the self *and* the other. As Berger and Berger (1972: 62) put it: "only if an identity is confirmed by others it is possible for that identity to be real to the individual holding it" (cited in Van Bochove & Burgers 2019). Identities are thus temporal constructions, which are "regularly constituted, negotiated and reproduced in social interactions" (Sveningsson & Larsson 2006: 206).

Organisational change or tensions could decrease one's sense of a coherent identity and trigger *identity work* which refers to the engagement of individuals in "forming, repairing, maintaining, strengthening or revising the constructions that are productive of a sense of coherence and distinctiveness" (Sveningsson & Alvesson 2003: 1165). Yet this does not necessarily mean that actors by definition seek a coherent sense of self. Rather, individuals can identify with multiple, contradictory selves (Ahuja et al. 2017; Beech et al. 2008). Switching between different selves can for example be a strategic act as it allows one to balance between different logics or objectives (Iedema et al. 2003).

In this study, we specifically build on the professional identity literature. Professional identity refers to "an individual's self-definition as a member of a profession and is associated with the enactment of a professional role" (Chreim et al. 2007: 1515). Professional identification is different than other types of social identification as it is established through selection, prolonged training, socialization and self-regulation and underpinned by professional autonomy and values (Freidson 2001). Professional identity is thus determined by what one does instead of where one works (e.g. organisational membership) (Chreim et al. 2007; Pratt et al. 2006; Spyridonidis et al. 2015). In contrast to 'other' identities, professional identity is often considered as relatively stable and detached from organizational contexts. Physicians are well-known for safeguarding their professional identity after 'identity violations' that potentially threaten their social status and professional autonomy, such as the increase of managerial logics and the presence of non-clinical actors in healthcare (Currie et al. 2012; Doolin 2001). The underlying assumption in these studies is that physicians do not want to fundamentally change their professional identity and remain oppositional towards organizational and institutional contexts and non-clinical actors.

However, increasing evidence criticizes the assumption that professional identities are stable and in opposition to the organizational context and instead shows that professional identities are becoming more fluid, hybrid and blurred with organizational contexts (Ahuja et al. 2017; Bevort & Suddaby 2016; Kyratsis et al. 2017; McGivern et al. 2015; Noordegraaf 2011; Spyridonidis et al. 2015; Reay et al. 2017). The concept of 'hybridity' emphasizes the mediation between professional and organizational logics and illustrates that 'organizing' is in fact an intrinsic part of professional work. Likewise, physicians are potentially active agents

who engage with organizational contexts in order to deal with contemporary healthcare challenges instead of detaching themselves to safeguard their 'old' professional identity. Studies following this line of reasoning, illustrate how physicians, increasingly confronted with cost-efficiency objectives, reforms, chronically-ill patients and multi-morbidity, in fact unravel and adjust parts of their professional identity in order to adapt to their 'new realities' (Kyratsis et al. 2017; McGivern et al. 2015; Reay et al. 2017). For example, Reay et al. (2017) show how physicians increasingly interpret themselves as 'head of teams' instead of 'autonomous experts' (p. 1064). Likewise, McGivern et al. (2015) argue how 'hybrids' – physicians in managerial roles – challenge and disrupt institutionalized professionalism to align their professional identities to 'new' managerial contexts.

In a similar vein, we aim to illustrate how physicians, by means of participating in a MLDP, try to un*do* (Nicholson & Carroll 2013) their often-assumed stable professional identity by reinterpreting their relational position towards hospital contexts to better deal with perceived institutional pressures. We show that physicians not only adapt to new realities and organizational contexts by reinterpreting their professional identities but that they increasingly interpret themselves as active agents who co-adjust these contexts with others, which we label as 'contexting' (Asdal & Moser 2012; Bevort & Suddaby 2016; McGivern et al. 2015). Given the increasing hybridity of professional work and identities, it is especially interesting to investigate *how* physicians give meaning to 'contexts' and construct their relational-agentic position towards 'the context' (e.g. organizational (hospital) contexts, institutional contexts and other (non-clinical) actors.

Leadership programs as identity workspaces

Numerous scholars have linked leadership to identity processes (Andersson 2015; Carroll & Levy 2010; Ford 2006; Gagnon & Collinson 2014; Martin & Learmonth 2012; Nicholson & Carroll 2013). These studies interpret leadership as a discursive phenomenon which is socially constructed and aim to demonstrate its performative effects on identities (Sveningsson & Larsson 2006). Various studies show how actors strategically use leadership rhetoric to reconstruct professionals' identities by prescribing preferred 'leadership' competencies and practices, thereby steering professionals' behaviour and attitudes (Berghout et al. 2018; Carroll & Levy 2010; Ford 2006; Martin & Learmonth 2012). Similarly, Sveningsson and Larsson (2006) argue that leadership can be considered as a 'symbolic attribute' which can be mobilized in identity work (ibid.: 208). They show how contemporary leadership discourses offer individuals a more appealing identity, one that is associated with charismatic and transformative visionaries, in contrast to management, which is laden with negative values such as bureaucracy and slow reforms.

In addition to studies of leadership development in organisations, a small number of scholars have begun to study LDP's as 'identity workspaces' (Carroll & Levy 2010; Gagnon & Collinson 2014; Nicholson & Carroll 2014; Petriglieri & Petriglieri 2010) which can be broadly understood as spaces that enable and stimulate individuals' identity work. Most research on

Leadership Development Programs (LDP) is underpinned by positivistic notions of leadership and mainly focus on competency development, ignoring the social, political and organisational contexts where LDPs are situated in (Carroll & Levey 2010). In contrast, social constructivist approaches to LDP's aim to study collective processes in professional identity construction, which is a relatively understudied phenomenon in research on professional identity reconstruction (Reay et al. 2017). In line with other authors (Pouthier et al. 2013; Reay et al. 2017), we argue that studying these collective processes is highly relevant to understanding identity work because identity un/doing is rarely an individual process; rather identity comes into being through ongoing interaction and collective discussions concerning who we are and where we stand for.

By using the term 'identity undoing' (Nicholson & Carroll 2013), we aim to show that LDP's are not merely spaces where actors work on *new* identities, but also spaces where identities are "destabilized, unravelled and deconstructed", influenced by power relations, individual and collective actions and discursive forces. We will show how a MLDP enables the deconstruction – 'undoing' – of professional identities and reconstruction – and 'doing' – of 'new' professional identities through collective identity work. In line with Sveningsson and Larsson (2006) we thus understand 'leadership' and the leadership narratives articulated by the MLDP participants as symbolic attributes in performing their identity work.

Methods

We conducted an ethnographic study of a 1-year MLDP (September 2017 - July 2018). Ethnographic methods allowed us to get a deep understanding of people's attitudes, beliefs and self-perceptions with the aim to understand the subjects of study 'from within', in people's own terms and frames (Willis & Trondman 2000).

The MLDP is developed and led by a Dutch university-affiliated centre for education in healthcare governance and management. The general aim of the programme is 'to enable physicians to take the lead in the continuous improvement of healthcare'. The programme consists of 6 collective sessions (total of 9 days) and 3 two-hour in-house hospital sessions. In addition to the collective sessions, every participant carried out a hospital-based improvement project (see Appendix 1 for project examples and content of the programme). The progress of the projects was discussed during the in-house sessions.

Participants are 23 physicians (6 hospitals) representing 13 different medical disciplines. The program was guided by four facilitators and 15 guest speakers. Three sub-sessions and all in-house sessions were attended by six hospital directors. Participants were chosen by the hospital board (n=19) or applied for a position in the programme (n=4). Although the majority was encouraged to participate, participation was in the end voluntarily and driven by physicians' affinity with leadership. Most participants were early-career professionals wanting to do more than 'the clinical'. A few participants held formal managerial positions, for example a

part-time position as head of a clinical department or director of the daily medical staff board. All participants and directors were first informed by e-mail about the possibility of participating in this study and subsequently briefed by the first author at the start of the program. Afterwards, all participants were asked for their consent, which was given by all participants. During the first two sessions, participants asked the first author several questions related to data collection and analysis. Thereafter, the presence of the first author was perceived as 'normal' and did not raise further questions. This was confirmed by the facilitators of the program.

The data consists of >200 pages of field notes, retrieved from around 100 hours of observations. The observations were guided by several 'sensitizing concepts' (Bowen 2006): identity, medical leadership and hybridity. Participants' relation to context (e.g. hospital context, colleagues, board of directors, managers) emerged as an important theme early in the program and steered the first author in the subsequent observations. The program did not entail explicit sessions on 'identity' but contained many sessions/discussions related to participants' current and future roles in healthcare – e.g. about who they are as physicians and where they want to stand for – which we labelled as 'identity work'.

In addition to the observations, informal interviews were held with participants, trainers and guest speakers during coffee breaks, breakfast, lunch, dinner or evening drinks to get a deeper understanding of participants' and facilitators' perceptions on the issues discussed. The data collection was conducted by the first author, who joined all collective sessions and six (50%) of the in-house sessions in five hospitals. The third author joined half of the collectives sessions and all in-house sessions. During the in-house sessions she was responsible for the introductory meeting. The development of the in-house sessions was discussed afterwards with the co-authors. During the program, the third author facilitated an introductory presentation in the first session about leadership styles. Participants were asked to collectively discuss what medical leadership entails. This stimulated participants to reflect upon their professional roles and identities. In the last module, the first author presented the preliminary findings as a member check to verify if the interpretations of these findings related to those of the participants. This was confirmed by the participants. Additionally, documents were analysed, including programme brochures, presentation slides and learning materials.

We analysed our data by investigating the different social constructions of medical leadership by participants in interaction with other participants, facilitators, hospital directors and guest speakers. We started our analyses with a first phase of inductive, or 'open' exploration of the data, which revealed three leadership narratives (heroic, clinical, collaborative; see Appendix 2). Identities often take the form of narratives, which can be understood as the stories we construct of ourselves in addressing questions such as who am/are I/we? or where do I/we stand for? (Beech 2008: 52; Brown 2015: 23) and identity work then thus reflects "the processes through which people develop narratives of the self" (Beech 2008: 52.). Important to note is that we understand narratives as the *means* to articulate a (preferred) identity. Yet, for an identity to be real for the one holding it, others need to confirm and validate the narrative

and thus the identity (Berger & Berger 1972). Physicians were not exclusively bound to one narrative but could shift between the narratives constructing diverse, or even contradictory, selves. Signifiers of the narratives are discussed in Appendix 3.

In the first phase of inductive coding a dominant tension between working with or against 'the context' emerged as an important theme. By 'context' we mean actors (e.g. peers, non-clinical colleagues, hospital directors, managers), organizations (e.g. hospitals, healthcare insurance companies) or institutions (e.g. the healthcare inspectorate, the Dutch healthcare system). In making sense of their role as medical leaders, participants continuously referred to 'the context' that either stimulated or hindered the development or execution of their leadership roles. Important to note is thus that we use to term 'context' to illustrate how participants refer to actors, organizations or institutions and as such 'context' can thus have multiple meanings. In the second phase we linked the narratives to the tension between working with or against 'the context'. Each narrative revealed a distinctive position towards organisational and institutional contexts: heroic (individually shaping the context), clinical (disconnected from the context), collaborative (collaboratively adjusting the context).

In the third and final phase we analysed the process of how identities are collectively made and unmade over the course of the program. By using the concept of 'identity un/doing' (Nicholson & Carroll 2013) we revealed the de/construction of participants' professional identities through collective identity work.

Results

The results show how physicians performed identity work in a medical leadership development program by constructing different leadership narratives of the self: i.e. the heroic, clinical, or collaborative leader. Each leadership narrative contains a particular relational-agentic view of physicians regarding *the context* of hospitals: respectively as shapeable by an individual heroic leader; as disconnected from the clinical leader; or as collectively adjustable by collaborative leadership. The results reveal how over the course of the program, interactions between teachers and participants, group discussions and in-hospital experiences contributed to the gradual and partial deconstruction of the heroic –and clinical leader narratives. In particular, their relational-agentic view regarding 'the context' was deconstructed: i.e. individualistic notions of agency [heroic narrative] and detached standpoints vis-a-vis the hospital context and organisational actors [clinical narrative]. In addition, the results demonstrate the rebuilding of a new identity of a 'collaborative leader' who collectively adjusts and reshapes organisational and institutional contexts by working across disciplinary and organisational boundaries. We reflect on the tensions between different leadership narratives and the consequences of these narratives for the reconfiguration of professional work in contemporary hospitals.

Entering the leadership program: different leadership narratives and relations to context

During the first two sessions of the leadership program, which entailed introductory rounds and discussions about the meaning of medical leadership, participants collectively discussed their aspirations to become medical leaders in their hospitals. We observed how participants expressed themselves in different and contradictory ways as as *heroic, clinical and/or collaborative leaders (see Appendix 2)*. Initially, participants understood themselves primarily as heroic or clinical leaders and just occasionally as collaborative leader. A collaborative understanding of leadership was gradually constructed over the course of the program.

The heroic narrative: individually shaping the context

The heroic narrative shows the construction of a heroic leader*, 'the pioneer'*, for whom being a physician is more than 'just' the clinical. The heroic leader has a strong vision about future healthcare and feels it is her/his responsibility as a physician to play a role in this by individually reshaping the existing organisational context: both financially and in terms of quality. Participants felt the urge to step up as 'leaders' who can 'radically transform healthcare' as they argued that current hospital and healthcare contexts are 'not-innovative', 'conservative' and 'in lack of financial resources', thereby obstructing quality and efficiency improvements. When mobilizing the heroic leader narrative, participants seemed to interpret themselves as the driving force in change processes, individually *shaping a new context*, for example by reorganizing clinical work or developing innovative medical apps.

Participants producing these narratives presented themselves in contrast to those who 'just come and go', 'lack an innovation mind' or are 'unwilling to change', thereby granting themselves much agency in comparison to others. Others (physician-colleagues) were often blamed in explaining why innovations – ranging from simple daily processes in care delivery to larger, multi-disciplinary improvement projects – failed as they were framed as 'unwilling to change', 'pursuing different interests' and 'bad communicators'. Through this discursive opposition, participants aimed to make the leader identity exclusive for a 'happy few', which would enable themselves to step forward as visionary and heroic leaders: *"It is as if everyone still thinks the world is flat, while I already know for a long time the world is round"* (respondent 8). Many interpreted the leadership program as a means to deal with colleagues 'who do not want to change' and to learn 'how to cope with frustration' and to 'keep going'. Interestingly, this narrative showed that physician-colleagues, and not managers, were perceived as the new 'anti-identity'.

The clinical narrative: disconnected from the context

The clinical narrative displays the construction of *'a 'patients' guardian'*, who aims to improve patient care and bring healthcare back to its essence: caring for patients. Participants expressed their needs to be this 'self' as they felt that healthcare was dominated and regulated by 'outsiders' -e.g. managers, the government, healthcare insurance companies- resulting

into an exhausting amount of administration and an excessive focus on costs rather than quality of care: *"The hospital is not ours [physicians] anymore. There are managers, a business director. And things aren't going very well"* (respondent 20). The clinical narrative suggested that physicians perceived the patient's and their own position as under threat and therefore felt they needed to step up as 'leaders' by safeguarding healthcare from interference of outsiders.

