Practising change in strongly institutionalized environments: using system capital, being system centric

A thesis submitted to the University of Manchester for the degree of PhD Business and Management in the Faculty of Humanities

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Abstract

University of Manchester, Simon Moralee, PhD Business and Management: Practising change in strongly institutionalized environments: using system capital, being system centric - 2016

This thesis outlines a study into institutional change analysing how certain senior individuals, called opinion leaders, were able to achieve change within the strongly institutionalized environment of medical education. It is situated in the complex and contested context of the English National Health Service, which for more than 60 years has seen numerous managerial, organizational, political and professional changes, which have impacted upon the roles and relationships of medical professionals, managers and government.

Adopting a retrospective case study approach, the research centres on the specific case of the Enhancing Engagement in Medical Leadership (EEML) project, which had national-level sponsorship and status, directly involving a multitude of senior NHS bodies, representatives and individuals, to embed leadership and management training into medical curricula. Medical curricula are a mediated result of cultural, social, political and economic forces (Kuper and D’Eon, 2011) rooted in the construction of professional identity and transformation from lay person to professional. Prior to this project, there had been limited attempts to engage the medical profession in leadership and management conspicuously through the curriculum, because of the difficulty of including new content into already crowded specialty curricula, given the constraints of time and resources for medical training.

Using conceptual insights into agency in institutional theory, such as institutional work (Lawrence and Suddaby, 2006) and institutional entrepreneurship (DiMaggio, 1988); practice theory (Feldman and Orlikowski, 2011; Nicolini, 2012); social position (Battilana, 2011) and capital (Lockett et al., 2014; Bourdieu, 1986), this study explores how project members enacted change within medical education. It analyses the processes involved in their actions and practices and establishes how this case furthers understanding of strongly institutionalized environments. Interviews were conducted with members of the EEML project team and steering group, many of whom had positions of influence and status in other relevant organizations in this field. In addition, a review of documentary data encompassing published and non-published project materials was undertaken. An open coding and thematic analysis approach was taken to gain deeper insight into the interview data, whilst the documentary evidence was used to confirm and support the interview analysis.

This case study research reveals that contextual and environmental conditions, as well as exogenous shocks and endogenous motivation led to this change initiative occurring. Routine and recognised ‘practices’ resulted in significant change through embedding the Medical Leadership Competency Framework (MLCF) into contested medical curricula space. Opinion leaders were able, with other project members, to adopt an approach to change, understanding the prevailing conditions, identifying the project’s purpose and committing to an emerging form of practice known as ‘mirroring’. Moreover, this study explores how opinion leaders achieved change through making use of theirs’ and others’ capital resources to form a cross-field collective capital, known as system capital. Using this, they adopted a disposition in their practice beyond professions known as system centrism.
Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification at this or any other university or other institute of learning.

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Acknowledgements

Since this research began in 2010, I have encountered many people along its course and am grateful to them for the time they have given and the effort they have made to support me in completing this work. They will, in all likelihood, wish to underplay their roles, but I hope the following will help to recognise their contributions.

This research study began whilst I was working at De Montfort University where Kathie Moore, the then Head of School of Applied Social Sciences, took a chance on me not only as a new lecturer but also gave me the opportunity and plenty of encouragement to set about this. Kaushika Patel allowed me to have some much needed space and time in which to carry out my fieldwork and Richard Jenkins set aside some Faculty of Health and Life Sciences research funds to enable that to happen. As supervisors and advisers, Allan Macpherson, Mairi Watson, Deborah Price and Peter Spurgeon, at different stages, and in many different ways, provoked, encouraged, nourished and advised me both academically and intellectually. Allan, in particular, was able to get me out of my health care management ‘comfort zone’ by introducing me to the world of organization studies. I am grateful to him for his influence in shaping the theoretical thinking behind this research and allowing me to get a feel for the PhD game.

Nicola Smorowinski provided adept and accurate transcribing of the interviews and saved me more time than I could ever imagine. A great group of fellow lecturers and researchers, namely Kylie Baldwin, Thilo Boeck, Rob Canton, Lorraine Culley, Stephen Handsley, Vic Knight, Jason Pandya-Wood, Raksha Pandya-Wood, Jane Parker, Sally Ruane and Ed Thompson offered everything from invites to relevant seminars, to corridor conversations, to tea and empathy; all of which helped to sustain me during my formative steps into this research and as realisation of this gargantuan task struck. Ed has also been a great resource to call upon in preparing for the final stages of submission and viva. My particular thanks also go to Nicky Hudson for her informal coaching; she was a constant source of support and encouragement in the early stages of this study, providing tiny bits of advice on an infinitesimal number of occasions. And thank you for not barring me from your office when I just happened to be popping by.

At Alliance Manchester Business School, to where the study transferred at an opportune moment, I would like to thank Jane Crombleholme and Kieran Walshe for their sponsorship, as well as Kieran’s encouragement and ability to work within the realms of academic systems to bring this research to Manchester. As supervisors, Damian Hodgson and Naomi Chambers took on the study (and me!), providing fresh impetus, and did so with enthusiasm, humour and some direct talking, giving me much needed focus and guidance. Recognising perhaps the lull involved in a PhD transfer, they took me back to basics, with deadlines, regular supervision meetings and numerous re-writes. Looking back, there was some trepidation in this revised approach, but I always enjoyed supervision with them and have benefited greatly from their contrasting styles and thinking. Damian has continued to challenge me to think all things organization studies, providing plenty of ‘you-should-reads’ as well as incredibly responsive and typically insightful comments on final drafts, whilst Naomi has constantly looked out for ‘development opportunities’ for me to road-test my thinking, acting as a
quasi-PR agent in promoting my work as well as offering unwavering support throughout the process.

Moreover – and latterly – Paula Hyde has provided a much-needed ‘sense check’ when I couldn’t see the wood for the trees and I am grateful to her for that and also, in recent weeks, to Christos Begkos for his advice about the viva process. Colleagues in the Health Group have also been very supportive, notably Ann Mahon, who has always understood that I needed time and space to get on with this. If only I had had the benefit of Ann’s mantra at the very beginning to ask myself ‘what is going on?’, it might have all become clearer sooner. Likewise, my fellow Anderson tutors have always taken an interest in my research (and my wellbeing) and understood with patience and kindness when I was distracted by this.

In addition, I am grateful also to the scholastic communities at the British Academy of Management and European Group for Organizational Studies, who have heard earlier versions of this work and provided insightful comments and suggestions as to where to take it.

Outside of work, I am, of course, extremely grateful to the participants who gave up their time to take part in some of the most fascinating conversations I have ever been fortunate enough to engage in, regarding what people do and how they throw themselves into trying to make health services better. They have challenged me to think differently and test out various answers to the various conundrums they inadvertently set. What follows is thanks to their willingness to invite me in and recall their involvement in change processes in an open and frank manner.

Much of this research has been written to and from the various destinations that my work takes me, so it would be remiss not to mention the various table and window seats in countless National Rail services to and from Manchester, Bristol, Leeds, London and the South (and everywhere else), which have provided me a spot to place my laptop and tap away, making the most of travelling time to progress the musing and writing-up of this research. I am looking forward to one or two future journeys where the laptop gets to stay firmly in its bag and I can, instead, enjoy the best of the British landscape.

Finally, and as this acknowledgments section reaches its long overdue finale, I’d like to thank Kerry, who is probably even more glad than I am that this is now completed. There’s much more that I could say but simply I hope now that you will get a bit more of your husband back.
**Glossary**

AoMRC  Academy of Medical Royal Colleges  
BAMM  British Association of Medical Managers  
BMA  British Medical Association  
CBET  Competency-based education and training  
CCT  Completion of Certificate of Training  
CoPMED  Conference of Postgraduate Medical Education Deans  
DMU  De Montfort University  
EEML  Enhancing Engagement in Medical Leadership  
ESRC  Economic and Social Research Council  
EWTD  European Working Time Directive  
FMLM  Faculty of Medical Leadership and Management  
GDP  Gross Domestic Product  
GMC  General Medical Council  
GP  General Practitioner  
HEE  Health Education England  
MES  Medical Engagement Scale  
MLC  Medical Leadership Curriculum  
MLCF  Medical Leadership Competency Framework  
MMC  Modernising Medical Careers  
MTAS  Medical Training Application System  
NCAS  National Clinical Assessment Service  
NHS  National Health Service  
NHSI  NHS Institute for Innovation and Improvement  
NICE  The National Institute for Health and Care Excellence  
NIHR  National Institute for Health Research  
NPM  New Public Management  
NSW  New South Wales  
PHOG  Prejudices, hunches, opinions and guesses  
PMETB  Postgraduate Medical Education and Training Board  
PT  Project Team  
QIPP  Quality, Innovation, Productivity and Prevention  
RCP  Royal College of Physicians  
SG  Steering Group  
ST8  Specialist Trainee near the completion of specialist training

