



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



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## ABSTRACT

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

## 1. Introduction

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

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

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

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

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

## 2. Institutional work and professionals

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

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

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

However, still scarce are studies that investigate how physicians proactively aim to reform the medical field rather than merely repairing the status-quo. Moreover, institutional work performed by

physicians operating in strategic arenas is relatively under-studied. Yet, we argue that studying physicians as institutional agents in strategic arenas is important due to their potential ability to influence the public debate and set the agenda regarding future change in the medical field.

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

## 3. Leadership as performative discourse

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

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

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

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

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 and Spicer, 2012; Martin and Learmonth, 2012; O'Reilly and Reed, 2010) because frontline professionals tend to negatively associate management with bureaucracy, profits and administration (Martin and Learmonth, 2012). Historical analyses of the use of managerial discourses in healthcare (NHS: Learmonth, 2017; Martin and Learmonth, 2012; O'Reilly and 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 and 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.

#### 4. 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 and Spicer, 2012; Martin and 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 and 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 and 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 and 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 (see Table 1, 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.

**Table 1**  
Documents analyzed.

Year	Title	Publication details
<b>Opinion papers</b>		
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
<b>Position papers</b>		
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
<b>Leaflets</b>		
2016	Medical Excellence: the professional and the system	Academy for Medical Specialists
<b>Research reports</b>		
2015	Research report Medical Leadership	The Medical Student Association
<b>Books</b>		
2016	Physicians with knowledge – Medical Leadership, Finance and healthcare organization	Medical Business Foundation
2016	The physician and the money	Individual medical director

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 & Suddaby's taxonomy of institutional work (2006) to illustrate how the 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.

#### 4.1. 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.

#### 4.2. 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.

#### 4.3. 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, 2015f; 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.

## 5. 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 and 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 from 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 and Mertz, 2012; Levay and Waks, 2009; Sheaff et al., 2013; Waring, 2007; Waring and 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 and 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 and 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 and 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 and McKimm, 2011, or

USA: Porter and 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 and Teisberg, 2007; Swanwick & McKimm 2011; Warren and 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 et al., 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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