This narrative came into being by a continuous process of de-identification from 'different-others' like managers and hospital directors with a background in business administration. Participants argued that improving patient care is something that only professionals (physicians/nurses) can do because of their unique link with the patient that managers lack*: "we really feel what people go through in the consultation room"* (respondent 14). By emphasizing a boundary between clinical and non-clinical professionals, participants aimed to preserve the clinical leader identity for an exclusive group. Within the clinical narrative this distinctiveness was further underscored by arguing that as a physician 'you don't work for the organisation' since 'that is not your primary concern' (respondent 24), thereby further *disconnecting themselves from managerial and organisational contexts* which were interpreted as pre-given barriers.

The collaborative narrative: collectively shaping the context with others

The collaborative narrative shows the construction of a leader as *'linking pin'*, who aims to bring actors together and balance different interests in order to ensure quality *and* cost-efficiency of care. Care delivery is considered as a co-production between different actors who have equal responsibilities for the quality of care. Collaborative leaders transcend disciplinary or organisational boundaries, thereby considering the collaborative identity inclusive for more than just a 'happy few'. Within this narrative, being a physician means being a responsible and accountable multidisciplinary team-player who places the patient central instead of her/himself. Participants argued that this sense of self is required to deal with the increase of multi-morbid patients, chronic diseases, and shifts in care delivery from hospital to primary care.

The construction of a collaborative leadership narrative entailed a particular view as to how actors saw themselves in relation to 'the context' and 'others'. Rather than viewing the hospital context as disconnected from themselves [clinical leader] or individually shapeable [heroic leader], the collaborative narrative shows how the context was interpreted as collectively adjustable and an as an important resource for change. Participants shaped their sense of self in relation to similar-others (physicians) and different-others (e.g. managers, business controllers or directors) by repeatedly reminding each other of the interdependencies in the delivery of care: 'you have to do it together' (respondent 2, 6, 24).

Conflicting leadership narratives

Initially, participants shifted between narratives adapting parts of the heroic/clinical/collaborative narrative, or expressed themselves merely through one narrative. Moreover, the

following interaction illustrates how participants constructed different and at times *conflicting* narratives. Participants discussed what medical leadership means to them during the first day of the program:

> *"You are an excellent doctor and therefore you will lead others."* (Heroic narrative; respondent 9)
> *"No one says I want to be a medical leader to increase productivity, you don't act from an economic perspective".* (Clinical narrative; respondent 16)
> *"First comes the work floor, then finance and then profits. That is what makes us special."* (Clinical narrative; respondent 9)
> *"For me medical leadership means collaboration, knowing the perspectives from different actors."* (Collaborative narrative; respondent 10)
> *"What distinguishes a medical leader is the patient. You don't primarily work for the organization, that's not your primary concern."* (Clinical narrative; respondent 24)
> *"But the organization must function properly."* (Collaborative narrative; respondent 2)
> *"It's a service you deliver, optimal patientcare is also the organisation's concern"* (collaborative narrative; respondent 20)
> *"A medical leader needs to transcend disciplines. You come from a certain blood type but you need to leave behind your own specialty. You need to develop a vision that is broader than your own little club."* (Collaborative narrative; respondent 8)
> *[…]*
> *The hospital is not ours [physicians] anymore. There are managers, a business director. And things aren't going very well" (*Clinical narrative; respondent 20*).*
> [14 September 2017 module 1]

The excerpt shows how participants adapted different parts of the narratives (heroic and clinical narrative, respondent 9, and collaborative and clinical narrative, respondent 20). Moreover, the quotes illustrate how narratives could conflict. By employing the clinical narrative, participants (16, 9 [second quote], 24) emphasized the importance of disconnecting from the context to increase quality of care. Several participants (10, 2, 8) reacted by expressing a collaborative understanding of leadership and underscored the importance of adapting to the new organizational context and presence of others.

Identity *undoing*: tensions and deconstruction

Over the course of the program, participants experienced 'identity violations' (Pratt et al. 2006) in the enactment of their preferred leader identities: a mismatch between participants' self-images and the perception of participants by others. Specifically *heroic* and *clinical* self-perceptions led to tensions in daily practices and in improvement projects. In response to these experienced tensions, hospital directors, facilitators, guest speakers and co-participants gradually deconstructed individualistic notions of agency [heroic narrative] and detached

standpoints vis-a-vis the hospital context and organisational actors [clinical narrative] to stimulate different understandings of leadership.

First, participants experienced that it was extremely hard to engage others in adopting their view on necessary change [heroic narrative] and to get others on board due to competing interests or a lack of time and support. This hindered them to perform their role as medical leaders:

> *"You receive a letter of the board of directors that you are a medical leader, but the rest of the hospitals thinks, what are you!?"* (Respondent 6)
> *"You can only be a leader when others grant you that role. It is difficult for us, we don't get any extra education, money or time. […] You can't be a leader on an uninhabited island"* (respondent 9).

Participants expressed their frustrations about their lack of mandate and formal authority, comparing themselves to a 'general without an army' (respondent 7). Several physicians experienced uncertainty about how others perceived them as a leader, which led to questioning their sense of self:

> *"I wonder… I am part of the daily medical board, do I see myself as a leader? I don't know… but I do encounter people reaching to me… do they do so because I have a link with 'above' or because they like me? […] Do you have followers because you have a mandate, or because they trust you?"* (Respondent 20; 15 September 2017, module 1)

Second, participants discussed that 'outsiders' – managers, politicians, healthcare insurance companies – increasingly determined physicians' work e.g. the duration of consults, type of care delivered, or the use of quality standards. Participants were especially dissatisfied with an excessive presence of managers in their hospitals. They argued that managers often hamper change because of their budget constraints and focus on costs rather than quality. They therefore tried to bypass or avoid them. However, avoidance was a difficult strategy to maintain. Requests from 'outsiders' for insights into quality and efficiency of care in the development of change projects made it impossible for participants to keep their disconnected selves intact [clinical narrative].

In response to these experienced tensions, hospital directors, facilitators, guest speakers and co-participants gradually deconstructed heroic self-images and anti-manager identities to stimulate different understandings of leadership. They criticized the physician's reluctant and oppositional attitude towards others – peers, managers, politicians, healthcare insurers or directors – and their relational-agentic views regarding 'the context' as being individually shapeable [heroic narrative] or disconnected [clinical narrative] (see Appendix 3)

To illustrate this collective deconstruction process we provide an excerpt from an interaction between participants and a facilitator. During the 4th module participants were split up

in subgroups to discuss how to engage physicians in quality improvements. The following excerpt shows a collective discussion afterwards and illustrates the experienced tensions, subsequent critique and deconstruction of heroic and clinical understandings of leadership:

> *"The problem is, if you want to change something, the answer you get is 'write a business case'."* (Respondent 2)
> *"Pff, I recognize this. No one who says: 'well that's a good idea.'"* (Respondent 15)
> *"Yes ok, but how do we turn this around? What is our advice?"* (Respondent 14)
> *"I think the problem is that we as physicians are too little involved in quality issues. So it's imposed by the board and then often resistance arises. We shouldn't blame the board of directors but we should blame ourselves. The medical staff should be more motivated to increase quality of care."* (Respondent 20)
> *"Shouldn't we move towards a participation model? [...] So that you have mandate in the boardroom and get medical staff involved in decisions. We need a medical staff board with formal authority."*(Respondent 7)
> *"But didn't we allow this to happen? We act as if this suddenly happens to us."* (Respondent 14)
> *"Quality standards are imposed upon us because we didn't make them ourselves. If we stand up and say 'this is what we define as quality of care' then no one has to tell us what to do."* (Respondent 24)
> *"But what is your common purpose? What you are saying, has been said by physicians over the last 20 years. You don't need to become a manager. Do you really need formal authority to have impact?* (Facilitator 1)
> (1 February 2018; module 4)

As the quotes show, respondents experienced tensions in their heroic and clinical understandings of leadership: 'outsiders' hamper proposed improvement objectives [clinical narrative] and a lack of formal authority obstructs engagement of medical peers [heroic narrative]. Fellow participants and a facilitator responded by deconstructing their relational-agentic views towards the context, e.g. 'others': instead of blaming others for obstructing quality improvement, physicians should increase their own participation in the formulation of quality standards.

Identity *doing*: the construction of the collaborative leader

The experienced tensions and subsequent critique during group discussions and in-house sessions led by many participants to a reconstruction of their sense of self as a *collaborative leader*. This was not an isolated but a relational process steered by co-participants, facilitators, guest speakers and hospital directors.

First, participants were stimulated to reinterpret change as a *continuous* and *collaborative* process instead of an individual or isolated process. Hospital environments were repeatedly

reframed as shared contexts that require collaboration from different stakeholders to solve mutual problems: *"[We] all have to face the same challenge: how can we improve healthcare through efficient use of resources? Collaboration and mutual trusts are key. Therefore, this program brings together all stakeholders: together with hospital directors, medical staff directors and participating medical specialists we discuss issues that are relevant in both the consultation –and board room"* (program's brochure).

Instead of blaming others, participants were encouraged to find 'common ground', reconsider their 'circle of influence' and to learn how to build consensus. Guest speakers were carefully chosen depending on their [political] position (facilitator 1) (i.e. the inspectorate, health care insurers, the director of a collaboration between 'top clinical hospitals' and the director of The Dutch Council for Public Health and Society). In this way, facilitators aimed to teach participants that these actors have to become their allies instead of their opponents (facilitator 1). The following quote exemplifies a shift from being reluctant towards others to valuing common ground:

> *"I have grown as a person. I agreed with the merger [between two locations of a hospital, to which she was reluctant at first]. It is difficult to act from your own optimal vision… A part of this is letting go, finding common ground. I found it very difficult to let go of my own opinion. I'm afraid that something is less good, but it is needed to let the process succeed."* (Respondent 5, in-house session, 17 January 2018)

Second, participants increasingly understood themselves as team players who collaborate across disciplinary and professional borders instead of individual professionals. To stimulate reflections on their professional identities and relation towards others and the organizational context, the program included several self-reflective sessions. During a boxing training (participants received sports-boxing training and boxing against a partner was meant as a metaphor for 'difficult' conversations), participants gained insights in how they related to others:

> *"I developed a broader perspective, broader than my own specialty, in which collaboration is really essential. […] The boxing session was really a moment of reflection on your own way of communicating and on perspectives of others. […] Collaboration, everyone knows it is important, but you are now more focused on its value. […] I think reflection and listening to each other are of real importance. Using change theories not to push your own ideas."* (Respondent 2, in-house session, 19 June 2018)

In addition, the following interaction during a session on innovation illustrates how a participant expressed a collaborative understanding of leadership that values being a team player over pursuing individual aims:

"Team interest is always more important than individual interest. […] If someone is an excellent chef, but a total asshole, then he has to leave. […] (Guest speaker 4)

"I'm in a conflict model with my project right now. [laughs] So what I'm getting out of this session is that from this conflict we can go into two directions. I have to work on establishing a relation with others, and then work towards innovation together. No more muddling through and then proceeding in the same old way." (Respondent 5, module 3, 8 December 2017)

Third, participants expressed an understanding of leadership that moves beyond excelling in clinical work. Optimizing care delivery processes and cost-efficiency were increasingly valued as an important part of being a 'modern' physician:

"We as physicians are used to focus merely on the clinical, searching for explanations. But now I realize how important the entire process around care delivery is and to involve others in your ambitions to realize change." (Respondent 10, in-house session, 18 June 2018)

Incorporating cost considerations into daily practices was at first perceived as controversial by several participants [clinical narrative]. However, through group discussions and deconstructions (see Appendix 3) most participants increasingly valued the importance of acquiring knowledge into cost issues. Participants realized that for the success of their improvement projects it was necessary to demonstrate cost-efficiency by developing a business case. The following two quotes illustrate the development of a participant's perception towards her responsibility in optimizing cost-efficiency of care:

"I agree that things could be more efficient… But if you don't know how much something [care] costs then you can't make it cheaper. No one has any idea in my department. […] And sorry if I keep complaining, but we as physicians we don't have any insights in these things right… neither does the hospital." (Respondent 11, module 5)
"I became more critical, for example after that sessions about hospital finances I really got started, I wanted to get more insights into how this works…" (Respondent 11, in-house session 19 June 2018)

Moreover, participations increasingly valued collaboration with other non-clinicians as they began to realize that they could share their responsibilities in optimizing care processes and cost-efficiency with others (e.g. business managers and supporting staff).

Tensions in being a collaborative leader in practice

Although the construction of the collaborative self was a key development in the MLDP trajectory, it was not always a smooth transition when physicians returned to their own hospital. Physicians particularly experienced a lack of support from peers and hospital administrators with regards to their project and personal developments. In addition, they were not always granted the extensive time required for executing improvement projects because the daily pull of clinical work was perceived as too strong. This arguably hindered some physicians from wholeheartedly embracing their preferred identity as *collaborative leader* as the following quote illustrates:

> *"I experienced difficulties in finding my role. You're not a medical manager, you're not part of the (hospital/medical) board. So what's your role then? But there's expected a lot from you. You receive no formal support or feedback while you do need that."* (Respondent 10, in-house session 18 June 2018)

A lack of support by others led to identity violations as this obstructed some participants to be their preferred collaborative self. These identity violations caused participants stress and work dissatisfaction and hindered some participants from fully realizing their collaborative ambitions.

Discussion

This paper examined the identity processes among hospital-physicians participating in a Medical Leadership Development Program. We showed how participants performed identity work as a means to deal with institutional pressures for change -e.g. demands of affordability, efficiency, quality, patient-centred care and task distribution- in contemporary hospital settings by constructing three different leadership narratives: i.e. heroic (*pioneer*), clinical (*patient's guardian*) and collaborative (*linking pin*). Each leadership narrative contains a particular relational-agentic view of physicians regarding *the context* of hospitals: respectively as shapeable by an individual heroic leader; as disconnected from the clinical leader; or as collectively adjustable by collaborative leadership.

Early on in the MLDP, most of the performed narratives of leadership portrayed heroic or clinical identities. However, in the enactment of their heroic or clinical self, participants experienced identity violations: 'others' did not engage in adopting their view on necessary change [heroic narrative] and 'outsiders' increasingly influenced professional work [clinical narrative]. In response to these tensions facilitators, guest speakers, directors and fellow participants gradually deconstructed individualistic notions of agency [heroic narrative] and detached standpoints vis-a-vis the hospital context and organisational actors [clinical narrative].Through collective discussions the 'collaborative leader' emerged as a desirable alterna-

tive: i.e. someone who collectively adjusts organizational and institutional contexts by working across disciplinary and organisational boundaries.

Our results contribute to professional identity literature (Kyratsis et al. 2017; McGivern et al. 2015; Pouthier et al. 2013; Reay et al. 2017) that shows how physicians respond to institutional pressures and 'identity violations' (Berghout et al. 2018; Chreim et al. 2007; Spyridonidis et al. 2015). We illustrate how physicians, in interaction with others, unravelled their often-assumed stable and detached professional identity through a reinterpretation of their position towards the 'context': other clinical and non-clinical actors, organizations and institutions. By using the concept of "contexting" (Asdal & Moser 2012) we demonstrate how physicians reinterpreted hospital contexts as collectively adjustable rather than as pre-given settings that hinder them in pursuing their aspirations to increase quality and efficiency of care. Individualistic notions of agency [heroic narrative] and detached standpoints vis-a-vis organisational and institutional contexts (e.g. hospital settings, the healthcare system, healthcare insurance companies) and organisational actors [clinical narrative] were gradually deconstructed. In turn, by constructing a collaborative sense of self, participants aimed to break down institutionalized contexts in healthcare (e.g. boundaries between primary care and hospital care; disciplines; care/cure) to enable multi-disciplinary teamwork and improvement of quality and efficiency of care.