**Preface**
**Education and Academic Qualifications**

2004 – 2005  MSc Health Care Management, University of Birmingham
2000 – 2002  PG Diploma Health Care Management, University of Birmingham
2000 – 2002  PG Certificate Managing in Health and Social Care, De Montfort University, Leicester
1998 – 2000  MSc Health Economics, University of York
1994 – 1998  BA Hons (2.1) Economics with French, University of Nottingham

**Present and previous employment**

2014 – 2014  Alliance Manchester Business School, Lecturer, Health Care Management and Tutor, Elizabeth Garrett Anderson Leading Care II (NHS Leadership Academy) programme
2007 – 2014  De Montfort University, Leicester, Senior Lecturer, Health Care Management and Programme Leader, Medical Education (2012–14)
2006  NHS Institute for Innovation and Improvement, Co-Production Consultant (secondment), Delivering Quality and Value Programme
2005 – 2007  Derby Hospitals NHS Foundation Trust, Assistant Director, Service Development
2003 – 2005  University Hospitals of Leicester NHS Trust, Service Manager, Ophthalmology, Leicester Royal Infirmary
2002 – 2003  University Hospitals of Leicester NHS Trust, Assistant Service Manager, General Surgery, Leicester General Hospital
2000 – 2002  NHS Northern and Yorkshire / Harrogate Healthcare NHS Trust, NHS Graduate Scheme
1999 – 2000  Department of Health, Leeds, Economist, Primary Care and PFI

**Memberships of academic and professional bodies**

2015 –  European Group for Organizational Studies (EGOS); Member, # 51075
2013 –  Higher Education Academy; Fellow, PR059585
2013 –  Higher Education Academy; Academic Associate
2011 –  British Academy of Management; Member, # 21592
Prologue

This research began out of my interest in the work and practices of the medical profession. My career began as an economist in the Department of Health, having completed undergraduate studies in economics and postgraduate studies in health economics. I then embarked on a career in NHS management, joining the NHS Graduate Training Scheme in 2000 and working directly alongside clinicians of all types, specialties and grades. Having undertaken a further postgraduate degree in healthcare management, with a thesis focussing specifically on how doctors might be involved in management within the health service, I can state now, with some certainty, that I have long been interested in the many different ‘hats’ doctors are asked to wear in performing their roles and duties. These can be considered as clinicians, care givers, organizers and managers, representatives of the profession, experts to advise boards/committees, resource decision makers and service planners, amongst others; and how managerial and governmental agendas bear upon those, largely because of having worked with doctors in that previous NHS management career. It is out of this interest and from this perspective that this research begins.

Given my background and career, I believe that people are at the heart of what happens, good or bad, within health services. The participants involved in this research joined a project that was about trying to improve health services through greater engagement of doctors in management and leadership. The participants and I share many of the same values and beliefs, as well as motivations and through the course of the research, they attested to what they considered to be the many successes behind the project, as those involved in it might be expected to do. These are not covered in any great detail within what follows but do include the tangible products of the Medical Leadership Competency Framework (MLCF), which was the forebear of subsequent NHS leadership models and frameworks; the Medical Leadership Curriculum (MLC), which provided the guidance for medical royal colleges to incorporate the MLCF into their speciality curricula; as well as the Medical Engagement Scale (MES), which outlines the relationship between medical engagement and organizational performance. All of these are defined outcomes that have impacted on medical education and help to demonstrate how changes have been brought to a strongly-institutionalized environment. My professional background gave me an understanding of the
rationale shared by the participants. As a consequence, it was important not to be captivated by this; instead to explicitly challenge various shared assumptions in my analysis of the case.

Beyond those evident outcomes, participants spoke of a greater awareness of leadership and management for doctors, changes to practice with examples given of small-scale improved outcomes, as well as the development of a common language of leadership and a common forum (the Faculty of Medical Leadership and Management) as successes of the Enhancing Engagement in Medical Leadership (EEML) project. For those intimately involved, they saw the major success as the start of a changing culture – the overt doctor-as-leader – within the managing, leading, decision-making and planning, as well as delivery, of health services, brought about through a change to medical training. The degree to which these are ‘successes’ to a wider group or audience can only be made after more time has passed; for those reasons, this study keeps its focus on explaining how change transpired within the strongly-institutionalised environment of medical education and the associated medical profession.
Chapter 1: Introduction

1.1 Overview of this chapter

The aim of this chapter is to provide the justification and rationale behind this research, including the specific case upon which it is based, as well as to outline the contributions of this research. There will be a concise critical review of relevant theoretical constructs, which help to provide clarity about the overall objectives of the research and its research questions, followed by a brief discussion of the literature review strategy employed. This chapter will also consider the rationale for the approach to this research and outline the research questions, aim and objectives. Finally, the remaining structure of this thesis will be outlined.

1.2 Overview of the research study

This research focusses on change within the strongly institutionalized context of medical education and the medical profession, with a specific case of a national change initiative in medical education. It draws on concepts within institutional theory, such as institutional work (Lawrence and Suddaby, 2006) and institutional entrepreneurship (DiMaggio, 1988), as well as practice theory (Feldman and Orlikowski, 2011; Nicolini, 2012) to explore how individuals used social position and their capital assets (Bourdieu, 1986; Lockett et al., 2014; Battilana, 2011) to bring about change to medical education through the introduction of leadership and management training.

This research seeks to address how actors from a significant social position (known herein as ‘opinion leaders’) have engaged with a change initiative that impacts upon the role of professionals. Situated in the case of the medical profession within the English National Health Service (NHS), this work intends to explore and explain how individuals have taken the opportunity and advantage of a particular context, time and space in the NHS ‘story’, to practise, act and work to bring about change to medical education.

Its key focus considers change within the case study of the Enhancing Engagement in Medical Leadership (EEML) project (Academy of Medical Royal Colleges (AoMRC) and NHS Institute for Innovation and Improvement (NHSI),
Medical education plays a key role in forming the medical profession and both can be conceived of as institutions, within a wider institutional field of the NHS. Opinion leaders are members of the EEML’s project team and steering group. The concept of opinion leaders describes senior individuals from organizations who carried out a leadership role within the EEML project and extended that back at their home organizations in terms of enacting the project and effecting change. As such they held a crucial role as leaders of opinion or thought as to the direction of the project within the medical professional and educational domains and formed part of the study sample.

Amongst the many different aspects that could be explored in the area of change, it is the practice and actions of agents, both organizational and individual, to their changing institutional context, that is the starting focus of this study. Its final focus is on concepts relating to forms of capital (Bourdieu, 1986; Lockett et al., 2014) and the study aims to offer some explanations as to why certain actors have the capacity and freedom to exercise agency within a particular institution or culture and explores the links between actors and institutional outcomes. For those reasons, literatures will be drawn on that span agentic practice across individual and institutional domains.

Primarily, this research aims to make an empirical contribution about how change can occur within medical education focussing on the EEML as a case, but with learning that extends beyond the realm of medical education. This is achieved through a four-phase process known as ‘mirroring’. Its prime focus, however, is not on the impact of this project per se on the wider medical profession, although there may also be learning to be drawn from this. There are also contributions to be made in respect of how individuals may use and share their capital resources to effect change, offering a theoretical extension to the work of Lockett et al. (2014). These contributions relate to how individuals use their capital resources in a collective cross-field form to enact change and incorporates the notions of cultural, symbolic and social capital. This is encapsulated as the concept of system capital. In creating a disposition towards change, individuals look beyond, but include notions of profession and allo-centrism, through adopting an approach conceptualised as system centrism.
1.3 The policy context and the case of the EEML project

Having worked in the field of health policy and management throughout my career, a number of informal conversations, most notably with a former academic supervisor, led me to an awareness of a recent project, which aimed to introduce management and leadership skills and knowledge into the roles of doctors through the medical curriculum. Before considering that in more detail, it is worth considering the historical and policy context of medical engagement that led to this project.

As will be discussed in chapter 2, professionalism and the medical profession more specifically have been affected by numerous managerial, organizational and financial events and challenges over the past one hundred and fifty years, including those that the NHS has faced throughout its near seventy-year history. With frequent managerial, organizational and structural changes – at the rate of one every two years for the past 30 years (Walshe, 2010) – including the recent white paper *Equity and Excellence: Liberating the NHS* (Department of Health, 2010) and subsequent *Health and Social Care Act* (2012), successive UK governments have been faced with increasing life expectancy, coupled with a greater burden of morbidity due to, among other things, improvements in technology (Dopson, 1994). The public, once accepting of its healthcare rights to be determined by government and delivered to appropriate standards by the profession on the payment of taxation (Ham and Alberti, 2002), as part of the original ‘compact’, are now keener than ever to see public money spent wisely. Governments, equally as keen for success at the ballot box, have not wanted to raise taxes to fund improvements – the private finance initiative is a case in point. They have, therefore, sought to gain greater control over the money spent in providing health care to the population as well as greater control over the doctors making the decisions to treat or not, as seen with the managerialism of New Public Management (NPM) (Simpson, 2000).

In the early days of the NHS, doctors dominated health care decision making, with a triumvirate of consultants, hospital secretary and the medical executive committee responsible for running the hospital (Davies and Harrison, 2003). The first real attempt at planning hospital services in 1962 (Ministry of Health, 1962) could be seen as the earliest endeavour to involve clinicians in management and
McClelland and Jones (1997) cite evidence that attempts to involve doctors in management date back at least to the *Cogwheel Report* (Ministry of Health, 1967). Moreover, there seemed to be significant local and regional inequalities in terms of the allocation of funds to different parts of the country and the emergence of the Resource Allocation Working Party (RAWP) in 1975, which recommended that resources should be allocated more evenly across the country, meant that the need to get a handle on expenditure and distribution of resources could no longer be ignored (Department of Health and Social Security (DHSS), 1975).

In 1976 the Priorities Document recommended that money should be directed away from the acute sector towards long-stay services (Allen, 1995), adding further pressure to hospital-based services. The 1980s saw the then Managing Director of Sainsbury’s, Roy Griffiths review management within the NHS. The *NHS Management Inquiry* (DHSS, 1983) report made a series of recommendations, emphasising the role of doctors in management and proposing the start of clinical budgeting. This reorganization dispensed with the system of consensus management and replaced it with a general manager from any discipline, whose role it was to stimulate “...initiative, urgency and vitality” among staff (Dopson 1994: 27). The Inquiry proposed that the development of budgets at unit level would lead to closer involvement of clinicians in managing resources and allow service objectives to be related to financial and workforce matters. The resulting report stated that, “…the nearer the management process gets to the patient, the more important it becomes for the doctors to be looked upon as the natural managers” (DHSS, 1983: para. 19). Not only had the cultural change from the administration to the management of health services with clinical professionals playing a key role begun (Austin and Dopson 1997), but with it came changes to the identity of the profession.

In 1989 the government proposed a new white paper, *Working for Patients* (Department of Health, 1989), that sought to impose managerial and fiscal discipline on clinicians through external influences, such as General Practitioner fund holding. This approach was embodied in the Resource Management Initiative (Farrar, 1993), which sought to encourage doctors to take responsibility for the resource implications of their clinical activities. Reforms of the type mentioned above have been aimed at getting doctors’ explicitly involved in
financial and policy making decisions (Garelick and Fagin, 2005) in order to get the most out of a capped budget and limited resources.

Balderson and MacFadyen (1994) depicted how doctors, themselves, showed a desire to be “involved” in management, even pre-dating the arrival of the clinical directorate structure. Other studies have indicated that, with a unique understanding of how health care works, coupled with a desire to help manage limited resources, doctors choose also to get involved to protect themselves and because they get self-satisfaction and benefit from their involvement (Chantler, 1999; Buchanan et al., 1997). However, this is not a universal experience. Doctors often do not understand what management is or what managers do, inhabiting an entirely different world from their non-professional colleagues, but suspecting that they are just pushing a finite government agenda (Ong et al., 1997; Fitzgerald, 1994; Dopson, 1994; Willcocks, 1998; Degeling et al., 2003). In addition, set against the context of a crammed curriculum and competing interests in terms of the content of medical education, doctors have not, traditionally, received much training – if any – in how to manage finances and services and lead other colleagues. They have often found themselves sitting between two systems – the professional and collegial world and the wider organizational view working alongside career managers (Dopson, 1994; Austin and Dopson, 1997; Simpson, 2000).

However, in recent years, moves have been made to change the historical norm of medical non-engagement. The General Medical Council (1993) first published *Tomorrow’s Doctors*, which outlines the outcomes and standards for undergraduate medical education in 1993, which required student doctors to have knowledge and understanding of organizational issues, including economic and practical constraints within which care is delivered. This has been updated twice; firstly, in 2003, where student doctors were made responsible under medico-legal and ethical issues for the “…practice of medicine within the context of limited resources (GMC, 2003: 15); and then again, more explicitly in section 23 of *Tomorrow’s Doctors* (GMC, 2009), entitled ‘Protect patients and improve care’, of a number of factors related to understanding the managerial framework of healthcare provision, risk management and quality improvement. Indeed, student doctors as professionals are now required to “…demonstrate awareness
of the role of doctors as managers, including seeking ways to continually improve the use and prioritisation of resources” (GMC, 2009: 29). Current policy rationale (Department of Health, 2008, 2010) continues this theme of encouraging the people with the knowledge of what works clinically to be part of the decision-making process. This has been supported more recently with international evidence that shows that “…organisations which achieve high levels of engagement with clinical (medical) staff are more likely to perform well (National institute for Health Research (NIHR), 2013) and that “…increased clinical involvement in management decision-making will have benefits for the performance of hospital services” (Veronesi et al., 2014). This conceptualization of the role of the doctor, perhaps as a decision-maker and leader will be considered more fully in the following chapter when discussing the nature of professionalism.

This brings us to the case in hand. In 2005, government and the medical profession sought to introduce new training and development in leadership and management for trainee and established doctors through the Enhancing Engagement in Medical Leadership (EEML) project, which resulted in the publication of the Medical Leadership Competency Framework (MLCF) in 2008 (NHSI and AoMRC, 2008). This framework (figure 1 below) describes leadership competences for all doctors in all settings becoming more actively involved in the planning, delivery and transformation of health services (NHSI and AoMRC, 2010).

![Figure 1: Medical Leadership Competency Framework (NHSI and AoMRC, 2010)](image-url)
It forms part of a wider approach to leadership within the NHS, centred on a model of shared or distributed leadership, which is deemed appropriate where tasks are complex and highly interdependent (NHS Leadership Academy, 2011). The rationale for its implementation comes from the premise that leadership is a key part of a doctors’ professional work regardless of speciality and setting. It is already a requirement of all doctors as outlined in *Good Medical Practice* (GMC, 2006a) and *Management for Doctors* (GMC, 2006b). The framework focuses on four key competence areas: knowledge, skills, attitudes and behaviours, which doctors will work towards achieving as they progress through their training. Its implementation may have significant implications in effecting change in the role, perception and identity of doctors and for medical education more broadly. These changes are not likely to be uniform for all doctors, both across and within the same grade, specialty and training programme.

In framing this research, it will be argued that the wider contextual and environmental conditions of the NHS in the mid-2000s, brought about by the events of the preceding years as outlined above, created a space and opportunity for the emergence of this competency framework. Contributions such as those by Lord Darzi (Department of Health, 2008) into the role of doctors in leadership processes were considered as part of these conditions for creating the competency framework, which has allowed those bringing it about to influence up towards the macro-government level and down towards meso- (colleges) and micro- (professionals) levels. Now that the project is complete and the framework has been published, it exists as a mediating artefact (Macpherson et al., 2006) and product against which management and leadership training for doctors can be interpreted and in which change in strongly institutionalized environments can be considered.

### 1.4 Rationale for this research: change in strongly institutionalized environments

#### 1.4.1 Institutional theory and institutional work

As the subsequent review of literature will argue, institutional theory is not sufficient to account for change (Willmott, 2014). However, recent developments in institutional theory have provided us with the concepts of institutional logics
(Friedland and Alford, 1991), institutional entrepreneurship (DiMaggio, 1988) and institutional work (Lawrence and Suddaby, 2006). In the emerging field of institutional work (Lawrence and Suddaby, 2006), its focus is more towards agency than structure, whilst accepting their inherent duality (Giddens, 1984). Within a broader context of professionalization and change, this research draws also on concepts within practice theory (Feldman and Orlikowski, 2011; Nicolini, 2012), whilst findings offer a contribution to concepts of capital (Bourdieu, 1986) and social position, building on the work of Battilana (2011) and notably Lockett et al. (2014).

In trying to understand these practical actions and how they impact on institutions, institutional work chooses to look at “...the nearly invisible, often mundane, day-to-day adjustments, adaptations and compromises of actors attempting to maintain institutional arrangements” (Lawrence et al., 2009: 1). The emphasis here lies in understanding “...the ways in which disparate sets of actors, each with their own vision, can become co-ordinated in a common project” (Lawrence and Suddaby, 2006: 249) such as the EEML. Using institutional work as a key theoretical framework allows the exploration of how a number of opinion leaders, in their practices and actions, engaged with and responded to changes and events in the institutional field of medical profession and medical education, and have used those changes and events to effect change within medical education.

As Barley and Tolbert (1997) suggest, where an institution is at risk of change over a period of time, where flows of actions can be charted over that period and where scripts can be identified and then examined for evidence of change, then an institution can be studied and any results linked to other sources of change within that institution. Incorporating an institutional work approach allows for a focus on the agency perspective related to this process of change within such institutions. For example, as the project that was conceived was purposive, intended, and effortful, it is a clear example of institutional work (Lawrence et al., 2009). Therefore, in the given context, how organizations and actors interact, what levels of agency they display and the role of ‘institutions’ in governing and guiding behaviour are central to understanding how change is enacted within this project. Moreover, to help further understand the dynamics and tensions within this case, the related theoretical concept of practice theory can help us to
understand how individuals practise both individually and collectively to navigate their way through this institutional and policy field.