During the course of the MLDP, participants increasingly identified with organisational objectives and non-clinical actors, showing the hybridity of their professional identities and confirming recent findings of other scholars (Kyratsis et al. 2017; McGivern et al. 2015; Numerato et al. 2012; Reay et al. 2017). Specifically, participants perceived the optimization of care processes and cost-efficiency as an important part of being a physician. However, the desirable identity as collaborative leader was not always easy to enact when physicians returned to their own hospital (e.g. when implementing their improvement project) as others (e.g. peers, directors) did not always support this new self-image. Our findings reveal that when 'new' (organisational) responsibilities, such as multidisciplinary collaboration, are not backed-up by a supportive environment this may lead to identity violations causing stress and work dissatisfaction. Although the MLDP offered an important supportive space to discuss these identity violations, physicians also needed a supportive space within the hospital environment itself to not become 'isolated' leaders with unrealized collaborative ambitions.

Moreover, our study reveals the influence and *importance* of 'others' in professional identity work. Participants were neither passive recipients of disciplining techniques imposed by facilitators, known in literature as identity regulation (Alvesson & Willmott 2002), nor individual directors of their own identity scripts. Rather, we observed how identity work was conducted in a *collective* manner. 'Others', educational instructors, directors, fellow participants, were actively engaged in identity work by stimulating participants to investigate their professional values and relation to the changing hospital context. Professional identity reconstruction is thus not merely an individual conduct regulated by professionals but others including *non*-clinicians can play a significant role in changing the professional self (Chreim et al. 2007).

Our findings confirm the importance of relating to or differentiating from others (different/similar) in identity work (Andersson 2015: 85; Brown 2015). The discourse of medical leadership was used by the participants to de-identify from other physicians (heroic narrative) and managers (clinical narrative) or to actually identify *with* these similar/different others (collaborative narrative). Physicians are well known for their ongoing struggles with 'others' over power (Suddaby & Viale 2011). Accordingly, our findings illustrate how managers were still partly considered as the 'anti-identity' in the heroic and clinical narrative (Martin & Learmonth 2012; Numerato et al. 2012). However, more interestingly, the collaborative leadership narrative shows that managers, other professions and directors, were increasingly regarded as equal and necessary partners in healthcare while colleague-physicians who refuse to collaborate in change initiatives were considered as the new 'anti-identity'. This implies that 'old' dichotomies between physicians and managers may be gradually supplemented or replaced with 'new' dichotomies between 'leading' and 'detached' physicians.

We argue that our specific approach of observing a MLDP reveals valuable insights into *collective* identity work, thereby contributing to recent studies in the professional identity literature (Kyratsis et al. 2017; McGivern et al. 2015; Pouthier et al. 2013; Reay et al. 2017). However, one could question to what extent the move towards a collaborative identity was solely caused by the MLDP program given the limited time span of the program (1 year). We argue that the program cannot be seen as entirely decoupled from practice. Rather, we argue that this move is a result from interactions between practice and the program and is caused by a variety of factors. Collective discussions during plenary sessions, the in-house sessions, practical experiences concerning individual improvement projects, feedback from facilitators or hospital boards and discussions with peers in daily medical practice all together fueled a move towards a more collaborative understanding of leadership. Further research could therefore consider longer periods of observations *in situ*, including shadowing physicians in their daily work, to gain a better understanding of identity processes of physicians in hospitals.

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APPENDIX 1 Content of the program and examples of individual improvement projects

Content of the program	Examples of individual improvement projects
Module 1: Introduction, theory on leadership styles, group discussion about medical leadership, personal reflection exercise	Establishing a multidisciplinary breast center
Module 2: Theory on quality dimensions, theory on short-cycle improvements, individual exercise in applying these on personal projects	Educating new professionals, for example a specialized nurse at the maternity ward
Module 3: Guest speaker on leadership in 'high performance organisations', exercise in applying insights on personal projects	Harmonizing care protocols among different hospital locations
Module 4: Guest speaker (physician) on personal leadership, guest speaker (psychologist) on relations in teams, session with directors on lifestyle and prevention	Improving emergency care by increasing collaboration with primary care
Module 5: Guest speakers (director top-clinical hospitals, patient) on shared decision making, guest speaker (director Dutch inspectorate) on policy making and accountability, guest speaker (financial advisor) on healthcare costs and efficiency, expert panel healthcare entrepreneurs	Developing a medical app (i.e. an app for pregnant women in which they can find personal information from midwives, gynecologists and about maternity care)
Module 6: Guest speakers (2 physicians, 1 nurse) about their role as 'medical leader', guest speaker (director Dutch Council for Public Health and Society)	Coordinating hospital-broad value based healthcare projects
In-house sessions (3): participants present the developments of their individual improvement projects to hospital directors, facilitators and peers	Establishing a disease-specific network among different disciplines, professions and organisations

APPENDIX 2 Example of the narratives *[quotes are from participants, unless indicated otherwise]*

HEROIC NARRATIVE *'the pioneer'*		
My goal as a leader is to convince others of my vision As a leader I think it is extremely important to get along the laggards I want to be an inspiration to others	**Visionary**	Shaping the context
Someone who is leading the fight. People who take up actions A medical leader is someone who can master burn-outs and who doesn't drown in the amount of work	**Hard worker**	
Not everyone is capable of being a medical leader It's time for a new (and young) generation	**Happy few**	
A medical leader is not only outstanding in her/his own medical specialty, but also takes responsibility in continuously improving patient care (program's brochure)	**More than the clinical**	
Someone who has organised patient care perfectly You are a good doctor and therefore you are going to lead	**Medical excellence**	
CLINICAL NARRATIVE *'the patients' guardian'*		
First comes the work floor, then finance and then profits. That's what makes us special You are the autonomous professional. You know that. You will make the difference, not the managers, not the board of directors (guest speaker)	**Specialness**	Disconnecting from the context
There are more and more suits in the cafeteria. I don't like it, we should keep all those guru's outside the hospital The board of directors has a hidden agenda. They just want everything cheaper and more efficient They [managers] don't have any insights about quality of care. They only care about costs	**Not-manager**	
What distinguishes a medical leader is the connection to the patient You [physician] don't work primarily for the organisation. That is not your primary concern No one says I want to be a medical leader because I want to increase production	**Disconnected**	
We [rather than managers] really feel what people go through in the consultation room A medical leader is someone who is part of the physicians	**Exclusive**	
Our role is to improve patient care, that's different than [medical] managers, who are occupied with work schedules, performance, finance etc. When I pick up a patient from the waiting room I really don't care about any costs	**Quality of care**	
COLLABORATIVE NARRATIVE *'the linking-pin'*		
You have to do it together that is a characteristic of a medical leader. Learning to speak each other's language. Learning to transcend your own discipline	**Inclusive**	Adjusting the context
I used to consider expressing emotions on the work floor as unprofessional behavior, now I realize I was wrong Peer support and open communication are important subjects what we as a young generation should stimulate to express more	**Reflexive**	
Everyone is shouting 'patient first' yet no one acts like it. We must leave behind our own blood group [medical specialty]	**Multi-disciplinary**	
If you want to be an entrepreneur, you should have financial knowledge A medical leader should be responsible for both quality and costs (guest speaker)	**Cost-efficiency**	
Hospital directors, medical staff directors and medical specialists all have to face the same challenge: how can we improve healthcare through efficient use of resources? (program's brochure)	**Emphasizing interdependencies**	

APPENDIX 3 Examples of identity *un*doing

Identity undoing	
Deconstruction of the heroic leader identity	
Tension: unable to engage others in adopting a vision	**Deconstruction**
"I developed an application for pregnant women in which they can follow their own care trajectory. […] So now my goal is to convince the midwives. [Then thinks deeply.] Yes, as a leader I think it is extremely important to get along the laggards. You see, I know what I want, but is much more important that I convince others too. Midwives can be very conservative." (Respondent 3, in-house session 15 January 2018)	"What really helps me in projects where everyone holds a different view is to ask them 'what do you need to get attached? And how can I help you?' You really have to realize that it is a new game you are playing. A very difficult game." (Hospital director)
"There are people in our organization… they just do not care at all. I found that extremely difficult…" (Respondent 19, module 3)	"Choose your battles. There are people who do listen [name respondent 19]. Who do want to change." (Guest speaker 4)
"Trust is lacking [in my project]. That's the big issue. I'm standing still for two years now." (Respondent 3, module 4)	"Ok, but what is your circle of influence? You all have the ambition to put the patient central. […] So which people do you need to address? And how?" (Guest speaker 5)
"Do you have a tool for pure reluctance? But when you cannot fire them." [everyone laughs loudly] (Respondent 18, module 3)	"The answer is attention. […] So, [name respondent 18] trust me, it's also because of you that those others do not want to change. So have a look at yourself too." (Guest speaker 4)
"Sometimes I just wish that someone just take a decision instead of having to argue over and over again and have another three meetings about the same issue" (Respondent 11, module 2)	"But you can also turn it around right. We wanted to change the mamma clinic into a multidisciplinary center. Every physician was reluctant. But then we asked PR to interview everyone, the radiologists, the pathologists. Slowly everyone became enthusiastic, you have to create a feeling of ownership. It can help to just give other people credits." (Respondent 6)
Deconstruction of the clinical leader identity	
Tension: others influence professional work	**Deconstruction**
"I noticed that [name Michelin-star restaurant] created their own quality norms. Compared to hospitals, so many quality norms are imposed upon us by outsiders…" (Respondent 3, module 3)	"Mister Michelin is just one norm, but we don't think this is high enough. So, how do you deal with norms that are imposed upon you from the outside? I think that you really need to know *yourselve*s that you deliver high quality of care and determine your own norms." (Guest speaker 4)
"External parties determine how you work and you have almost no influence on that." (Respondent 18, module 5)	"And therefore it is so important to acquire knowledge of your external environment. There is so much knowledge available, but maybe you don't possess it yet." (Guest speaker 2) "I thought that the hospital board would deal with that, but I guess I shouldn't count on that." (Respondent 9)
"Our department is a flat organization, like a family. Who doesn't like that is the hospital. It is extremely hard for them to involve with us. So what you get is that managers are trying to do stuff behind our backs. And that causes friction." (Respondent 19, module 3)	"You reign too much in your bastions and take too little notice of your surroundings. I would hate you too. And I blame you for the consequences. […] Although you think you are accessible… you are not, and so there is friction." (Guest speaker 4)
"It is often a battle between managers and physicians. Managers don't have any insight into quality of care. Only into costs. So a medical leader has to do both. Causes a lot of tensions. Collaboration is very difficult. […] They are not the ideal partner." (Respondent 20, module 5)	"I don't really recognize this. If you have an experienced business manager. […] We are lucky with business managers with backgrounds in nursing and they have insights in both quality and costs. […] There is often more room than you think there is." (Respondent 24)
"I am extremely bothered by managers. We're just not like minded. […] They have their budget and I see my patients and those are two totally different worlds. I don't know what he does and he doesn't have a clue what I am doing." (Respondent 18, module 4).	"I get the creeps from managers too. But I do sit down with business managers very consciously because they often are the key to logistics [in change projects]." (Respondent 6)

7

Conclusions on investigating medical leadership in the Dutch Healthcare sector

Conclusions on investigating medical leadership in the Dutch healthcare sector

> *"Are we telling physicians they all need a title? No, we're not. All physicians need to be leaders, whether or not they have a formal title. Physicians in every area of medicine have opportunities to lead right now. Some physicians lead small teams in their offices. Some lead by educating their peers. Others lead by advancing their fields or by advocating for better care. There are a few, necessary, titled positions, but there are countless ways to lead in everyday practice and to share the opportunity to lead in team-based health care."* (Dath et al. 2015: 4.)

Executing merely clinical work is not enough for being a modern physician. According to the authors of the 2015 Canadian CanMEDS competency model for physicians (Dath et al. 2015: 4) all physicians need to be leaders, within their daily clinical work or by performing formal leadership positions. Only by becoming medical leaders, physicians would be able to save healthcare from insurmountable crises. Physicians who act as advocates for medical leadership argue that medical leadership will lead to improved health outcomes, higher patient satisfaction, increased efficiency and cost containment. By pleading for medical leadership, advocates aspire to reconfigure medical professionalism in terms of the core of professional work, the medical professional identity and the content of educational curricula. What it means to be a modern physician is currently a matter of debate.

In the ongoing discussion about medical leadership, two different views on medical leadership become visible, which have potential consequences for the reconfiguration of medical professionalism. On the one hand, advocates portray medical leaders as heroes who proactively deal with an increasingly complex healthcare system. On the other hand, advocates portray medical leaders as victims who, because of this complexity, need to regain the lead from external 'intruders' and safeguard their medical domain from administrative burden. What these different views have in common, is that they both depict medical leadership as necessary for *every* physician. By framing physicians as leaders, they encourage peers to reconfigure medical professionalism in terms of their medical professional identity, the core of professional work and the content of educational curricula. However, an investigation of how physicians use medical leadership discourses *in practice* to reconstruct their profession lacks. So far, research mainly focused on eliciting skills and competencies thereby neglecting the social construction of medical leadership in practice and its consequences. Therefore, the aim of this thesis is to investigate *how* physicians aim to change medical professionalism by pleading for and acting as medical leaders.

The central research question of this thesis is:

How is medical leadership socially constructed in academic literature and clinical practice and what are the implications of these constructions for the reconfiguration of medical professionalism?

This question is divided in the following sub-questions:

(4) *How is medical leadership constructed in academic literature?*
(5) *How is medical leadership constructed in daily practice?*
(6) *What are the implications of medical leadership for the reconfiguration of medical professionalism?*

To answer these questions qualitative research designs are predominantly used, supplemented with quantitative research methods (Q-methodology). The research begins with a systematic review of the academic literature on medical leadership. By means of this review we aim to investigate the diversity of constructions of medical leadership in the scientific literature. Based on the outcomes of this study, a Q-methodology is performed to investigate the views of hospital-based professionals (nurses, managers, physicians and laboratory technicians) on the importance of the elicited constructions of medical leadership in the academic literature. Then, 'strategic arenas' – i.e. different media platforms and national conferences – that advocates of medical leadership use to stimulate peers to become medical leaders are investigated. By performing a discourse analysis we are able to investigate how and for what purposes medical leadership is constructed in these arenas. These investigations show that advocates frame physicians as leaders in order to construct a new medical professional identity. Whether physicians in practice feel the urge to take up these leadership calls, remains however unclear. Therefore, it is subsequently investigated how physicians construct their medical leadership roles in daily practice. For this purpose, observations and informal interviews are conducted at a one-year medical leadership development program. This study enables us to get a deeper understanding of how physicians in collective discussions construct their new role as leader and what the perceived implications are for their medical professional identity. Finally, this thesis zooms in on the work of physicians who are in fact (formal) 'leaders' in their daily work: medical managers. Six medical managers working in a hospital setting during their daily work are shadowed to study the constructions of their leadership role. In specific, this research focuses on how they construct and perform their leader-self to others and balance their credibility. Shadowing allows us to investigate how physicians as medical managers perceived and executed their assumed leadership role in addition to their clinical work.

In the further conclusions of this thesis, the different constructions of medical leadership in academic literature and daily practice are illustrated. Then, reflections on the implications of medical leadership for the reconfiguration of medical professionalism in terms of a (new) medical professional identity, the repositioning of the medical profession in the field of healthcare and recent adjustments to educational curricula are provided. The chapter ends by providing theoretical, methodological, and practical implications of this research.

Different constructions of medical leadership in academic literature

This thesis shows that academic literature lacks conceptual clarity when describing the term medical leadership. The outcomes of a systematic literature review (chapter 2) illustrate that medical leadership often is constructed as either formal or informal leadership, and as activities, and personal features. Moreover, the academic literature refers to context-specific factors that are necessary for the development of medical leadership in hospitals.

As *formal leaders*, physicians execute formal leadership positions in their organizations. For example, as medical directors at executive level, or as medical managers or clinical directors at management level. Physicians perform these positions either full-time or part-time in addition to their clinical work. As *informal leaders*, physicians act as leaders in their daily work increasing efficiency of care delivery or initiating quality improvement projects. This type of medical leadership is not considered an extra 'duty' on top of clinical work, but rather as an inherent part of professional work.

Another way how medical leadership is constructed in literature is in terms of activities and roles. The literature reveals a distinction that is made between general 'management' and 'leadership' activities on the one hand and activities that physicians as medical leaders carry out in order to balance 'between management and medicine' on the other hand. *General management and leadership activities* are described as activities that are not distinctive for the medical field and include for example finance, strategy making, staff management, human resources, leading innovation, building consensus, or empowering peers. *Activities to balance between management and medicine* are related to the context in which medical leaders are expected to operate: at the border between management and medicine (objectives). These activities include for example bridging managerial and medical objectives (e.g. aligning quality and efficiency objectives) or safeguarding department objectives over hospital objectives.

Medical leadership is also constructed in terms of *personal features* that are characteristic for a medical leader. The most cited factor is having credibility among medical peers. Credibility is an important source of legitimacy, influence and recognition that enables a medical leader to actually get things done. Credibility is said to be derived from medical excellence, respect by peers, commitment to clinical work, and a collegial disposition. Other personal features that are elicited from the academic literature are skills (e.g. communication, empowering others, resolving conflicts) fields of knowledge (e.g. clinical knowledge, finance, IT, knowledge on organizational structures or healthcare systems) and attitudes (e.g. motivation, assertiveness and being a team player).

Finally, the scientific literature reveals *context-specific factors* that are related to medical leadership in hospital settings, which are interpreted as facilitators or barriers in developing or executing medical leadership. These factors are specific for hospital contexts in which medical leaders operate. For example, the presence of competing logics in hospitals between management, focused on costs and efficiency, versus medicine, focused on quality and affordability of care, is often experienced as a barrier for physicians in executing leadership roles. The issue of competing logics could make a medical leader feel stuck between quality

and efficiency issues, being autonomous versus a subordinate, and committing to clinical or managerial work. Others factors are (a lack of) time, support or role clarity.

The answer to the first sub-question, shows that medical leadership is constructed in the academic literature in many diverging ways, thereby lacking conceptual clarity. Yet, we argue that medical leadership is not merely a set of skills, tasks or competencies. Rather, medical leadership can be a normative term prescribing the desired identity and core of professional practices of 'modern' physicians. To investigate how physicians strategically use the discourse of medical leadership, the next sub-question turns to the social constructions of medical leadership by physicians – and other professionals – in daily practices.

The social construction of medical leadership in daily practice

In answering the second sub-question of this thesis we aim to investigate the different social constructions of medical leadership in daily practices. This thesis illustrates the different social constructions of medical leadership in three settings: the strategic arena, a medical leadership development program and a hospital setting.

First, physicians use strategic arenas to construct medical leadership in their institutional work to change medical professionalism. As described in chapter 3, physicians who advocate for medical leadership use different media platforms, i.e. influential medical journals, national conferences and well-visited websites, to plead for a reconfiguration of medical professionalism. By framing physicians as leaders in these strategic arenas they try to (1) regain the lead in medical professionalism, (2) denounce old professional values, and (3) construct the 'modern' physician. By framing physicians as leaders, they encourage physicians to 'get back in the lead' and safeguard their autonomous position from alien 'outsiders' such as politicians, managers, civil servants and insurance companies. Yet at the same time, physicians use the discourse of medical leadership to denounce old professional values such as hierarchy, strong socialization and an unquestioned autonomy. By encouraging physicians to become medical leaders they are in fact stimulated to question and abandon these 'old' values that are obstructing multidisciplinary collaboration that is necessary for quality and safety of care. Moreover, physician advocates use the discourse of medical leadership to construct the 'modern' physician by prescribing skills, responsibilities and preferred behavior necessary for a 'new' medical professional identity. As leaders, physicians are stimulated to act as multidisciplinary team players who pro-actively engage in the improvement of quality and efficiency of care.

That pleas for medical leadership are not just rhetorical, is also shown in the case of leadership development programs, as described in chapter 6. In these programs physicians perform identity work by collectively constructing three distinctive identities of medical leaders as heroic leaders, clinical leaders and collaborative leaders. These constructions show different interpretations of what it means to be physician and of physicians' relational-agentic views towards hospital contexts, other (non)clinical actors, or larger institutional contexts, such as the healthcare inspectorate or the Dutch healthcare system. The heroic leader represents a 'pioneer' who has a strong vision on the future of healthcare and extends clinical

work with quality –and efficiency improvement. This construction reveals an interpretation of the hospital and the broader institutional context as individually shapeable. In this view, peers who do not want to change are regarded as the new 'anti-identity'. In contrast, the identity of 'the clinical leader' reflects a 'patients' guardian' who considers clinical practice as the core of being a physician. Hospital or institutional arrangements (i.e. a strong focus on costs and performance management) and non-clinical actors (i.e. managers) are regarded as obstructions to perform the essence of their work. Physicians constructing this view on leadership, therefore aim to disconnect themselves from these contexts and actors. Finally, the collaborative leader can be described as a 'linking-pin' who perceives hospital contexts and institutional arrangements as collectively adjustable in collaboration with clinical and non-clinical peers. Within this construction, being a physician means being a multidisciplinary team player –within and beyond the care team- who does more than merely clinical work, i.e. initiating clinical or organizational improvement projects or executing financial responsibilities. The constructions of three different identities are co-constituted through collective discussions with peers, facilitators, hospital directors and guest-speakers. By critically questioning heroic and clinical constructions of medical leadership, other actors co-steer the emergence of collaborative leadership as a desirable new medical professional identity. The reconfiguration of medical professionalism is thus not an individual act merely performed by physicians. Others, including peers and non-clinical actors, such as educational instructors or hospital directors, actively engage in identity work too.

This is also shown in chapter 4, which describes how hospital based nurses, technicians, managers and physicians construct medical leadership. By highlighting their views on what is important for medical leadership in hospitals, professionals and managers construct three distinctive type of leaders based on the elicited factors discussed in the systematic review in chapter 2. First, a *strategic leader*, who participates in hospital strategy and aims to align hospital objectives with specific department objectives. Second, a *social leader* who has strong communication and collaboration skills. And third, an *accepted leader* who has credibility among peers and who is guided by a clear job description. These constructions contain the most overlap with the collaborative leadership construction described in chapter 6 and the construction of the 'modern physician' described in chapter 3. These constructions all emphasize the need for physicians to become team players who collaborate with clinical –and non-clinical actors within and across disciplinary and organizational boundaries. Moreover, these constructions urge physicians to increase their participation in achieving hospital objectives, such as quality or efficiency improvement: not in addition to clinical work but as *inherent* part of their professional work.

Finally, by zooming in on the daily work of medical managers in chapter 5, it is investigated how physicians as medical managers construct and perform their (new) self to others. This group of physicians is especially interesting to study as they are expected to act as 'leaders' in their daily work. Using the work of sociologist Irving Goffman on the 'presentation of self in everyday life' (1956, reprint 1978) we illustrate that medical managers construct four

distinctive performances of the 'self': a comfortable self, an uncertain self, a political self and a mediator self. Each performance of the self shows a different interpretation and performance of the medical management role. The comfortable self enjoys the performance and uses the medical management role to engage peers in increasing quality and efficiency of care. The uncertain self dislikes the managerial role as it obstructs clinical practice and generates uncertainty about how to perform this role convincingly. The political self uses the managerial role to safeguard department objectives and budgets towards other clinical departments. The mediator self considers translating interests within and beyond the clinical department as the main responsibility. Each construction shows how credibility among clinical peers, managers and directors is balanced. The systematic review described in chapter 2 demonstrates that commitment to clinical work is said to generate most credibility among peers, yet the observations show that the sources of credibility are shifting. Among peers, credibility is foremost derived from the ability to represent department interests and motivation to engage in hospital management and governance. Among business managers or hospital directors, credibility stems from the ability to reason from cost-effectiveness arguments and align department objectives with hospital projects.

In conclusion, the different constructions of medical leadership show how physicians – and other professionals – aim to reconfigure medical professionalism in practice. What these constructions have in common, is that they incorporate new understandings of what it means to be a physician in today's healthcare. Physicians aim to broaden their professional practice by engaging in improvement of patient care (e.g. quality and safety of care or the efficiency of care delivery processes) in addition to mere patient consultations. Yet, the constructions also show an important difference. A majority of the advocates constructs a collaborative understanding of medical leadership. Instead of highly autonomous and authoritarian professionals, these physicians aim to become responsible, multidisciplinary team players who work across disciplinary and professional borders to improve quality and (cost)efficiency of healthcare. A smaller group of advocates, however, argues that in order to improve healthcare, physicians should get back into the lead to regain their autonomous position in healthcare and decrease the influence of non-clinicians. In strategic arenas (chapter 3), the medical leadership development program (chapter 6), or in a hospital setting (chapter 5), these physicians use medical leadership discourses or their medical leadership role to safeguard the medical profession from external influences (i.e. excessive focus on costs and performance management) caused by non-clinical actors, such as managers, politicians or directors. These advocates argue that improving healthcare and decreasing complexity and administrative burdens, is something that only physicians can do. This thesis, however, shows that the latter attitude is increasingly criticized by clinical peers, facilitators in medical leadership development programs and medical directors. Moreover, physicians experience in their daily work that in order to improve healthcare they increasingly need to engage with non-clinical actors or participate in cost-efficiency objectives (e.g. by writing business cases or supporting clinical arguments with financial ones). It is thus questionably to what extent the second view remains sustainable in the future.

Implications of medical leadership for the reconfiguration of medical professionalism

The final aim of this thesis is to investigate what the implications of medical leadership are for the reconfiguration of medical professionalism in terms of the core of professional work, the medical professional identity and the content of educational curricula. As shown in this thesis, advocating medical leadership and framing physicians as leaders are no neutral acts. Rather, we claim that these rhetorical pleas for leadership have real consequences in practice as they co-constitute new realities, i.e. what it means to be a modern physician in contemporary healthcare. In that sense, rhetorical pleas for leadership have performative effects and should be taken more seriously in terms of consequences (Alvesson & Karreman 2000; Austin 1962, Gond et al. 2016).

First, medical leadership constructions have implications for the core of professional work.

Collaborative notions of medical leadership, underscored by the majority of advocates, imply a significant change in the core of professional work. Care delivery –especially for chronic patients, frail elderly or patients suffering from multi-morbidity– must become a team effort instead of an individual effort. In order to do so, physicians must work across disciplinary, professional and organizational borders. Moreover, instead of mere patient consultations, advocates consider financial, organizational or quality improvement responsibilities as an increasingly important part of the work of a physician due to changing patient preferences and financial pressures. Other professionals such as hospital-based nurses, technicians and managers underscore the importance of multidisciplinary collaboration and the participation of physicians in achieving hospital objectives such as quality and efficiency improvement and argue that this needs to become an inherent part of professional work (chapter 4).

Yet, not all medical leadership advocates aim to change the core of their professional practice. A small group of advocates depict a more conservative or 'clinical' notion of medical leadership. Their medical leadership constructions are used as a means to return their practice to its 'essential' core: treating patients. Similar to other advocates, however, these constructions incorporate multidisciplinary notions of care delivery. Yet, an important difference is that they do not consider engagement in improvement projects, organizational objectives or participation in hospital management or governance as an inherent part of professional work. Rather they interpret these activities as -sometimes unwanted- duties *in addition* to their clinical work. Being a medical manager, for example, is by some physicians perceived as an obstacle in performing clinical practice (chapter 5). These advocates use medical leadership discourses to safeguard their clinical work from external pressures such as regulatory pressures, administrative burdens, the focus on performance management and costs (chapter 3 and 6). The engagement of physicians in improving healthcare is merely considered as a means to bring simplicity back in healthcare and to subsequently bring the core of their work back to the essence of medicine: i.e. treating patients.

Second, medical leadership constructions have implications for the medical professional identity. Identity has to do with how actors interpret themselves and give answer to questions such as who am I? and where do I stand for? (Brown 2015). According to the majority of

medical leadership advocates, physicians need to transform their identity from being highly autonomous and authoritarian professionals to multidisciplinary team players. These collaborative notions diminish 'classic' characteristics of professional identities, such as a strong socialization process, an unquestioned autonomy and hierarchy as these would hinder the development of collaborative medical identities. Rather, advocates argue that the medical identity will be increasingly characterized by transparency, collaboration and responsibility to adapt to changing patient and organizational demands. Physicians who refuse to change their practices or engage in improvement projects are regarded as the new 'anti-identity' – instead of, for example, business managers, policy makers or politicians. Medical leadership constructions also reconfigure the position of the medical profession in the Dutch healthcare sector vis-à-vis other actors, such as managers, policy advisors, politicians, healthcare insurance companies, the healthcare inspectorate or hospital directors. Physicians increasingly identify with these 'others' and the context they work in, e.g. hospital contexts or the Dutch healthcare sector and financial system, with whom they share similar aims: improving quality and efficiency of care.

A smaller group of advocates that constructs more conservative notions of medical leadership, however, aims to regain 'the lead' in medical professionalism. Chapter 3 and 6 show how physicians construct leadership identities, to safeguard their elite position in healthcare from influences from, for example, healthcare insurance companies, the government, business managers or hospital directors. These physicians argue that these 'outsiders' increasingly dominate and regulate healthcare resulting into exhaustive amounts of administration and focus on costs rather than quality of care. Moreover, physicians argue that they – instead of non-clinical actors – are most able to decide over clinical-related issues. Chapter 6, for example, shows how physicians participating in a medical leadership development program develop clinical leadership identities that de-identify from non-clinical actors, such as managers, politicians or hospital directors. In a similar vein, chapter 2 and 5 reveal that medical managers who serve as formal leader of their clinical department can perceive their role as a political act safeguarding department objectives (e.g. quality of care) from 'managerial' objectives (e.g. cost containment or performance management).