1.4.2 Practice theory

Incorporating a practice theory perspective allows for an understanding of how institutions, which are acclaimed for their stability and enduring nature, can be subject to change, yet remain institutions within a social world. In a typical organization theory diagram Feldman and Orlikowski (2011) depict practice as the ‘arrows’, which permits an understanding of how actions produce outcomes. The use of practice theory allows for focus, not only on the entity that results from actions and practices and ultimately the change they create, but also on understanding the dynamic and relations between practices that constituted the entity. Chia (2003) explains how people and their actions, within the context of their ‘in-work’ and ‘out-of-work’ experiences, form institutionalized codes of behaviour, rules, procedures – and practices – that give them an organizational world that appears external, objective and seemingly stable. Focussing on what interactions may have occurred between different agents (individual actors, organizations and institutions), may include consideration of the responses of individuals towards the context (organization, institution etc.), without falling into a trap of reifying either the individual or institution. Practice theory therefore allows a focus on the practices themselves and the dynamics between practices, agents and the routines and processes they negotiate and (re)produce. The subsequent findings and insight resulting from its application can therefore help to understand how agency is shaped by, but also produces, reinforces and changes structure (Feldman and Orlikowski, 2011; Nicolini, 2012).

1.4.3 Connecting institutional work and practice theory

Where institutional work and practice theory can be drawn together is in the recognition of “…the role of actors in socially constructing elements of work and organizations that were previously seen as either ‘natural’ or beyond the control of individual actors” (Phillips and Lawrence, 2012: 224). As Lawrence et al. (2013: 1024) reflect on Phillips and Lawrence (2012), what connects these kinds of work is that actors are engaged in purposeful effort, one of the key tenets of institutional work. This highlights institutional actors as reflexive, goal-oriented and capable, focusing on their actions as the centre of institutional dynamics and striving to
capture structure, agency and their interrelations (Lawrence, et al., 2013: 1024; Battilana et al., 2009).

Moreover, Zietsma and Lawrence (2010: 190) discuss explicitly the links between institutional work and practice, referring to “…institutional work aimed at creating, maintaining or disrupting practices as ‘practice work’”, expanding our understanding of the interplay between institutional and practice work, the latter of which is defined as “recognized forms of activity” (Barnes, 2001: 19). Smets and Jarzabkowski (2013: 1279) take this beyond purposive institutional work to further “…current understanding of agency, intentionality and effort in institutional work by demonstrating how different dimensions of agency interact dynamically in the institutional work of reconstructing institutional complexity.” This situates “…institutional work in the practical work through which individuals encounter contradictory institutional practices, negotiate adaptations that facilitate task accomplishment, and reconstruct their underlying institutional logics” (Smets and Jarzabkowski, 2013: 1280).

Therefore, in concert with institutional work, practice theory can offer an innovative and critical perspective on the role of institutions and agency within them, given that institutions not only shape individuals’ practices but individuals’ practices constitute and reproduce institutions (Battilana and D’Aunno, 2009).

1.4.4 Capital and social position

How might such practice be informed? Lockett et al. (2014: 1122) examined the influence of actors’ unique context, as characterized by their social position, on their sensemaking about organizational change and concluded that “…actors within a professional group may sensemake in different ways which are shaped by their individual endowments of cultural capital.” From the starting point of the influence of context on sensemaking, Lockett et al. (2014) frame context as the raw materials for actors’ “disciplined imagination” (Weick, 1995: 18) to help explain why their “…sensemaking may differ when confronted with a common phenomenon and how the social processes of sensemaking will be influenced accordingly” (Lockett et al., 2014: 1103).

Relatedly, Battilana (2011) examined the relationship between social position and organizational change in diverging from the institutional status quo and found two
types of change that diverged from the institutionalized template of role division: firstly, among organizations and professional groups and secondly, how actors with different social position profiles were likely to undertake the different types. Actors may be at the centre of one field but at the periphery of another and high-status individuals may be the ones to initiate organizational change. In understanding this puzzle of “…how central players become motivated to effect changes in practice” (Zietsma and Lawrence, 2010: 190), the interdependence of practice, context and social position (Suddaby and Viale, 2011) becomes more important. Each actor’s context and endowments of capital can act as a force that impinges “…from the inside” (Martin, 2003: 1), which may help us to understand how endogenous change occurs even from those in positions of strong structural legitimacy (Lockett et al., 2012; Suddaby and Viale, 2011).

Influenced by their social position, which helps actors to utilise their cultural capital, both the Battilana (2011) and Lockett et al. (2014) papers further help to frame the exploration of the role of opinion leaders within a change initiative, by highlighting the role, position and capital endowments they have that inform how they make decisions regarding practice in the institutional change process.

1.5 Literature review strategy

In order to explore the case, it was important to consider what theoretical framings may help to inform the general context towards some core research questions. These have been discussed briefly in chapter 1.4. The subsequent literatures reviewed and discussed in chapters 2 and 3 are informed by a number of initial areas of interest, built up from previous study in this area and previous experience and knowledge of the field. To begin with, a review of literatures on medical education and the curriculum was carried out, starting with focus on a special edition of *Medical Education* to celebrate 100 years since the Flexner Report (1910). This will be discussed in chapter 2.

Subsequently, I undertook a number of informal conversations with key contacts (doctors in training; medical consultants; medical profession researchers; managers), where a number of potential areas of interest for exploration and investigation arose. These different themes are not mutually exclusive and indeed, following these discussions it was evident that making sense of what was
important to different stakeholders in this debate would not be clear cut. Firstly, there was a theme around identity and values. Training is integral to the professional identity of doctors. What would doctors’ attitudes be towards the MLCF? What would be the motivators for or the barriers against medical engagement? How might doctors display resilience or resistance towards this and would it differ across specialties? Secondly, what relationships did doctors in training already have with others in leadership positions that might influence their engagement and was there enough evidence of positive ‘role-modelling’ amongst those current leaders?

Thirdly, a theme developed around the relevance of the MLCF to clinical training. Was this another ‘tick-box’ approach to management and leadership development, with more interest in style rather than in substance? Previous experience of initiatives such as workplace-based assessment suggested that a seemingly functional, rather than truly effective, approach had not engaged doctors in training. Would the MLCF be just another ‘tool’ introduced into an already demoralized workforce? A fourth theme was rather more practical in origin: was there space in the already-crowded medical curriculum for more training and development, especially when it was the introduction of something ‘new’ such as management and leadership skills and knowledge? Finally, one contact felt there was something worth exploring in the differences between the languages of medicine and management (e.g. the acronym CRP stands for both cost reduction programme and C-reactive protein, depending on which language is being spoken).

Combining the initial literature review, the conversations and ideas of knowledgeable parties and my prior knowledge, provided me with even more areas of the literature to search. Exploring literatures for academic concepts with which to frame the research started with an examination of organizational and institutional theory and key journals in those disciplines, as well as from conversations with supervisors of literatures to read. The resulting literatures are those that were discussed in chapter 1.4.

In the process of determining the core research questions (chapter 1.7) to focus on, a number of overarching questions were developed as a consequence of the above:
• How and why did this change initiative take place and what have its consequences been?
• What types of events and activities took place?
• What types of actors were involved?
• What types of behaviours did they display?
• How did other stakeholders act?
• What are the consequences of that?
• How do actors acquire, manage and use legitimacy, position and power?
• How are new organizational forms (such as the Medical Leadership Competency Framework [MLCF]) created and institutionalized?
• Who has the ability to institutionalize a novel form?
• Who are the change makers, institutional entrepreneurs or institutional workers?

1.5.1. Literature search strategy

I adopted a narrative review method for the literature review. As Bryman (2008) describes it, the narrative review tends to be less focussed and more wide-ranging than a systematic review, adopting both a critical and appreciative stance of relevant literature on topics. In terms of specific keyword search terms and inclusion/exclusion criteria, I took a decision to focus on anything written in the English language, but with no exclusion based on date of publication, taking the view that the evolution of medical education from its origins to the present day was important. I ran searches via databases such as Web of Science (Thomson Reuters) and subscribed to table of contents and email alerts in the disciplines, journals and areas listed in appendix 1. In addition, I read specific texts and adopted a ‘snowball’ approach by reading articles and journals from their reference lists. Furthermore, I searched for key policy documents and unpublished reports within so-called grey literatures, as outlined in appendix 1.