Finally, the medical leadership constructions from literature, physicians and other hospital-based professionals have implications for the content of medical educational curricula. The constructions reveal certain skills and tasks that physicians arguably need to acquire and contextual factors that need to be in place to adapt to changing clinical and organizational demands (chapter 2 and 4). By pleading for medical leadership, scientists, physicians, nurses, managers and laboratory technicians advocate the incorporation of new skills such as strategic skills (i.e. developing a vision on healthcare improvement and aligning clinical and efficiency objectives) and social skills (i.e. communication and collaboration) in medical educational curricula. Additionally, the observations of medical managers in chapter 5 demonstrate that physicians who aim to become formal leaders in hospitals need to acquire new sources of credibility in addition to medical excellence. The ability to serve department objectives, align

these to hospital interests and reason from cost-efficiency arguments are increasingly necessary to perform effectively as medical manager. Chapter 3 at last, shows that young, less powerful medical students also advocate change. They use medical leadership discourses to criticize their current medical curriculum and plea for the incorporation of medical leadership skills. Medical students argue that medical education now lacks key skills, e.g. financial, organizational or social skills, which they perceive as necessary to become a future physician in a changing healthcare sector.

The above investigations demonstrate that the development of medical leadership among physicians has real consequences for the reconfiguration of medical professionalism. By framing physicians as leaders, advocates aim to adjust the core of professional work, the medical professional identity and medical educational curricula. Yet, not all physicians aim to reconfigure medical professionalism. By pleading for medical leadership some physicians aim to regain their elite position in healthcare and bring the core of their work back to the essence of medicine: treating patients. However, as argued before, more conservative views of medical professionalism are increasingly criticized by clinical peers, hospital directors and managers, and educational facilitators. Moreover, physicians experience that these notions could hinder them in achieving improvement of quality or efficiency of care. The sustainability of more conservative interpretations of medical leadership thus remain questionable.

Theoretical implications

This thesis has several theoretical implications. First, the outcomes contribute to the sociology of professions literature that deals with questions of how 'professions' (such as lawyers, accountants or physicians) are defined, organize their work and evolve over time in interaction with other occupational groups and in reaction to, for example, changing client, organizational and public demands (Abbott 1988; Evetts 2011; 2013; Freidson 2001; Muzio & Kirkpatrick 2011; Noordegraaf 2007; 2015; Waring & Currie 2009). The advocacy for and construction of medical leadership reflects the aim of physicians to reconfigure medical professionalism in order to better adapt to changing patient and organizational demands. Instead of being a highly autonomous and authoritarian professional, several physicians increasingly perceive a 'good' professional as a team player who works across professional, disciplinary and organizational boundaries. These outcomes are opposite to the well-known assumption that (medical) professional identities are relatively stable and detached (i.e. detached from organizational objectives, hospital contexts or non-clinical actors) (Abbott 1988; Currie et al. 2012; Doolin 2001; Freidson 2001; Pratt et al. 2006). Instead, this thesis demonstrates that medical professional identities become more hybrid, fluid and blurred with organizational and managerial contexts, which is in line with recent research (Kyratsis et al. 2017; McGivern et al. 2015; Noordegraaf et al. 2016; Reay et al. 2017; Spyridonidis et al. 2015). Medical leadership advocates consider achieving organizational objectives, such as the optimization of care processes and efficiency, as an inherent part of professional work, which is also reported by other scholars (McGivern et al. 2015, Muzio & Kirkpatrick 2011; Kyratsis et al. 2017; Noordegraaf 2007; 2015;

Noordegraaf et al. 2016; Numerato et al. 2012; Reay et al. 2017; Veenstra et al. 2017; Voogt et al. 2016; Wallenburg et al. 2019). These findings are in the sociology of professions literature described as 'organized professionalism' or the hybridity of professions (McGivern et al. 2015; Opdahl Mo 2008; Noordegraaf 2007; 2015; et al. 2016; Postma et al. 2015; Spyridonidis et al. 2015). Scholars use these concepts to highlight that organizational (or managerial) and professional logics are not intrinsically conflicting, but are in fact increasingly connected and overlapping (Noordegraaf 2007; 2015; Numerato et al. 2012; Postma et al. 2015; Wallenburg 2012; et al. 2016; Waring & Bishop 2013). In a similar vein, the results in this thesis show that physicians are changing their relational-agentic view towards hospital contexts and non-clinical actors. Instead of merely safeguarding their practices and field from these 'others' (Burri 2008; Currie et al. 2012; Suddaby & Viale 2011), physicians increasingly perceive managers, directors, financial administrators as allies in their aims to improve healthcare (see also Reay et al. 2017; Veenstra et al. 2017; Wallenburg et al. 2019. Moreover, they perceive peers who do not aim to change their practices or collaborate across professional or disciplinary borders as the new 'anti-identity'.

An additional implication for the sociology of professions literature is that this thesis shows that hospital-based physicians wanting change (in organizational and or clinical issues) need new sources of credibility. Traditionally, medical excellence and showing peers commitment to clinical work were important sources of credibility (Andersson 2015; Llewellyn 2001; Witman et al. 2011). Yet, physicians increasingly experience that this is not enough. They also need to be able to align department objectives to hospital broad objectives (i.e. cost-containment or efficiency), reason from cost-efficiency objectives or know how to write an appropriate business case. Hence, sources of credibility become more varied in addition to the increasingly diverse audiences that physicians need to address. Physicians now need to give credible performances: not only to their peers, but also to financial managers, hospital directors or policy makers.

However, with regards to the sociology of professions literature, this thesis only partly counters the often-made argument that physicians by their very nature react hostile to external pressures, such as managerial objectives, increased calls for transparency, or the introduction of new professions (Abbott 1988; Burri 2008; Currie et al., 2012; Doolin 2001; Freidson 2001; Kitchener, 2000; Kitchener & Mertz, 2012; Levay & Waks, 2009; Numerato et al. 2012; Sheaff et al., 2013; Waring, 2007; Waring & Currie, 2009). While the above described developments and reconfigurations of medical professionalism are embraced by an increasingly larger group of physicians, they are not embraced by everyone. In fact, some physicians also use medical leadership discourses to safeguard their traditional elite position in healthcare. By framing non-clinical actors, such as managers, politicians, directors or healthcare insurance representatives, as incompetent to improve healthcare they encourage physicians to regain 'the lead'. Medical leadership is in this way used to decrease influence of actors without a clinical background on clinical practices and reduce administrative burdens and regulatory pressures. This can be considered as an exercise of conservative power, which

physicians are known for in literature (Currie et al. 2012; Learmonth 2017; Numerato et al. 2012; Suddaby & Viale; Waring 2007; Waring & Currie 2009). The outcomes of this thesis thus show that we should take the diversity between physicians more seriously, thereby avoiding the trap of treating physicians as a homogenous group. Although physicians thus might become increasingly 'hybrid' (McGivern et al. 2015; Noordegraaf 2015; Spyridonidis et al. 2015) and organizational and managerial logics blur and intertwine (Noordegraaf 2007; Postma et al. 2015), boundaries between medicine and management also get resurrected when it is strategically convenient. This thesis thus demonstrates that boundaries are negotiated in practice (Bijker et al. 2009; Gieryn 1983; Hernes 2004; Oldenhof et al. 2016). Medical leadership advocates for example draw a discursive boundary between medical and non-medical actors (e.g. managers, politicians, policy makers) to regain their exclusive position in healthcare. In contrast, the findings also show how by constructing collaborative notions of medical leadership, physicians deconstruct boundaries between physicians and non-clinical actors by emphasizing their mutual dependence in improving healthcare.

Finally, this thesis has implications for New Public Management (NPM) literature (Evetts 2009; Hood 1995; Lane 2002; McLaughlin et al. 2002; Noordegraaf 2007; Noordegraaf & Abma 2003; O'Reilly & Reed 2011). The medical leadership discourse is often presented as a promise to move beyond NPM developments that are said to negatively affect clinical practice, such as performance management or increased regulation. In strategic arenas, for example, physicians positively associate medical leadership with heroic skills or radical change. In contrast, they negatively link management with New Public Management (NPM) reforms, excessive administration and bureaucratization. Likewise, physicians participating in the medical leadership development program construct leader identities that criticize NPM objectives, such as efficiency or transparency, in order to bring the focus back on clinical work. Yet, at the same other physicians construct medical leadership identities that in fact incorporate skills or activities, such as (cost)efficiency, responsibility or transparency, that have been previously linked to NPM reforms (Learmonth 2017; Martin & Learmonth 2012; O'Reilly & Reed 2010). Furthermore, the results show that physicians need NPM-related skills to actually achieve clinical improvement in daily clinical practice, such as reasoning from cost-efficiency arguments, providing transparency into their work, or writing business cases. This poses the question whether advocates of medical leadership may be re-introducing 'old' NPM objectives under the label of 'leadership'. In doing so, they potentially co-opt physicians into implementing practices that are at the same time critiqued as NPM or management reforms. Therefore, it is important that medical leadership advocates and policy makers move beyond the seductive appeal of the term. If medical leadership results in NPM related changes, this could diminish physician's positive reactions towards medical leadership and efforts to reconfigure medical professionalism.

Methodological implications

Methodologically, this thesis shows the added value of using multi-methods to study medical leadership. By applying mixed-methods with a specific focus on social constructivist approaches and on the use of written and spoken language in local settings, this thesis shows the profession building processes of physicians who plead for medical leadership. Using this methodological approach, I was able to highlight what is 'going on' among Dutch physicians, and how the medical profession aims to adapt to organizational and societal demands: e.g. calls for more transparency, efficiency, changing patient demographics and needs (Wagner & Lombarts 2015).

The outcomes of the systematic review reveals the great diversity of medical leadership constructions in the academic literature. The lack of conceptual clarity highlights that advocates can potentially use medical leadership for multiple purposes as it can have multiple and distinctive meanings. Conducting a discourse analysis is a means to subsequently investigate for what specific aims physicians use medical leadership discourses. Discourse analysis is especially useful to study how actors use language in specific settings and to subtract meaning therefrom (Alvesson & Karreman 2000; Alvesson & Spicer 2012; Philips & Hardy 2002). By analyzing the details of speech or written texts, it is possible to study broader patterns and consequences of medical leadership discourses in strategic arenas (Alvesson and Karreman 2000). Importantly, in this thesis, discourse is understood as having real implications for reality by constituting someone's subjectivity and framing someone's action (Austin 1962; Gond et al. 2016). We were therefore able to illustrate that framing physicians is leaders is not a neutral act but has performative effects on medical professionalism.

Ethnographic methods, and more in specific observations and shadowing, allowed us to move from written texts in academic literature and strategic arenas to ad-hoc constructions of medical leadership in practice. By observing a medical leadership development program, it was possible to study how medical leadership identities are constructed collectively in interaction between participating physicians, peers, facilitators, guest speakers and directors. This is important, as we know from literature that the reconfiguration of (professional) identities is not an individualistic act (Brown 2015; Sveningsson & Alvesson 2003). Rather, new identities come into being through a collective process of discussions and negotiations concerning who one is or is not (Brown 2015; Reay et al. 2017). These observational investigations are taken one step further by observing in-depth how physicians actually perform their leadership identities in daily clinical practices. Shadowing made it possible to study 'what people do instead of merely what they say they (aim to) do' (Mintzberg 1973; Noordegraaf 2014; Sveningsson & Larsson 2006; Tengblad 2012; Ybema et al. 2009; Oldenhof 2015). Finally, Q-methodology is used to investigate the perceptions of hospital-based professionals and managers on medical leadership. Q-methodology contains a mix of quantitative (factor analysis) and qualitative (interviewing) methods and is particularly suitable to capture the views and perceptions of actors on a certain subject (Van Exel & De Graaf 2005; Watts & Stenner 2005). By applying Q-methodology the constructions of medical leadership by a diversity of professionals (nurses, physicians, technicians and managers) are studied in addition to physicians.

Applying this combination of methods is a way of methodological triangulation, which is used to enhance and broaden our understanding of medical leadership, thereby increasing the validity of the research (Bekhet & Zauszniewski 2012; Mortelmans 2013: 483). Yet, the specific methodological approach also has certain drawbacks. The main focus is on investigating the perceptions of medical leadership by physicians who already show an interest in leadership (e.g. by writing about it, participating in a course, or adopting managerial tasks). Moreover, the practice-based investigations are only focused on hospital-based physician. Therefore, the outcomes are not generalizable to the entire population of physicians in the Netherlands. At the same time, the ethnographic methods used in this thesis are open enough to capture critical voices on leadership. For example, shadowing the hospital-based medical managers shows that not every physician wants to be involved in hospital management, financial issues or efficiency improvement. Moreover, the Q methodology does arguably include the perceptions of actors who do not actively plead for medical leadership.

Second, only medical managers (chapter 5) are shadowed and professionals and managers (chapter 4) in one hospital setting are interviewed. This hospital is actively advocating for leadership among professionals (physicians, nurses) in its strategy and has developed leadership programs. One could argue therefore that investigating how medical leadership is constructed in this hospital produces a certain bias. The findings might indeed not be generalizable to other hospital contexts where, for example, medical leadership is not on the hospital's strategy agenda. Yet, chapter 6, which investigates the medical leadership constructions in a medical leadership development program by physicians from six different hospitals show similar results.

Finally, the research – except for the systematic review – is located in the Dutch healthcare sector. Despite similar developments that increase the need for medical leadership in other Western counties, (such as an increase of market and business instruments, healthcare costs, chronic patients and multi-morbidity), there are also differences, which make the Dutch setting to study medical leadership unique. Dutch physicians, for example, have a relatively strong and unique autonomous position in healthcare compared to other countries (Denis & van Gestel 2016; Scholten et al. 2019). This may explain why medical leadership is used by physicians themselves to advocate change. In New Zealand (Daly et al. 2014) or the UK (Edmonstone 2009), 'clinical leadership' is instead advocated top-down by governments to steer professionals towards preferred behavior. It is therefore likely that investigations of the construction of medical/clinical leadership in those contexts will generate different insights.

Although generalizability to other populations or settings is in fact not the main purpose of qualitative research (Leung 2015; Mortelmans 2013) an aim of this thesis is to produce *inferential* generalizability. By using thick descriptions of our case studies, sensitizing concepts (Bowen 2006) and constant comparison between theory and the data to guide the analyses, we aimed to produce more generalization of our findings. The results of this thesis indeed show that the theoretical implications are relevant for contexts and settings that go beyond the ones studied in this research.

Implications for future research

The outcomes of this thesis provide various opportunities for future research.

First, future studies could specifically look for organizational sites and actors that do not share an active interest in medical leadership. In this thesis, the perceptions of advocates of medical leadership are specifically studied. Yet, investigating interpretation of the changes in medical professionalism that are required according to rank –and file physicians in other settings is relevant. These other settings are not only hospitals but could also be, for example, general practitioners practices or nursing homes. Future studies could study the perception on and construction of medical leadership among, for example, general practitioners, rehabilitation doctors or geriatricians. This is especially relevant as chronic patients and frail elderly are increasingly treated in networks of multiple professionals working in different organizations (Looman 2018). This arguably requires different ways of practicing medicine for physicians. Investigating the views and perceptions of these professionals could potentially reveal additional or different insights into the reconfiguration of medical professionalism (see for example Maaijen et al. 2018 and Reay et al. 2017).

Second, this thesis shows that medical leadership is depicted as a promise to move beyond NPM reforms. Yet, the results potentially question whether this is always the case in daily practices, or that 'old' NPM reforms are sometimes re-implemented under the guise of 'new' leadership. Therefore, we need further research to study whether the discursive move from management to leadership is effectuated in practice. The method of shadowing has proven to be fruitful to study the daily practices of physicians. Scholars could use this method to investigate the uptake of leadership discourses by physicians in daily settings and whether (and how) they succeed to move beyond NPM practices to improve healthcare.