An alternative approach to conducting the literature review in a narrative manner may have considered the use of a systematic approach as suggested by Denyer and Tranfield (2009) in the locus of management and organizational studies. The benefits of systematic reviewing include transparency over what sources were consulted and inclusivity of studies and research designs, which can result in explanatory syntheses and useful, practitioner-focused application. Critics of such an approach (Hammersley, 2001; Learmonth and Harding, 2006; Morrell,
2008) view systematic reviews as too managerialist, lacking in situational judgement and interpretation and too closely aligned and privileging to a medical tradition of evidence based practice. The nature of this research is exploratory, with no single initial cause and effect as the focus of study and the approach outlined above was felt to engage appropriately with key literatures in a meaningful manner, whilst appendix 1 outlines elements of the strategy employed.

1.6 Rationale for study approach

How might it be best to examine the practices and actions of individuals within a context of change, be they organizational, institutional or at a systems-level? Chia (2003: 111) argues, “...the issue of language and social convention and the manner in which they shape our understanding of organization [and organizing] ...are central to an expanded realm of organization studies...It is through acts of differentiation, fixing, naming, labelling, classifying and relating that social reality is systematically constructed, sustained and modified.” Suddaby (2010: 17) also looks at the role of language and specifically, “…the deliberate use of persuasive language to influence the creation and maintenance of cognitive categories”, and how distinct rhetorical strategies are used to legitimate institutional change (Suddaby and Greenwood, 2005). Lawrence et al. (2002) also provide support for the approach adopted here. They argue that “… [a]lthough contemporary research in institutional theory has been dominated by large-scale, quantitative methods that track change across a field over time, there is much to be gained from examining more localized dynamics that can be dealt with in a more intensive fashion” (Lawrence et al., 2002: 289), which is what this approach will attempt to achieve with its focus on a qualitative approach to the study of phenomena.

Talking to individuals about their involvement in this project, in the form of interviews, thus, became an important and necessary step. This research seeks to examine what individuals did and how and when they carried out their actions in relation to others. Moreover, it aims to explore the EEML project to bring about a better understanding of micro-level practices of change within the medical profession and medical education. This will be achieved through not only
speaking to relevant participants in the project but also examining historical and contemporaneous written documentary accounts of the project’s practices and processes.

1.7 Research questions, aim and objectives

Following the initial research and scoping, as well as the review of literature outlined above, three central research questions were determined, which resulted in the study being designed to explore:

- How do opinion leaders enact and effect change within medical education?
- What processes are involved in opinion leaders' actions and practices that are important in effecting change?
- How does this case further our understanding of strongly institutionalized environments?

The aim therefore was to explore and understand how individuals practise change within medical education. This will be achieved by interviewing key actors engaged with the Enhancing Engagement in Medical Leadership (EEML) project and the creation of the Medical Leadership Competency Framework (NHSI and AoMRC, 2010) and by analysing documentary evidence from the EEML project (2005-10, Academy of Medical Royal Colleges, n.d). In light of the theoretical context of institutional change and the political environment of public and healthcare sector reform, it will seek to:

- Explore how opinion leaders experience and practise change;
- Understand how this is related to their social position;
- Explore the processes involved in creating meaning, perspective and sense of actions, practices and change;
- Critically reflect on changes within medical education and the medical profession;
- Identify implications for theory and for practice.

The relationship between the research questions and the different theoretical constructs outlined in chapter 1.4 is depicted in Table 1.
Table 1: Theoretical Map connecting research questions to literatures

<table>
<thead>
<tr>
<th>Background and Context</th>
<th>Research Questions</th>
<th>Theoretical Constructs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest in management and professions</td>
<td>How do opinion leaders enact and effect change within medical education?</td>
<td>Agency (institutional work / entrepreneurship)</td>
</tr>
<tr>
<td>A relevant case in the EEML project</td>
<td>What processes are involved in opinion leaders’ actions and practices that are important in effecting change? i.e. what do people do?</td>
<td>Practice Theory</td>
</tr>
<tr>
<td></td>
<td>How does this case further our understanding of strongly institutionalized environments?</td>
<td>Capital and social position</td>
</tr>
</tbody>
</table>

1.8 Chapter Summary

This chapter has provided an overview of the research study and a rationale for focussing on a change initiative in the form of the EEML case study within the strongly institutionalized environment of the medical profession and medical education. It has outlined the literature search strategy adopted and discussed key theoretical literatures to support the research questions, outlined in the previous section. In doing so, it has provided a firm basis for the purpose of this research, which is to understand the work (actions, practices) of opinion leaders in effecting change in medical education through the EEML project.

1.9 Structure of this thesis

The following chapter (chapter 2) will review debates regarding the professions, professionalism and professionalization. It will discuss the impact of managerialism through the lenses of New Public Management and hybrid-professionalism and consider the specific issue of medical professionalism, including the impact of change upon it. Finally, it will provide background and context to how medical education and curriculum development has evolved.

Chapter 3 will then consider the underpinning theoretical concepts that help to explore this case, starting with a discussion of the concept of institution. It will consider how institutional theory has attempted to deal with change practices and
continues with a focus on agentic processes that may help to explain change within neo-institutional theory, notably through consideration of institutional work and practice theory and what theoretical constructs help to shape work and practice. It will conclude by considering how constructs of capital and social position influence practice.

Chapter 4 will attempt to build on chapters 2 and 3 by outlining the relevant research paradigms, strategies and methodologies as well as provide justification for the data collection and analysis methods employed. It will consider the selection and recruitment of research participants and the use of supporting and confirmatory documentary evidence.

Chapter 5 will begin to present the findings and analysis from the research, demonstrating the importance of particular environmental conditions and motivations in determining the initiation of the EEML project.

Chapter 6 will then continue this discussion, outlining how an emergent approach to practising change was adopted.

Chapter 7 begins by offering an empirical contribution to how to practise institutional change and then outlines the major theoretical contributions of this thesis, exploring the findings in light of appropriate literatures and relevant theoretical frameworks, notably those linked to capital and social position. It concludes by considering alternative explanations to the findings presented in chapters 5 and 6.

Finally, chapter 8 will draw together the major themes of the work, consider limitations of the study and provide conclusions and direction for future inquiry. It will also capture my reflections on the research process.
Chapter 2: Professionalism, medical professionalism and medical education

2.1 Introduction

The previous chapter has begun to outline issues relevant to medical professionalism, notably efforts at medical engagement. There is value in exploring the nature of professionals as individuals and the profession as a collective entity. This chapter will consider the concept of professionalism and its evolving nature, including the impact of new forms of ‘managerialism’ (Halford and Leonard, 1999) on professional status, role and behaviour, specifically through the lens of New Public Management (Hood, 1991). The chapter will then consider the particular concept of medical professionalism; how it has evolved and been impacted upon by New Public Management in the case of the NHS. It will also aim to consider potential future scenarios for both professionalism at large and medical professionalism. It will finish by considering the evolution of medical education, which is relevant not only as a debate about knowledge and skills for the medical workforce but also about the construction, credentials and identity of the medical profession itself.

2.2 Understanding professionalism and associated terms

Larson (1977) suggests that professions can be grouped into four types: ancient, medieval, industrial-era and modern, which goes some way to explaining the difficulty in categorizing what is a profession in the current era. Leicht and Fennell (2001:8) describe a professional as someone who belongs to a profession and professions as “…elite classes of occupations with a focus on the characteristics or attributes of such occupations as a taxonomy.” Professionalism, the “…institutional circumstances in which members of occupations rather than consumers or managers control work” (Freidson, 2001: 12), is the end point of the professional project, a term that derives from Freidson (1986) and Abbott (1988), as attempts to both “…enhance the autonomy and freedom of action for occupational incumbents under a set of well-defined professional norms; and defend a specific task domain from encroachment by competing occupational groups or stakeholders” (Leicht and Fennell, 2001: 8).
Moreover, many more authors have written greatly about what constitutes a ‘profession’, a ‘professional’ or even ‘professionalism’ (Belfall, 1999; Evetts, 2005; Freidson, 1983, 1986; Greenwood, 1957; Hickson and Thomas, 1969; Hoyle, 1980; Hoyle and John, 1995; Johnson, 1972; Millerson, 1964; Parsons, 1951, 1954; Schein, 1970). In summarising these numerous definitions or classifications, to capture the essence of what professionals do, means using terms such as: altruism; autonomy; self-regulation; authority; theoretical knowledge; specialised training; membership of a qualifying association; distinctive occupational culture; code of conduct; legal recognition; and testing of competence through formal examination, amongst others. Perhaps the most well-known of these is the so-called ‘attribute model’ of professionalism (Carr-Saunders and Wilson, 1933, table 2), which enables a form of distinction to be drawn between ‘professional’ and other ‘occupational’ groups. However, it is worth noting that some occupational groups, for example, managers, may have some of these attributes and individual managers may be able to demonstrate they have all of them, so eliciting an absolutely clear distinction between ‘professions’ and ‘occupations’ is not straightforward.

Table 2: Attribute Model of Professionalism (Carr-Saunders and Wilson, 1933)

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<tr>
<td>1.</td>
<td>Knowledge based on theory; complex intellectual techniques</td>
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<tr>
<td>2.</td>
<td>Mastery of knowledge base requires long period of training, usually university based, technically specialised, designed to socialise trainees into the culture and symbols of the profession</td>
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<tr>
<td>3.</td>
<td>Tasks inherently valuable to society, relevant to key social values (health, technological progress, legal rights)</td>
</tr>
<tr>
<td>4.</td>
<td>Practitioners are motivated by service to client’s welfare and to the profession</td>
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<tr>
<td>5.</td>
<td>Performance of tasks characterised by high degree of autonomy</td>
</tr>
<tr>
<td>6.</td>
<td>Practitioners exhibit long-term commitment to profession</td>
</tr>
<tr>
<td>7.</td>
<td>Practitioners enjoy a well-developed sense of community within the profession</td>
</tr>
<tr>
<td>8.</td>
<td>The profession has a well-defined code of ethics that guides professionals’ behaviour and defines the profession’s values</td>
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Nonetheless, to attempt to draw together terms, attributes and traits associated with professionalism, three perspectives can be acknowledged, which relate to the idea of the professional project. Firstly, Parsons (1951) set out to define the binding and distinguishing features in the functionalist perspective, such as the above attribute model. Secondly, the interactionist perspective saw professions as part of a broader classification of occupations, within which their access to a “...circumscribed body of knowledge and skills thought to gain particular productive ends” (Freidson, 2001: 18) made them a more discretionary specialist occupational group, as opposed to those who might be required to display less discretion or judgment. Moreover, Abbott (1988: 40) would suggest that professionals stand out from other groups due to their ability to diagnose, infer and treat, where these three acts embody “…the essential cultural logic of professional practice.” Both of these perspectives begin to differentiate between professions and other occupational groups, through both classifying their characteristics and drawing distinctions between the levels of skill, knowledge and ability to enact those.

Thus, it could be argued that professionals are more than just specialised workers as they provide services of great social value (Freidson, 2001), because the particular knowledge and skills they possess set them apart from other workers. Beyond knowledge and skills, they bring a special attitude of commitment and concern to their work, which gives us that concept of ‘professionalism’ (see the work of Spencer, 1896; Tawney 1920). This professionalism is kept in check through self-regulation in the form of social control by contemporaries and fellow professionals in named associations, whose “…silent pressure of opinion and tradition is constantly around throughout [their] professional career” (Carr-Saunders and Wilson, 1933: 395-396 as cited by Freidson, 1984: 2). Goode’s (1957) view of a profession as a ‘community’ that shares a common experience and identity, with a long tradition, a distinct public image and identity and fairly homogenous training, allows us to characterize each individual profession, both from each other and from other non-professional occupations.

Thirdly and finally, the theory of closure focused on the strategies professions use to achieve closure (of labour markets), control and, implicitly, power (Ferlie et al., 1996), building on their ability to differentiate themselves from others. By
setting standards and controlling entry into the profession, a degree of control can be exerted over those wishing to join and those subject to the dominance of the profession, such as the consumer. Although Marx was not concerned specifically with the group called professionals, the concept of power follows a neo-Marxist tradition of understanding the control of one group over another (Ovretveit, 1988).

2.2.1 Professionalism as an ever-changing project

The above notions of professionalism largely accept professionalism as a naturally accepted concept in contrast to other occupations. In contrast, Bourdieu (1994a, as cited by Schinkel and Noordegraaf, 2011) argues that by classifying professionalism, with its associated definitions and characteristics, those who occupy positions outside of it within the field of social life (‘occupations’, ‘semi-professionals’) are subscribing to its positional legitimacy and credibility, because it has been categorized as something unique and special, what Durkheim (1915) described as a “well-founded delirium”, albeit he was talking about religion. Bourdieu’s main critique “…comes down to the idea that its use involves an uncritical acceptance of a concept laden with distinctive profit and symbolic value particular to a specific social space” (Schinkel and Noordegraaf, 2011: 80).

Schinkel and Noordegraaf (2011: 85), in building on Bourdieu’s work, look to cast professionalism as a form of symbolic capital, taking place within historical and structural contexts, making the ‘self-behaviours’ above more dynamic, “…constantly at stake, …continuously contested within the limits of a context.”

Rather than being a fixed and static entity with a number of defined characteristics, Bourdieu is, like Freidson and Abbott, alluding to ‘professionalization projects’, which serve distinctive organizational, social and ideological objectives within different societies. In reference to the work of Weber, Allan (2012) considers the case of the emergence of professional magicians and sociologists through such ‘professionalization projects’ that are as similar as those we might attribute to lawyers, doctors or the clergy. In order to understand the law, medicine or religion, Allan (2012) argues that professionals have created vast and complex webs of language so that others have to pay for such understanding, which protects the vested interests of those professional groups. This allows professional groups to avoid inspection – who can challenge the
knowledge of a profession if they themselves do not have that knowledge? – and thus further secure their position and status. This is perpetuated through the professions’ self-administration, self-recruitment and self-governing behaviour. Reed (1996: 583) surmises how liberal professionalism therefore became the “…dominant occupational mode and organizational form for institutionalizing the provision and evaluation of expert services in modern capitalist societies,” using their “…highly specialized knowledge and skill in such a way as to maximize the [profession’s] stability, portability, generality and legitimacy across a wide range of relatively secure and cohesive jurisdictional domains.”

However, Freidson (1984, 2001) is one author who has noted that political and economic events over the past forty years have altered the traditional, and perhaps accepted, view of the role and behaviour of the professions, as organizations have grown in size and complexity and the relationship with the consumer or customer of professional services has altered as well. This has created a new form of social control that has somewhat eroded professional status along two lines: firstly, professionals have become increasingly ‘deprofessionalized’, which is the process by which professional prerogatives have been eroded (Leicht and Fennell, 2001: 8) and their positions of prestige and trust diminished, an argument closely associated with the work of Haug (1973, 1975, 1977). These organizational professions (Child, 1982) are “…unable to realize the degree of indetermination, monopolization and control of their knowledge base enjoyed by the liberal/independent professions” (Reed, 1996: 584). Secondly, the professions have become increasingly ‘proletarianized’, along the lines that Marx’s theory of history attests (Freidson, 1984), which is to say that, with the emergence of large-scale organizations, they have become dependent on selling their labour in return for subsistence (Braverman, 1974).

As Leicht and Fennell (2001: 8) argue, this loss of earnings power and prestige that often accompanies the loss of professional prerogatives means that “…proletarianized professionals work in contexts where none of their prerogatives remain, and the content, control and location of the work is managed by outsiders.” One of the main factors to impact on professionalism, which itself is often situated within public services, and which contributed to the discourses of deprofessionalization and proletarianization, was the emergence of
managerialist approaches, notably in the form of New Public Management (NPM) to which this chapter now turns.

### 2.2.2 Public services, professionalism and managerialism

**Introduction**

Institutions and individuals do not exist within a vacuum, rather they belong in societies, which are made up of both private and public sector entities, where no one definition of the latter exists. In the publics’ view of the public sector (Steele and Corrigan, 2001), it comprises: the financing of and authority over services by government; the intention that services should be of benefit to society; and the view that ‘public’ services are different from ‘private’. According to Flynn (2007) and Doherty and Horne (2002), the spending on public services, akin to the size of the public sector, accounts for approximately 40% of GDP in the UK and despite ideological attempts to reduce this, it has remained within the 35-45% bracket since the Second World War. Some public services started life as religious or charitable organizations, some have been private, then public and now privately owned again and are often defined by legislation in fields such as law and order, environmental health and national defence services, with the most important differences between public and private ownership lying in their resourcing and accountability arrangements.

In terms of characteristics, there are four predominant areas: public goods, that is, the provision of services where the market fails to do so, such as street lighting; public financing, for example, taxation as opposed to direct payment; public ownership, although the waters are muddied here because how are public transport or refuse collection categorized where they are privately operated but with a public interest; and finally, the public customer, where there is a lack of a direct connection between the ability to pay and access to the service (Lane, 1995)

**New Public Management emerges**

Traditional notions of public sector management were based on Taylorist philosophies of scientific management as well as concepts that are, as Weber may have defined them: bureaucratic, impersonal, procedural, hierarchical and
technical (Lynn, 2006; Ahmad and Broussine, 2003). This approach and ethos was criticized for being inefficient and ineffective; leading neither to cost containment (Niskanen, 1971), nor quality improvement; opening the way to undue influence for employees, who were protected by virtue of their membership of professional associations or mass trade unions; and, if unchecked, leading to unacceptable growth in tax bills, an increasingly dissatisfied electorate and declining standards of public service (Dawson and Dargie, 1999, 2002).

Supporting this, Public Choice Theory (Niskanen, 1971) declared that individuals are motivated by self-interest and therefore act accordingly, hence politicians, bureaucrats, professionals, interest groups and so on are seen as budget maximisers, resulting, at an aggregate level, in public sector expansion. This theory, therefore, advocated competition and market forces, for example, the ideas of Alain Enthoven (1985), as a means of challenging the existing status quo, leading to the birth of the internal market within public services.