Third, the results show the performativity of the medical leadership discourses by outlining how they co-constitute a new reality: a reconfigured medical professionalism. Future studies could further investigate to what extent physicians in their daily work incorporate the leadership discourses and how this affects their professional practice, identity and relational dynamics with clinical peers, and other non-clinical professionals such as managers, policy makers or directors. Following upon the advice of Lawrence et al. (2013) and Wallenburg et al. (2016), researchers could move beyond strategic arenas or medical leadership development programs and focus more on institutional work performed in messy and actual day-to-day practices and its implications for medical professionalism. Especially given the outcome of this thesis that there are different social constructions of medical leadership. Whereas the majority constructs a collaborative understanding of medical leadership, a small group of advocates argues that physicians need to regain the lead to maintain their autonomous position and decrease the influence of non-clinical actors. Observational studies combined with the technique of shadowing specific persons in their daily work would be especially suitable methods to capture institutional –and identity- work practices and investigate how the advocated changes will turn out in practice.

Finally, the specific methodological approach and the theoretical concepts used (institutional work, identity work, performance of the self), are not only useful in studying the use of leadership discourses among physicians. For example, studies investigating the rise of leadership discourses among nurses (in the Netherlands; Vermeulen et al. 2018) or other professions could benefit from using discourse analysis and observational methods, as this could potentially reveal profession building processes in other domains as well.

Practical implications

Does every physician needs to become a leader? This chapter started with a quote from the 2015 CanMEDS (competency model) report (Dath et al. 2015: 4), which raised this question. Yes, is their answer. Every physician should be a leader in their daily work regardless of title or position. Yet, does this means that physicians have to add another 'skill' or 'task' to an already enlarging list of responsibilities?

The first practical implication of this thesis concerns the daily work of ***physicians*** and addresses the question what medical leadership means for physicians in practice. This unfolds in three implications for physicians. The results of this research shows that the advocacy for medical leadership does not represent *extra* work, but rather a *re*configuration of work. If physicians wish to transition from individualistic and authoritarian professionals to multidisciplinary team players in order to better deal with changing patient preferences and ensure high quality and safety of care, they need to structurally reconfigure their work practices, identity and education. The increase of multi-morbidity, chronically-ill patients and frail elderly (Looman 2018) who increasingly age in place, urges physicians to collaborate more closely with professionals from other disciplines and organizations (Heineman 2010). In a similar vein, the government, scientists, the public and professionals themselves increasingly call for a shift of focus in healthcare from a medical perspective to a more holistic patient-centered perspective that includes well-being, quality of life and social components (ibid.; Federatie Medisch Specialisten 2017). Furthermore, the decentralization of care to municipalities and re-placement of less acute care in hospital settings to primary –or home care facilities are reasons for (young) physicians to adapt their work practices and skills to these changes. Importantly, this does not necessarily mean that all physicians, for example those who are highly specialized in a specific discipline, need to become generalists. Rather, it is important that individual physicians reconsider the boundaries of their own field of knowledge and skills, and when necessary, collaborate with other (non)clinical peers in order to deliver high quality and efficient care.

In addition to becoming team players, this thesis shows the urge for physicians to structurally engage in improving quality, efficiency, safety and organization of care. For example, they increasingly participate in improvement projects. Yet when doing so, they may experience barriers for the implementation of their improvement projects or feelings of exclusion when others decide over their work, resulting in frustration and stress. Therefore it is important that physicians take into account that in such complex settings such as hospitals, improve-

ment projects are often not realized solely but rather through team effort. Physicians should develop a collaborative attitude towards other (non)clinical actors. Instead of interpreting hospital contexts as individually shapeable or as a barrier to healthcare improvement, physicians should collectively engage in reshaping hospital contexts through consensus building and collaboration.

The last practical implication for physicians shows the importance of the participation of physicians in formal management, governance or political positions in healthcare. As this thesis shows, physicians aim to increase their influence in healthcare to improve quality, safety, organization and efficiency of care. While this can be seen as a means to regain their elite position in healthcare, it is more important to point out that their clinical knowledge is arguably vital in improving healthcare that is becoming increasingly complex (see for example Rotar et al. 2016). Having said this, it is important to note that not every physician needs to engage in formal leadership positions as each individual has different ambitions and skills.

The recommendation to change the work and identity of physicians is easier said than done. The second practical implication of this thesis therefore addresses the importance of ***organizational back-up***. As this thesis shows, physicians do not always receive time, support or have the knowledge or skills they perceive needed to increase multidisciplinary collaboration or engage in improvement projects. Physicians often feel unheard, unsupported, unexperienced, stressed, frustrated or fear burn-outs (Kippist & Fitzgerald 2009; Llewellyn 2001). The possibility for hospital-based physicians to participate in external leadership development programs is potentially fruitful as this thesis shows. Physicians highly value the ability to zoom-out and reflect on daily practice with like-minded professionals. Yet, the actual transition of physicians' work practices *in situ* are often difficult due to organizational, financial or cultural structures in hospitals. Different actors in hospitals (directors, policy makers, managers and medical staff) should therefore better facilitate physicians in their aspirations to reconfigure their work practices by providing sufficient, time, compensation and support. This potentially not only increases the success and effectiveness of physicians' attempts to reconfigure work routines, it also may prevent higher levels of burn out and stress.

Moreover, hospitals should formalize the selection and training of physicians who aim to transition into formal hospital management or governance positions. There lacks a clear selection procedure or physicians are forced to do managerial duties. Moreover, formal training or clear job descriptions are often lacking. This thesis demonstrates that this could lead to frustration, stress and a lack of motivation, which arguably hinders the effective performance of managerial positions for physicians. Hospitals should therefore offer more training in hospital management or offer the possibility to participate in external courses or educational programs.

The third practical implication addresses ***professional associations***. Due to their strategical position in healthcare and great reach among physicians, professional associations can play an important role in facilitating physicians in their aims to transform medical professionalism. Professional associations, such as The Federation of Medical Specialists and the Royal Dutch

Medical Association are in fact important advocates for medical leadership. Yet, at the same time 'new' concepts are launched, such as 'network medicine' or 'value-based healthcare' (Federatie Medisch Specialisten 2017), without explicitly outlining how these different concepts relate to each other. Although their differences, these concepts all convey the same message towards physicians: a reconfiguration of medical professionalism is required to adapt to changing patient and organizational needs. Therefore, we advise these associations to prevent that 'medical leadership' and similar concepts become a disillusion for physicians: another 'popular' term that requires physicians to do something 'extra'. Rather, these associations could better highlight the core of the 'problem' – the need for a fundamental change of medical professionalism – and offer a strong platform where physicians can collaborate to meet their aspirations.

Moreover, professional associations should ensure that physicians engage in political agenda setting and policy making regarding the future of healthcare in the Netherlands. They are advised to facilitate physicians in taking on formal political, government, or policy positions and to ensure that medical knowledge is integrated in future policies regarding the sustainability and affordability of healthcare.

The fourth implication for practice concerns the ***education*** of current and future physicians. Concerning medical students, this thesis reflects their wish to incorporate new skills and knowledge in medical educational curricula. This is largely confirmed by other research (Denis & Van Gestel 2016; Lucardie et al. 2017; Voogt et al. 2016) and student initiatives in the Netherlands (De Geneeskundestudent 2015; Platform Medisch Leiderschap 2016; Website De Jonge Specialist; Website Medical Business). Medical business, for example, is a foundation initiated by Dutch medical students, which aims to challenge future physicians to engage in governance, organization and financial issues as they argue that this is part of your responsibility as a physician. The enormous success, shown by the high attendance and quick enrollment of their education programs, conferences and seminars, reflects the lack of attention for organizational and leadership subjects in medical educational curricula. Currently, 'leadership' is not an integral part of Dutch medical curricula. Across the Netherlands, universities are increasingly trying to incorporate 'medical leadership' in their curriculum for example by offering separate courses in developing a pro-active attitude, negotiation skills or initiating change projects (De Geneeskundestudent 2015; Lucardie et al. 2017; Voogt et al. 2016). Yet as this thesis shows, medical leadership is not a separate skill or ad-on. Rather, current pleas for more attention for leadership reflect the need to reconfigure medical work and the medical professional identity on a more profound level. Educational curricula and medical leadership development programs thus need to move beyond leadership as merely a list of skills that can be acquired in a short course. It is important that future medical students throughout their entire education are trained to become multidisciplinary team players instead of individualistic, authoritarian professionals. Related skills that are inherent to this 'new' professional identity of team players should be incorporated throughout the entire medical education, for example collaboration, communication, self-reflection, being

attentive to developments in healthcare and the society, and developing and conveying a vision. Concerning medical leadership development programs for current medical specialists, this thesis illustrates that participating physicians undergo transitions on an identity level which have to do with answering questions such as who am I? And what do I stand for? Therefore, it is important that the facilitators of certain programs incorporate sufficient sessions, such as (collective) reflection or coaching sessions, which stimulate and facilitate the identity processes of physicians.

Finally, it is important to note that 'medical leadership' is not the magic bullet. Medical leadership is often portrayed as the solution for everything that is 'wrong' in healthcare. As a consequence, medical leadership is conceptualized as more than fifty skills, types of knowledge or activities (chapter 2) becoming an arguably vague and confusing term. This will most certainly raise the question among physicians how they can master all these competencies and even more what the real essence of medical leadership is. Therefore, it is important that researchers and practitioners do not further develop skills or competency models. Instead, more focus is needed on facilitating the reconfiguration of medical work and professional identities to adapt to changing patient, health system and organizational demands.

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Website links

https://dejongespecialist.nl/over-ons/
https://medicalbusiness.nl/over-ons/

Summary

Medical leadership is highly promoted among physicians as it is considered to be vital in improving the quality, safety and efficiency of care. Physicians as medical leaders are either portrayed as heroes who pro-actively adapt their practices to changing organizational and clinical demands or as victims of administrative and regulatory burdens who need to regain the lead in healthcare and safeguard their medical domain from non-clinical 'intruders'. Despite their differences, both views have in common that they perceive it necessary for every physician to become a medical leader, regardless of specialty, position or age. By framing physicians as leaders, advocates stimulate their medical peers to adjust the core of their professional work, their medical identity and educational curricula. So far, however, medical leadership is foremost interpreted as a set of skills, competencies or tasks. Yet, medical leadership can also be understood as a strategic discourse that physicians use to construct an envisioned future of a 'new' medical profession. Therefore, it is important to further investigate the rhetorical and prescriptive use of the term.

The aim of this thesis is to investigate *how* physicians aim to change medical professionalism by pleading for medical leadership, thereby gaining insights into transitions in professional work. This thesis foregrounds the different constructions of medical leadership in the academic literature and daily practices. The analysis sheds light on how advocates give meaning to medical leadership and thereby reveals the corresponding ideals, values and purposes regarding the future of the medical profession. Moreover, the empirical analysis investigates the implications of the different social constructions of medical leadership for the reconfiguration of medical professionalism in terms of the core of professional work, the medical identity and the content of educational curricula.

To study the multiple ontologies of medical leadership, a multi-sited and multi-method research approach is used. Medical leadership advocates are active at multiple sites, describing, pleading for or practicing medical leadership: in the academic literature, in strategic arenas (i.e. media fora and national conferences), in hospital settings and in medical leadership development programs. A systematic literature review, a discourse analysis, a Q method study and two ethnographic observational studies are conducted to capture the various constructions of medical leadership at these different sites. Not only the perceptions of physicians, but also the perceptions of hospital-based nurses, laboratory technicians and managers are investigated. The data collection and empirical analyses are guided by several sensitizing concepts derived from literature, such as 'identity work', 'institutional work' and 'self-presentation'. Together, the results provide an answer to the main research question: "How is medical leadership socially constructed in academic literature and clinical practice and what are the implications of these constructions for medical professionalism?"

Chapter 2 examines how medical leadership is constructed in the academic literature. Conceptual clarity of medical leadership remains lacking despite its increasing popularity and high expectations in healthcare. By means of a systematic review, the academic literature on medical leadership is synthesized to investigate the different constructions of medical leadership in terms of definitions, activities, personal features and context specific factors. Eight

databases are searched for relevant scientific and peer-reviewed articles that focused on physicians in leadership roles or positions in hospital settings. The search led to the inclusion of 34 articles and their findings are systematically reviewed, synthesized and analysed. The results reveal that scholars define medical leadership as either formal or informal leadership. As formal leaders, physicians fulfil formal managerial or governance positions in their hospitals. As informal leaders, physicians act as informal leaders within their daily clinical practices by, for example, re-organizing clinical work, initiating multidisciplinary collaboration or establishing quality –and efficiency improvement projects. Credibility among peers is most often mentioned as an important factor for medical leaders to be effective in their role as formal or informal leader. This is followed by a scattered list of 'management' and 'leadership' activities, activities to bridge management and medical objectives, personal skills and context specific factors. The findings question whether physicians should possess all elicited features if they aspire to become a medical leader. The results furthermore demonstrate that most research designs are underpinned by positivistic notions assuming that medical leadership is an objective phenomenon inherent to skills, traits, styles and activities. The chapter suggests further research to use stronger research designs that are based on theory to study the social constructions of medical leadership and the subsequent influence of medical leadership on professional work.

Chapter 3 provides a critical investigation of how the discourse of medical leadership is used by physicians who act as opinion makers in the Dutch healthcare sector and for what purposes. Informed by critical leadership studies and institutional work theory, this chapter considers medical leadership as a discourse that can be strategically employed by physicians to initiate change in the medical professional domain. The physician opinion makers use 'strategic arena's' (i.e. media platforms and national conferences and seminar) to convey their message: that clinical peers need to become medical leaders. A discursive analysis is performed of key documents produced in these strategic arenas, including opinion papers published in national medical journals, position papers, leaflets, research reports and books, an online course and the content of two websites on medical leadership. Additionally, observations are conducted at three large national conferences and field notes are included as data. The findings reveal that advocates use medical leadership discourses for three purposes: (1) regaining the lead in medical professionalism, (2) disrupting 'old' professional values, and (3) constructing the 'modern' physician. By framing physicians as leaders, advocates stimulate their peers to regain 'the lead' in healthcare and safeguard their elite position from non-clinical actors, such as business managers, policy makers, politicians and health insurance companies. The advocates, however, similarly use medical leadership discourses to reject traditional professional values, including hierarchy, a high degree of unquestioned autonomy and strong socialization processes. Subsequently, medical leadership discourses are used to construct the 'modern' physician by prescribing the responsibilities, competencies and preferred attitude required for a new medical identity. The chapter concludes that by framing physicians as leaders, opinion makers encourage their colleagues to become team-players,

who work across professional and organizational boundaries to increase healthcare quality –and efficiency.

Chapter 4 investigates the different perceptions among healthcare professionals and managers on medical leadership. So far, research on medical leadership has revealed scattered and encompassing lists of factors that are deemed important, yet insights in their relative importance are lacking. Moreover, evidence is merely based on the opinions of physicians, neglecting perceptions from other healthcare professionals or non-clinical actors. By using Q-methodology, 39 hospital-professionals (11 physicians, 10 nurses, 4 laboratory technicians and 14 managers) from three different hospital departments are asked on their opinion regarding what makes an 'ideal' hospital based medical leader. Factor analysis of their rankings of 34 statements on medical leadership reveal three views on 'ideal' medical leaders in hospital settings: (1) a strategic leader, (2) a social leader, and (3) an accepted leader. A strategic leader prioritizes hospital's objectives by participating in hospital strategy and decision-making. A social leader is characterized by strong communication and collaboration skills. An accepted leader gains influence by acknowledgement among peers and is guided by a clear job description. Despite differences between the three views, all interviewees consider personal skills in collaboration, communication and having integrity and a clear vision as highly important for a successful medical leader. The findings do not show differences in views related to particular healthcare professionals, managers, or departments as all views were defined by a mixture of departments and participants. The chapter concludes by outlining practical recommendations for hospitals who wish to increase the engagement of physicians in improving clinical and financial performances through medical leadership. They are advised to focus on selecting and developing leaders who are strong strategists, socially skilled and accepted by clinical peers.

Chapter 5 describes how hospital-based physicians who work as medical managers of their department in addition to clinical practice, interpret and perform their medical management role. To perform effectively as a medical manager, credibility among peers derived from showing commitment to clinical work and medical excellence is perceived to be most important in previous research. Based on an ethnographic account of the daily work of six medical managers, this chapter investigates how medical managers aim to construct and balance a credible performance towards other (non) clinical actors. The dramaturgical framework and corresponding metaphors of the theatre developed by sociologist Erving Goffman in his work 'The Presentation of Self in Everyday Life', are used to illustrate how each performance represents a different construction and interpretation of the medical-manager self. The findings demonstrate the following four performances of the medical manager 'self': (1) the performance of a fluid self, (2) the performance of an uncertain self, (3) the performance of a political self, and (4) the performance of a mediator self. The fluid self perceives the medical management role as an important addition to clinical practices and uses the role to

stimulate peers to engage in improving quality, safety and organization of care. In contrast, the uncertain self feels uncomfortable and uncertain as medical manager and interprets the managerial role as an obstacle in performing clinical work. The political self perceives the managerial role as a means to safeguard department ambitions and budgets vis-à-vis other clinical departments. The mediator self perceives being a medical managers as being a coach for clinical peers and a translator of interests within and between departments.

The constructions show that sources of credibility and the audiences of medical management performances are shifting. Credibility is not only derived by medical excellence or showing peers commitment to clinical practices. Rather, medical managers increasingly derive credibility from showing hospital directors and financial managers, in addition to peers, their ability to align department with hospital governance objectives, represent department-specific ambitions, acquire approval for investment requests and support clinical arguments with cost-efficiency arguments. Theoretically, this chapter provides an alternative interpretation of credibility. Instead of a state of being, credibility should be understood as 'credibility work': a state of doing. Finally, the chapter concludes by emphasizing that hospitals should offer sufficient time, adequate training and support for medical managers in order to prevent excessive stress, frustration or overburdening.

Chapter 6 demonstrates how a one-year medical leadership development program enables physicians to reconstruct their professional identities to deal with changing organizational and clinical demands. Historically, physicians are well-known for protecting their professional identities from 'external' managerial or market influences. Yet, this chapter illustrates how participating in a medical leadership development program, enables physicians to increasingly identify with organizational contexts, objectives and actors and adjust their professional identity accordingly. Based on an ethnographic study, this chapter shows how physicians initially construct different and conflicting leadership narratives in explaining their self-perceptions as a medical leader in their hospitals: an heroic (*pioneer*), clinical (*patient's guardian*) and collaborative (*linking pin*) leader. The narratives show different interpretations of the participant's agency and relationship towards hospital contexts. These are, respectively, perceived as individually shapeable, disconnected or collectively adjustable. The findings further demonstrate how heroic and clinical perceptions of leadership are partly deconstructed over the course of the program by interactions between teachers, guest speakers and co-participants and in-hospital experiences. Through collective discussions a preferred medical leader identity of a collaborative leader is constructed who acts as a team player, working with rather than against non-clinical actors and organizational contexts. The findings thus illustrate how physicians and other (non)clinical actors use medical leadership discourse to reconfigure medical professional identities to adapt to changing organizational and clinical demands. The chapter concludes by discussing how physicians participating in a medical leadership development program increasingly perceive business managers and hospital directors as necessary

partners in improving quality and efficiency of care delivery, and peers who do not wish to change as the new 'anti-identity'.

Chapter 7 provides an answer to the main research question of how medical leadership is constructed in literature and daily practice and what the implications are for the reconfiguration of medical professionalism. This chapter concludes that physicians –and other (non)clinical actors- use medical leadership discourses to reconfigure the core of professional work, the medical professional identity and educational curricula. The medical leadership constructions reveal new understandings of what it means to be a physicians in today's healthcare. To be able to better adapt to changing clinical and organizational demands, physicians aim to broaden their clinical practice by engaging in the improvement of quality, safety and efficiency of care. The constructions, however, also demonstrate an important difference among medical leadership advocates. The majority of physicians develops a collaborative understanding of medical leadership. These physicians aspire to transform from authoritarian and highly autonomous professionals to transparent team players who work across disciplinary, professional and organizational borders to increase the quality –and (cost)efficiency of care. Yet, a minority of advocates use medical leadership discourses to regain 'the lead' in healthcare and decrease the influence of non-clinical actors, such as managers, politicians or hospital directors. However, critique from peers and negative experiences in daily practices question how sustainable the latter view remains in the future.

The results of this thesis show important implications for the reconfiguration of medical professionalism. Regarding the core of professional work, the findings illustrate that medical leadership does not imply an extra addition top of medical work but rather a reconfiguration of physician's work. Considering the medical identity, the medical leadership constructions show that physicians increasingly perceive being a physician as being a multidisciplinary team player. Physicians furthermore increasingly identify with other types of professionals (e.g. nurses or physician-assistants) and non-clinical actors in pursuing clinical and organizational objectives. In contrast, they consider peers who do not wish to transform professional practices as the new 'anti-identity'. Concerning educational curricula, the results highlight that physicians -both medical students and specialists- plead for a broadening of medical curricula by incorporating strategic, organizational and social skills over the entire course of medical education. Theoretically, the findings contribute to the sociology of professions literature as they highlight how physicians use medical leadership to develop a new medical professionalism. Moreover, the outcomes confirm that boundaries between medicine and management increasingly overlap and blur. Yet, this thesis also illustrate how physicians restore these boundaries when it is strategically convenient. The possible negative consequences of medical leadership pleas are emphasized when advocates do not adequately show the distinction between medical leadership and New Public Management objectives. Practical recommendations are offered to physicians to significantly adjust their practices, identity and educational curricula if they wish to transform from highly autonomous and authoritarian professionals

to team players who continuously engage in quality and efficiency improvement. Finally, the fact that the aim for medical leadership is bottom-up initiated by physicians, necessitates hospitals, professional associations and educational institutes to provide the tools and support that enable physicians to reconfigure medical professionalism.

Samenvatting

Medisch leiderschap wordt sterk gepromoot onder artsen om de kwaliteit, veiligheid en efficiëntie van zorg te verbeteren. Aan de ene kant worden artsen als medisch leiders gezien als helden die hun dagelijkse werk proactief aanpassen aan veranderende organisatorische en klinische eisen. Aan de andere kant worden artsen gezien als slachtoffers van administratie -en regeldruk. Door zich als medisch leider te profileren, proberen artsen zeggenschap in de gezondheidszorg terug te krijgen en die in te zetten om het medische domein te beschermen ten opzichte van niet-medische 'indringers'. Ondanks deze verschillen pleiten beide perspectieven er voor dat alle artsen medisch leiderschap gaan tonen, ongeacht specialisme, positie of leeftijd. Tot nu toe is medisch leiderschap vooral geïnterpreteerd als een set van skills, competenties of taken. Medisch leiderschap kan echter ook gezien worden als een strategisch discours dat artsen gebruiken om een andere toekomst te creëren van hun 'nieuwe' medische professie. Door artsen als leiders te beschouwen, stimuleren voorstanders van medisch leiderschap hun collega's om de kern van hun professionele werk, hun medische identiteit en opleidingscurricula te veranderen. Daarom is het belangrijk om het retorische en normatieve gebruik van de term medisch leiderschap verder te onderzoeken.

Het doel van dit proefschrift is om te onderzoeken hoe artsen door te pleiten voor medisch leiderschap proberen de medische professie te veranderen. Dit proefschrift laat zien wat de verschillende constructies van medisch leiderschap zijn in de academische literatuur en dagelijkse praktijk. De analyse geeft inzicht in hoe voorstanders betekenis geven aan medisch leiderschap. Hierdoor worden de bijbehorende idealen, waardes en doelen met betrekking tot de toekomst van de medische professie zichtbaar. Daarnaast laat de empirische analyse zien wat de implicaties zijn van de verschillende sociale constructies van medisch leiderschap voor de kern van het professionele werk, medische identiteit en opleidingscurricula.

Om de meerde ontologieën van medisch leiderschap te onderzoeken is een multi-sited en multi-methode aanpak gebruikt. Voorstanders van medisch leiderschap zijn actief op meerdere 'sites' of plekken waar ze medisch leiderschap beschrijven, praktiseren of bepleiten: in de academische literatuur, in strategische arena's (media en nationale congressen), in ziekenhuizen en in medisch leiderschapsprogramma's. Om de verschillende constructies van medisch leiderschap te kunnen duiden op deze verschillende plekken zijn de volgende methoden ingezet: een systematische review, een discours analyse, een Q-methode studie en twee etnografische observatie studies.. Niet alleen de percepties van artsen, maar ook de percepties van ziekenhuis verpleegkundigen, laboratorium assistenten en managers zijn onderzocht. De dataverzameling en empirische analyses zijn ondersteund door verschillende 'sensitizing concepten' vanuit de literatuur, zoals 'identiteit werk', 'institutioneel werk', en 'zelfperceptie'. Samen vormen de resultaten een antwoord op de hoofdvraag van dit proefschrift: "Hoe is medisch leiderschap sociaal geconstrueerd in de academische literatuur en klinische praktisch en wat zijn de implicaties hiervan voor medisch professionalisme?"

Hoofdstuk 2 onderzoekt hoe medisch leiderschap is geconstrueerd in de academische literatuur. Tot nu toe is er geen conceptuele duidelijkheid , ondanks de populariteit van het concept

en de hoge verwachtingen ervan voor de gezondheidszorg. Er is daarom een systematische review uitgevoerd waarbij acht databases zijn gescreend voor relevante wetenschappelijke en peer-reviewed artikelen die focussen op artsen in leiderschap rollen of posities in ziekenhuizen. The screening heeft geleid tot de inclusie van 34 artikelen. De uitkomsten van de artikelen zijn systematische gereviewd en geanalyseerd in termen van definities, activiteiten, persoonlijke eigenschappen en context-specifieke factoren van medisch leiderschap. De resultaten laten zien dat wetenschappers medisch leiderschap definiëren als ofwel formeel of informeel leiderschap. Als formele leiders vervullen artsen formele management -of bestuursfuncties in hun ziekenhuizen. Als informele leiders acteren artsen als informele leiders binnen hun dagelijkse klinische praktijk, door bijvoorbeeld klinisch werk te reorganiseren, multidisciplinaire samenwerking te initiëren of kwaliteit -en efficiëntie verbetertrajecten op te zetten. Geloofwaardigheid onder collega-artsen wordt het vaakst genoemd als een belangrijke factor voor medisch leiders om effectief te kunnen zijn in hun rol als formele of informele leider. Hierna volgt een uiteenlopende lijst van andere factoren zoals 'management' en 'leiderschap' taken, activiteiten om management en medische doelen met elkaar te verbinden, persoonlijke skills en context specifieke factoren. Een discussiepunt op basis van deze bevindingen is of het realistisch is dat artsen aanvullende taken naast hun klinische werk moeten en kunnen uitvoeren en een variëteit aan skills moeten hebben naast medisch inhoudelijke skills. De bevindingen laten verder zien dat de meeste onderzoeksopzetten onderbouwd zijn door positivistische noties van medisch leiderschap die veronderstellen dat medisch leiderschap een objectief fenomeen is dat kan worden gemeten in termen van skills, vaardigheden, stijlen en taken. Dit hoofdstuk sluit af met de aanbeveling voor toekomstig onderzoek om alternatieve, kwalitatieve designs te gebruiken om sociale constructies van medisch leiderschap te onderzoeken en de invloed daarvan op professioneel werk.

Hoofdstuk 3 beschrijft hoe de discours van medisch leiderschap gebruikt wordt door artsen die acteren als opiniemakers in de Nederlandse gezondheidszorg en voor welke doelen. Gebruikmakend van critical leadership studies en theorie over institutioneel werk, beschouwt dit hoofdstuk medisch leiderschap als een discours dat strategisch gebruikt kan worden door artsen om verandering in het medische domein te initiëren. Deze artsen gebruikers 'strategische arena's' (media platformen en nationale congressen en seminars) om hun boodschap uit te dragen: dat hun collega-artsen medisch leiderschap moeten gaan tonen. Een discours analyse is uitgevoerd van kerndocumenten geproduceerd in deze strategische arena's, zoals opiniestukken gepubliceerd in nationale medische tijdschriften, visiedocumenten, flyers, onderzoeksrapporten, boeken, een online cursus en de content van twee websites over medisch leiderschap. Daarnaast zijn observaties uitgevoerd van drie grote nationale congressen en de aantekeningen daarvan zijn geïncludeerd als data. De bevindingen laten zien dat voorstanders medisch leiderschapsdiscoursen gebruiken voor drie doeleinden: (1) zeggenschap terugkrijgen in het medische domein, (2) verwerpen van 'oude' professionele waarden, en (3) creëren van een nieuwe identiteit als 'moderne' arts. Door artsen als leiders

te framen, stimuleren voorstanders hun collega's om zeggenschap in de gezondheidszorg terug te krijgen en hun elite positie veilig te stellen ten opzichte van niet-klinische actoren zoals bedrijfskundige managers, beleidsmakers, politici en zorgverzekeraars. Voorstanders gebruiken medisch leiderschapsdiscoursen echter tegelijkertijd om klassieke professionele waarden ter discussie te stellen, zoals hiërarchie, een grote mate van autonomie en een sterk socialisatieproces. Vervolgens worden medisch leiderschapsdiscoursen gebruikt om de 'moderne' arts te construeren door het voorschrijven van de verantwoordelijkheden, competenties en gewenste houding die nodig zijn voor een nieuwe medische identiteit. Het hoofdstuk concludeert dat door het framen van artsen als leiders, opiniemakers hun collega's stimuleren om teamspelers te worden die over professionele en organisatorische grenzen heen werken om kwaliteit en efficiëntie van zorg te verbeteren.