Further criticisms of the public sector centred on: a lack of customer focus; unresponsiveness, with organizations prone to inertia; a preference for risk aversion; and a lack of integration with other public services (Ahmad and Broussine, 2003). In all, traditional public sector management was being challenged, through a rejection of old forms of public service administration, the emergence of the politics of the New Right and neo-liberalism and the beginnings of New Public Management (NPM) (Clarke et al., 2000).

**What is NPM?**

NPM, itself, is a mix of the new institutional economics of public choice, such as contestability, user choice, transparency, for example, in the form of the Freedom of Information Act, and incentive structures; alongside business-type managerialism, which could be considered a mix of the principles of scientific management, professionalism, with a freedom to manage away from government control (Hood, 1991). Academically, it could be seen as an amalgamation of thinking on political science, economics (rational/public choice theory) and organizational theory and it borrows from across these three distinct areas (Osborne, 2006).
It originated in the late 1970s and early 1980s and was worldwide in countries where there were strong traditions of directly organising, providing and managing publicly funded public services, such as the English NHS. As a response to perceived public sector inefficiency and ineffectiveness, where there was little apparent cost containment or quality improvement, NPM replaced these with private sector ideals and management theories, combining structural and social processes. In a sense, it was private sector principles applied to the public sector, with the efficacy of competition and the marketplace as its value base (Osborne, 2006). This was in contrast to notions that professionals could be left alone to manage services guided solely by their knowledge and expertise of the field (Reed, 1996).

Proponents of NPM (Drucker, 1968; Niskanen, 1971; Peters and Waterman, 1982; Osborne and Gaebler, 1993) would collectively argue that as a movement, it added a new approach to public sector governance without replacing any existing frameworks. One of the key facets of NPM was that government should ‘steer, not row’ to borrow from Osborne and Gaebler’s (1993) words (Walshe and Smith, 2011). Having emerged out of strong criticisms of large public sector states and governments, it served the politics of the New Right and neo-liberalism well. This was dominated by the dogma of the three E’s – economy, efficiency and effectiveness – and the public sector, because of its inherently bureaucratic and monopolistic nature, was unable to satisfactorily fulfil this dogma (Osborne and Gaebler, 1993). Moreover, growth in the public sector, it was argued, also impeded the private sector from fulfilling this role, a concept known as crowding-out (Tomlinson, 2010).

In terms of characteristics, there are a number that can be associated with NPM (Cairney, 2012). Separation of the purchaser from the provider of public services is one example, whereby public authorities had been, firstly, encouraged and then obliged to tender for non-core services, such as cleaning and catering. Flynn (2007) outlined the different degrees of competition that existed, from outsourcing with no internal bid, through price testing and benchmarking and a limited choice of supplier with partial outsourcing, to competition for whole services and complete choice of supplier. The HM Treasury (1991) White Paper *Competing for Quality* introduced market testing, strategic contracting and the concept of the
private finance initiative. Such creation of quasi-markets, where market-like conditions would become prevalent in public services, is a further example of the movement towards NPM. These operated under two major constraints: firstly, the available funds in the market were determined on an annual basis by government, that is to say they were cash-limited; and secondly, the activities in which the created organizations could engage were laid out by law and subject to careful regulation (Flynn, 2007).

Furthermore, increased accountability and performance management in the form of models of Human Resource Management were imported from the private sector, which themselves had originated out of US Business School environments. Public sector workers, whose salaries had long been established as a result of collective bargaining, saw increased flexibility in their pay and conditions, with a new focus on the recipient of services as a ‘customer’. One of the results of the changes in pay and conditions was that employment in UK public services fell from 7 million to 5 million between 1981 and 1998 (Flynn, 2007). Changes in the regulatory role of government were another characteristic of NPM, as an attempt to separate the political from the management process. Perhaps the most well-known examples of the changing relationship between the state and its services, thus impacting on the ‘compact’ between those services and their public, were the high profiles sales of telecommunications, airspace, oil, gas, electric and water that took place between 1979 and 1990 – long-established ‘public’ companies sold to the private sector (Flynn, 2007).

However, critics of NPM felt it to be nothing more than New Right ideology and rhetoric, over emphasising the argument of economic efficiency, whilst neglecting other criteria such as quality and equity; as well as an extension of existing ‘contracting out’ arrangements, introducing an incoherent mix of popular ideas into public sector life to support those ideologies (Dunleavy, 1997; Dunleavy et al., 2006; Simonet, 2013). The effects of NPM were that it reshaped relationships between a number of different actors: professionals, managers, central and local government, but offered a dynamic image of the process of management, in contrast to the seemingly fussy and staid administrative approaches that had been in place before. At its heart was a desire to see efficiency and long-term effectiveness as key to public sector performance (du Gay, 2000).
In response to managerialism: hybrid forms of professionalism and a new model professional?

In light of the rise of managerialism, was the professional response one of wilful acceptance of deprofessionalization and proletarianization? Freidson (1984:7) provided a sound critique of arguments that discussed the deprofessionalization and proletarianization of professions, contending that there was little evidence to suggest a “steadily shrinking jurisdiction” of professional knowledge and skills, as well as reasoning that employment status is not a good measure of control over one’s work, citing those who suggest the proletarianization and corporatization of professions to be offering hyperbole, rather than sound analysis (Freidson, 2001). He did, however, recognize that the bureaucratization of professionals, through an ordering of positional hierarchy, “...has led to the loss of professionals’ traditionally asserted right of self-direction” (Freidson, 1984: 10), albeit with the creation of hybrid approaches of ‘organized anarchy’ or ‘professional bureaucracies’ to create some form of control over professional groups.

Moreover, McGivern et al. (2015) conceptualise individuals taking on roles within these new organizational forms as ‘incidental’ or ‘willing’ hybrids, whose work represents, protects and maintains professionalism’s foundation or alternatively challenges and disrupts traditional professionalism.

In contrast, Hodgson et al. (2015: 745) describe how non-collegial professions, such as in project management, have purposefully pursued “…a corporate professionalization project” in an effort to combine distinct logics to maintain legitimacy with stakeholders in that field. These approaches allow professionals to continue to exercise discretion and judgement in their daily work, partly because the organized hierarchy above them is filled with fellow professionals, who are responsible for overseeing their work. This may inhibit individual freedom to act, but at the same time it ensures professional influence is maintained (Freidson, 1984). This continued influence relies in large parts on the close associations professions have with universities, where schools of professionals are “…devoted to research, experimental practice and theorizing” (Freidson, 1984: 16), which helps to promote the knowledge elite and expertise through inquiries and committees upon which modern public policy relies.
Related to this, Freidson (2001) argues that, at their inception, formal professional associations contain elite, unusually successful and distinguished practitioners, whose aim is maintenance rather than a “collective mobility project” to enhance status (Larson, 1977). As the organized hierarchy, they act “…to preserve and solidify their official and public status, in part by gaining state recognition and support, and in part by preventing the decline in status that might occur if practitioners of more humble origins become members” (Freidson, 2001: 142).

Once the association is established, the ‘project’ becomes one of increased specialization and contention between differently credentialled practitioners (for example, personal injury versus criminal defence lawyers) within the official sheltered marketplace of the professional association; driven by the expansion of knowledge, skills and their applications, the invention of new skills and the variety of practices that develop. Prominence and influence for certain individuals comes by virtue of their reputation for gaining the trust and respect of the political, economic or social elite. At this point, the community becomes multiple sub-communities, loosely held together by a common occupational title (‘lawyer’) (Freidson, 2001). The source of their legitimate position lies within the profession, not necessarily within the programme of its multiple associations; for example, The Law Society, The Bar Council and the International Bar Association, but all being professionals “…they are legitimate even when they contradict each other” (Freidson, 2001: 144).

Furthermore, research by Evetts (2005: 3) has focussed on “…the increased use of the discourse of professionalism in a wide range of occupations and organizational workplaces”, with three different interpretations. The first is that of professionalism as an occupational value, the second as an ideology and thirdly as a discourse of occupational change and managerial control. These are distinct from the concepts of ‘profession’, as a category of occupational work and ‘professionalization’, as the process to pursue, develop and maintain the closure of the professional group. Evetts’ (2005) research describes two different types of discourse regarding professionalism; firstly, organizational, where managers use it to control and secondly, occupational, where professional groups maintain their collegial authority. It is the tension between these two different types, which respectively follow Weberian models of organization and Durkheimian models of
occupations as moral communities, that may say much about the future direction of professions within modern work organizations.

Undoubtedly, a professional working today has to balance the requirements of these different discourses, playing out an archetypal case of institutionalized role conflict (Etzioni, 1964). The ways in which the two discourses are used by numerous stakeholders such as the state, the professions and managers within organizations may help to elucidate how professionalism becomes an instrument of occupational change and social control (Evetts, 2005). In a study of management accountants by Shafer et al. (2001), there was a correlation between those who committed to certain professional ideals, which can relate to Evetts’ (2005) definition of occupational professionalism, and perceptions of conflict between organizational and professional values, a factor that relates to Evetts’ (2005) organizational professionalism. As the authors note, “...specifically, higher levels of dedication to the profession and autonomy demands were associated with higher levels of organizational-professional conflict” (Shafer et al., 2001: 61).