Hoofdstuk 4 onderzoekt de verschillende percepties onder zorgprofessionals en managers ten aanzien van medisch leiderschap. Wetenschappelijk onderzoek naar medisch leiderschap heeft zich tot nu toe voornamelijk gefocust op het in kaart brengen van de benodigde competenties en vaardigheden en de bijbehorende taken. Echter, heeft dit geleid tot zeer uiteenlopende lijsten van competenties, vaardigheden en taken die belangrijk worden gevonden voor medisch leiderschap. Inzichten in het relatieve belang van deze factoren ontbreekt echter. Daarnaast zijn wetenschappelijke bevindingen vooral gebaseerd op de visies van artsen en zijn de percepties van andere zorgprofessionals of niet-klinische actoren vaak niet meegenomen. Met gebruik van de Q-methode zijn 39 ziekenhuis professionals (11 artsen, 10 verpleegkundigen, 4 laboratorium assistenten en 14 managers) van drie verschillende ziekenhuis afdelingen gevraagd naar hun visie op wat een 'ideale' medisch leider in een ziekenhuissetting maakt. Factoranalyse van hun ordening van 34 stellingen over medisch leiderschap laten drie visies zien over 'ideale' medisch leiders in ziekenhuizen: (1) een strategische leider, (2) een sociale leider, en (3) een geaccepteerde leider. Een strategische leider prioriteert ziekenhuisdoelen door het participeren in ziekenhuisstrategie -en besluitvorming. Een sociale leider wordt gekenmerkt door sterke communicatie en samenwerkingsvaardigheden. Een geaccepteerde leider heeft invloed dankzij erkenning onder peers en heeft een duidelijke rolomschrijving voor zijn of haar leiderschapsrol. Ondanks de verschillen tussen de drie visies, vinden alle geïnterviewden persoonlijke skills met betrekking tot communicatie, samenwerking, integer zijn en een duidelijke visie hebben, erg belangrijk voor succesvol medisch leiderschap. De bevindingen laten geen verschillen zien in visie tussen de verschillende type geïnterviewden of afdelingen. De drie visies komen voort uit de percepties van een mix van verschillende type professies en afdelingen. Het hoofdstuk sluit af met praktische aanbevelingen voor ziekenhuizen die de ambitie hebben medisch leiderschap te ontwikkelen om de betrokkenheid van artsen in het verbeteren van klinische en financiële uitkomsten te vergroten. Ziekenhuizen worden geadviseerd leiders te selecteren die sterke strategische en sociale skills hebben en gerespecteerd worden door hun peers.

Hoofdstuk 5 beschrijft hoe medisch specialisten, die naast hun klinische werk ook werkzaam zijn als medisch manager van hun afdeling, hun medisch management rol interpreteren en uitvoeren. Tot nu toe wordt in de literatuur vaak gesteld dat de geloofwaardigheid van medisch leiders onder peers vooral wordt bepaald door een sterke betrokkenheid met klinisch werk en medische excellentie.. Dit hoofdstuk onderzoekt op basis van etnografisch observaties van het dagelijkse werk van zes medisch managers en hoe deze artsen op verschillende manieren een geloofwaardige performance proberen te creëren ten op zichten van andere (niet) klinische actoren. Het dramaturgische framework en bijbehorende metaforen uit het theater, ontwikkeld door socioloog Irving Goffman, wordt gebruikt om te illustreren hoe elke performance een verschillende interpretatie en constructie van het medisch manager-zijn is. De uitkomsten laten vier verschillende performances van het medisch manager-zijn zien: (1) de performance van een fluïde zelf, (2) de performance van een onzekere zelf, (3) de performance van een politieke zelf, en (4) de performance van de mediator zelf. De fluïde zelf interpreteert de medisch management rol als een belangrijke toevoeging aan klinisch werk en gebruikt de rol om peers te stimuleren zich te betrekken in het verbeteren van de kwaliteit, veiligheid en organisatie van zorg. Daarentegen voelt de onzekere zelf zich oncomfortabel als medisch manager en ervaart de rol als een obstakel in het uitvoeren van klinisch werk. De politieke zelf interpreteert de medisch manager rol als een middel om afdelingsambities en budgetten veilig te stellen ten opzichte van andere medische vakgroepen. De mediator zelf interpreteert het zijn van een medisch manager als het zijn van een coach voor peers en een vertaler van doelen binnen en tussen afdelingen.

De constructies laten zien dat de bronnen van geloofwaardigheid en het publiek van medisch managers aan het veranderen zijn. Geloofwaardigheid wordt niet meer alleen verkregen door medische excellentie of het laten zien van betrokkenheid bij klinisch werk. Medisch managers verkrijgen juist steeds vaker geloofwaardigheid door te laten zien aan ziekenhuisbestuurders, managers en peers dat ze in staat zijn afdelingsdoelen af te stemmen op ziekenhuisdoelen, afdelingsambities kunnen vertegenwoordigen, investeringsaanvragen te kunnen behalen en klinische argumenten te kunnen onderbouwen met doelmatigheidsargumenten. Theoretisch gezien biedt dit hoofdstuk een alternatieve interpretatie van geloofwaardigheid. In plaats van een staat van zijn, kan geloofwaardigheid geïnterpreteerd worden als 'geloofwaardigheidswerk': een staat van actie. Tot slot concludeert het hoofdstuk dat ziekenhuizen voldoende tijd, adequate training en ondersteuning moet bieden aan medisch managers om overmatige stress, frustratie en overbelasting te voorkomen.

Hoofdstuk 6 laat zien hoe een eenjarig medisch leiderschapsprogramma artsen faciliteert in het reconstrueren van hun professionele identiteit zodat zij beter in kunnen spelen op veranderende organisatorische en klinische vraagstukken. Historisch gezien staan artsen bekend om het veiligstellen van hun professionele identiteiten ten opzichte van 'externe' marktinvloeden en management. Dit hoofdstuk laat echter juist zien hoe het participeren in een medisch leiderschapsprogramma artsen ondersteunt in het steeds meer kunnen identi-

ficeren met organisatorische contexten, doelen en actoren en hoe zij hier hun professionele identiteit vervolgens op aan kunnen passen. Gebaseerd op een etnografische studie laat dit hoofdstuk zien hoe artsen initieel verschillende en conflicterende leiderschap narratieven creëren van hun rol als medisch leider in hun ziekenhuizen: een heroïsche leider (*pionier*), klinische leider (*beschermvrouw/heer van de patiënt*) en verbindend leider (*linking pin*). Deze leiderschapsnarratieven beschrijven verschillende houdingen die de participanten van de cursus hebben ten op zichte van ziekenhuiscontexten. Deze contexten worden respectievelijk geïnterpreteerd als individueel maakbaar, losgekoppeld of collectief aanpasbaar. De uitkomsten laten verder zien hoe de heroïsche en klinische interpretaties van leiderschap gedeeltelijk gedeconstrueerd worden gedurende het programma door interacties met de trainers, gastsprekers, co-participanten en door praktijkervaringen in het ziekenhuis. Door middel van collectieve discussies wordt de ideale medische identiteit geconstrueerd: een verbindende leider die zich opstelt als teamspeler en samenwerkt met andere niet-klinische actoren en organisatorische contexten. De uitkomsten illustreren hoe artsen en andere (niet) klinische actoren het medisch leiderschapsdiscours gebruiken om medische professionele identiteiten te veranderen om deze beter aan te laten sluiten op veranderende organisatorische en klinische vraagstukken. Het hoofdstuk concludeert dat de deelnemende artsen van het medisch leiderschapsprogramma in toenemende mate bedrijfskundige managers en ziekenhuisbestuurders als noodzakelijke partners zien in het verbeteren van kwaliteit en doelmatigheid van zorgverlening. Peers die niet willen veranderen, worden daarentegen gezien als de nieuwe 'anti-identiteit'.

Hoofdstuk 7 geeft antwoord op de hoofvraag hoe medisch leiderschap geconstrueerd is in de literatuur en dagelijkse praktijk en wat de implicaties hiervan zijn voor de verandering van de medische professie. Dit hoofdstuk concludeert dat artsen -en andere (niet)klinische actoren- medisch leiderschapsdiscoursen gebruiken om de kern van het professionele werk, de medische professionele identiteit en opleidingscurricula te veranderen. De medisch leiderschapsconstructies laten nieuwe betekenissen zien van wat het betekent om een arts te zijn in de huidige gezondheidszorg. Om beter in staat te kunnen zijn om in te spelen op veranderende organisatorische en klinische vraagstukken, streven artsen ernaar om hun klinische praktijk te verbreden door actief deel te nemen in kwaliteit, veiligheid en doelmatigheidsverbetering. De constructies laten echter ook een belangrijk verschil zien tussen de voorstanders van medisch leiderschap. Het merendeel van de voorstanders heeft een collectief en verbindend begrip van medisch leiderschap. Deze artsen streven ernaar om te veranderen van autoritaire en sterke autonome professionals naar transparante teamspelers die over disciplinaire, professionele en organisatorische grenzen heen werken om kwaliteit en (kosten)efficiëntie van zorg te verbeteren. Een klein deel van de voorstanders gebruikt de medisch leiderschapsdiscoursen echter om 'de leiding' in de gezondheidszorg terug te krijgen en de invloed van niet-klinische actoren, zoals managers, politici of ziekenhuisbestuurders te verkleinen. Kritiek van peers en negatieve ervaringen in dagelijkse werkpraktijken naar

aanleiding van deze houding roepen de vraag op hoe houdbaar deze perceptie blijft in de toekomst.

De resultaten van dit proefschrift laten belangrijke implicaties zien van medisch leiderschap voor de invulling van medisch professionalisme. Met betrekking tot de kern van professioneel werk laten de resultaten zien dat medisch leiderschap geen extra taak bovenop medisch werk betreft, maar juist onderdeel wordt van het dagelijkse werk van artsen. Wat betreft de medische identiteit, laten de medisch leiderschapsconstructies zien dat artsen zichzelf steeds meer interpreteren als multidisciplinaire teamspelers. Daarnaast identificeren artsen zich in toenemende mate met andere type professionals (verpleegkundige of physician assistants) en niet-klinische professionals die ook klinische en organisatorische doelen nastreven. Peers die niet mee willen gaan in deze veranderingen worden als de nieuwe 'anti-identiteit' beschouwd. Wat betreft opleidingscurricula, tonen de resultaten aan dat artsen – zowel geneeskunde studenten als specialisten – pleiten voor een verbreding van medische curricula door het integreren van strategische, organisatorische en sociale vaardigheden gedurende de gehele opleiding. Theoretisch dragen de uitkomsten bij aan literatuur over de sociologie van de professie. De resultaten illustreren hoe artsen medisch leiderschap gebruiken om een nieuw medisch professionalisme te ontwikkelen. Daarnaast bevestigen de uitkomsten dat grenzen tussen het medische en management domein steeds meer overlappen en vervagen. Dit proefschrift laat echter ook zien hoe artsen deze grenzen weer versterken wanneer dit strategisch in hun voordeel is. De mogelijke negatieve uitkomsten van het pleidooi voor medisch leiderschap worden zichtbaar wanneer voorstanders niet adequaat het verschil laten zien tussen medisch leiderschap en New Public Management doelen. Praktische aanbevelingen aan artsen betreffen het substantieel aanpassen van hun praktijk, identiteit en opleidingscurricula als artsen willen veranderen van autoritaire en autonome professionals naar teamspelers die zich continue bezighouden met verbetering van kwaliteit en doelmatigheid. Tot slot, het feit dat het pleidooi voor medisch leiderschap bottum-up geïnitieerd is door artsen benadrukt de noodzaak voor ziekenhuizen, professionele verenigingen en opleidingsinstituten om artsen te faciliteren en te steunen in hun wens om medisch professionalisme te veranderen.

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Curriculum Vitae

PhD portfolio

Name:	Mathilde Berghout
Department:	Erasmus School of Health Policy & Management (ESHPM)
PhD period:	2015-2019
Promotor:	Prof.dr. Carina Hilders
Copromotors:	Dr. Isabelle Fabbricotti
	Dr. Lieke Oldenhof

Courses

Academic writing in English	2016
Supervising theses	2016
Ethnography and its varieties	2017
Brush up your research design	2017
Effective communication	2017
Qualitative data analysis	2017
Open interviewing course	2017
Great thinkers of the 20th century	2018
Group dynamics	2018
Speak up my dear	2018
Intervision sessions for teachers	2018
Self-presentation: confidence, focus, persuasion	2019

Presentations

European Health Management Association (EHMA), Porto	2016
Critical Management Studies (CMS) Conference, Liverpool	2017
European Group for Organizational Studies (EGOS), Copenhagen	2017
Organizational Behaviour in Health Care (OBHC), Montréal	2018
Imagine2, Clinical Leadership Development Program, Ede	2018
EGOS, Tallinn	2018
Advisory Committee Imagine2, Rotterdam	2019
Erasmus Centrum voor Zorgbestuur, Rotterdam	2019
Masterclass Nieuwe Zorg, Apeldoorn	2019
Strategiedagen Reinier de Graaf Gasthuis, Delft	2019

Attended national conferences

Symposium Medisch Leiderschap, Utrecht	2016
Masterclass Medical Business, Amsterdam	2016
Congres Mayo Clinics, Nieuwegein	2016
Masterclass Platform Medisch Leiderschap, Utrecht	2017
Federatie congres medisch specialist 2025, Den Bosch	2017
De dokter kan alles!? AMC, Amsterdam	2018

Teaching activities

Supervising bachelor theses	2016-2018
Workgroups Critical Studies of Management and Innovation (Bachelor)	2016-2017
Workgroups Critical Studies of Management and Innovation (Pre-master)	2016-2019
Lecture 'Medical Leadership'	2017
Course: Critical Studies of Management and Innovation (Bachelor)	
Workgroup Doing Observations	2019
Course: Management of Healthcare Organizations	
Lecture 'Medical Leadership'	2019
Course: Critical Studies of Management and Innovation (Pre-master)	

Research collaborations

Visiting scholar at the University of Auckland Business School, Auckland	2018

Additional activities

Peer reviewer PLOS ONE	2017
Board member of PhD Council ESHPM	2017-2018
Participation workgroup Bachelor Reform	
Course Management of Healthcare organizations	2018
Supervising junior-researcher (Merlijn van de Riet)	2018-2019

International publications

Berghout, M.A., Oldenhof, L. van der Scheer, W.K., & Hilders, C. G. (2019). From context to contexting: professional identity un/doing in a medical leadership development program. *Sociology of Health and Illness* 42(2), 359-378

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Dhana, K., Berghout, M. A., Peeters, A., Ikram, M. A., Tiemeier, H., Hofman, A., ... & Franco, O. H. (2016). Obesity in older adults and life expectancy with and without cardiovascular disease. International journal of obesity, 40(10), 1535.

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Berghout, M., van Exel, J., Leensvaart, L., & Cramm, J. M. (2015). Healthcare professionals' views on patient-centered care in hospitals. BMC health services research, 15(1), 385.

Cramm, J. M., Leensvaart, L., Berghout, M., & van Exel, J. (2015). Exploring views on what is important for patient-centred care in end-stage renal disease using Q methodology. BMC nephrology, 16(1), 74.

About the author

Mathilde Berghout was born in Amstelveen on the 4th of September 1990. She studied healthcare policy and management at the Erasmus University in Rotterdam. She obtained a Research Master in health economics from the Netherlands Institute of Health Sciences (NIHES). During the research period of her master she started her PhD on medical leadership at the Erasmus School of Health Policy & Management (ESHPM). In 2018 she worked as a visiting scholar at the Business School of the University of Auckland during a period of two months. The outcomes of her PhD research were published in peer reviewed journals and presented at national and international conferences. Next to conducting research, Mathilde taught several courses on change management and doing observations and supervised a number of theses. In addition, she served as a board member of the PhD association of ESHPM: YoungESHPM. She currently works as an organization developer and advisor at Bureau de Bont, Amersfoort.

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