Nonetheless, the relationship between the corporation and professional groups is not as clear cut as might be argued above through hybrid approaches that accommodate professional behaviour within bureaucratic structures. Ackroyd (1996) argues that despite the periodical marginalization of professions, caused by political and economic forces, they have shown considerable capacity to adapt to external controls through the creation of informal organizations. Drawing on case studies from manufacturing industry and public services, he argues that professions work in “...cooperation with other middle-class groups such as employers, managers and supervisors” (Ackroyd, 1996: 601), at times subordinating themselves to organizational controls, whilst maintaining a monopoly over key knowledge and employees.

In support, Hanlon (1998) discusses the notion of professionalism-as-enterprise as a response to changing forces that reflected society’s outlook on the purpose of professions; a type of professionalism that requires managerial and entrepreneurial skills, in order to respond to emerging views where experts were no longer simply ‘trusted’ and where their autonomy was now considered a ‘luxury.’ Hanlon (1998) goes on to discuss how this created a fissure between
more commercially-minded professionals and those who stood by a social service logic. This, of course, could be considered as further evidence of the deprofessionalization of professions, if they are resorting to adopting new modes to endure in changing times, although it may equally be considered that the active shaping of practice and design of the organizational field by professions is a means of maintaining some say over professional development (Muzio and Kirkpatrick, 2011).

Therefore, the evolving ‘new model professional’ (Ackroyd, 1996) has adapted in different ways to a world where commercial and service industries are more prevalent than manufacturing ones, by cooperating with managerial and organizational demands to ensure their survival, even thriving in environments where their uniqueness, innovation and expertise are valued as an economic premium (Reed, 1996). As Reed (1996: 586) continues “…[t]his pushes [them] towards an organic or network type of organizational form in which a logic of decentralized flexibility and autonomy…move[s] them away from the administrative structures typically associated with both the liberal and organizational professions.”

Therefore, in attempting to organize and lead the professional within the organization, Grint (2012) proposes a four-way typology of professionals (individualists-egalitarians-hierarchists-pragmatists), each of whom require handling with different approaches dependent on their association with group orientation and adherence to rules and roles. Indeed, Tony Blair (1998) argued that traditional (for here, read: professional) values could be maintained in a changed world if pragmatism was adopted, rather than keeping to principled stances, defining modern public sector management for the UK by saying politics could no longer be labelled simply as left or right. The mantra of ‘what works is what counts’ was born and Ahmad and Broussine (2003: 46) capture this continuing approach as a “…renewal of government and public services through collaboration, partnership and inclusion. Modernisation [as it was to become known after 1997] was to bring about a programme of reconciliation and renewal.”

2.2.3 The future for professionalism?

In considering the place of professionalism in the twenty-first century, Lester (2009) considers four developments that may impact on the status of
professionals. Firstly, changes in the nature of work organizations, towards higher skill and more knowledge intensive work means that an increasing proportion of jobs can now be described as professional, resulting in an increase in the number of occupations being described as professional, thus diluting the special position and standing of current professional groups. Secondly, the balance between competition, regulation and accountability has changed, with notably European and worldwide labour markets meaning that the provision of professional services is carried out by a greater number of professionals who have not been subject to the inculcation of home-grown professional associations. Moreover, the provision of services is much more a joint effort of ‘co-production’ (Reeves and Knell, 2006) and is more evidence of the effect of social, cultural, economic and political forces, which alters the role of the professional. Thirdly, the nature of the knowledge required to be a professional has changed, with more focus on reflective practice, action learning and critical action research and less on technocratic, positivist roots. Finally, Lester (2009) argues that changes in further and higher education have led to a far larger pool of graduates available to professions and modifications in the way professional education and training is taught and received.

2.2.4 Summary

This section has discussed the defining characteristics, attributes and distinctions of professionalism, both in the context of other occupational groups and those who would seek to control the autonomy and practice of professional work. This context might also be seen with regards to health care and the medical profession, perhaps particularly in how the medical profession has sought to extend control and dominance over other professions and resist changes from managerial forces. This will now be considered.

2.3 The medical profession

In considering the case of the medical profession, this section will build on the previous section and its associated effects on medical professionalism.
2.3.1 Historical evolution

Freidson (1970: 6) describes how historically disease evolved from being a “...consequence of responsible personal choice or of an irrevocable state of sin or genetic inferiority” to something that was pathological and amenable to scientific treatment. In doing so, moral arguments for social reform were displaced by ‘scientific’ arguments, ‘deviant’ behaviour became treatable, rather than punishable and, in many respects, those responsible for treating the sick became increasingly influential in promoting science. In addition, as economies grew and capitalist societies abounded, illness became increasingly organized, in some instances provided directly by the state, in others by corporations, and governments turned to the medical profession as a key source of not only scientific knowledge, but also organizational knowledge in the broadest sense. Both the Apothecaries Act (1815) (Provincial Medical and Surgical Journal, 1851) and the Medical Act (1858) became significant milestones in certifying the medical profession and making them stand apart from other occupations (Macdonald, 1995). The latter act provides an example of leaving the profession to both initiate and control the reform process, by which means it was then able to dominate paramedical professions (Larkin, 1983) and ultimately control medical education through the formation of teaching hospitals and all post-qualifying examinations (Macdonald, 1995).

Moreover, Schinkel and Noordegraaf (2011: 88) have outlined how the medical profession were able to use their scientific knowledge – Foucault’s (1976) ‘medical gaze’ – to set them apart from previous understandings of medicine to gain autonomy, set up entry requirements through education and use that to transmit “...the professions’ cultural capital, its medical expertise, and that hence contribute[d] to the (re)production of ...cultural capital as symbolic capital.” The ‘medicalization’ of illness has become institutionalized with the “...public’s awareness...to the grosser, more symbolic aspects of the profession” (Freidson, 1970: 16) meaning that, for many years, the medical profession was held in high regard. Professional autonomy, which underpins the dominant position of the medical profession, can be divided into three different forms: political, the right of the profession to make policy decisions as the legitimate experts; economic, the right to determine remunerations; and technical, the right to set standards and control performance (Ferlie et al., 1996: 169), which in the case of the medical
profession is seen in the guise of clinical autonomy or freedom to practise. Bilton et al. (2004) describe these three processes as the creation and defence of a specialist body of knowledge; the establishment of control over a client market and the control over professional work practices, an example of which might be the complete rejection of the work of chiropractors.

Scott et al. (2000: 21), writing in the American context, describe such an era of professional dominance between 1945 and 1965, where professional bodies dominated the ‘field’ and the “...central value governing service provision was medical care quality as determined by professional providers.” In the English context, the NHS Act (Great Britain, 1946) heralded in the NHS and with Aneurin Bevan, its architect, later remarking that the medical profession had been brought on board by ‘stuffing their mouths with gold’ (Webster, 1991; Timmins, 2001: 115), doctors were given the “…responsibility for ensuring clinical standards and delivering care to patients” (Ham and Alberti, 2002: 838), in return for government guaranteeing access to care for all and determining the budget through which to achieve that. Bevan (1948: 1) himself stated that bringing the medical profession into the fledgling institution that was the NHS had not been altogether trouble-free, but that he wanted:

“…vigorously to watch that your own intellectual and scientific freedom is never at risk of impairment by the background administrative framework, which has to be there for organizing purposes, … My job is to give you all the facilities, resources, apparatus, and help I can, and then to leave you alone as professional men and women to use your skill and judgment without hindrance.”

Indeed, Mintzberg (1979) described the NHS as a professional bureaucracy to encapsulate the effect and impact of the strong cultural hold doctors had throughout its first thirty years over health care organizations. There is no doubt that their presence and behaviour within an organization or system can influence, even dominate, its inner workings and ability to evolve, thus making it a difficult world to penetrate; however, a number of factors can be seen to have contributed to the changing of the original ‘compact’ and the nature of the medical professional role. In support of, but prior to Evetts’ (2005) study on professions highlighted in the previous section, Abernethy and Stoelwinder (1994) undertook a healthcare-specific study in a large public teaching hospital in Australia and their results indicated that there was conflict when professionals engaged in
behaviour which was directed towards increasing their own autonomy at the same time as management was implementing controls systems designed to control that behaviour. This is not unsurprising; however, the degree of conflict experienced depended on the individual role orientation of the professional and the extent to which administrative and bureaucratic systems were used to restrict professionals’ activities.

2.3.2 Changing medical professionalism?

In light of Ferlie et al.’s (1996) argument, it could be argued that political autonomy remains strong with the continuing influence of the British Medical Association (BMA) and that economic autonomy has been out of the reach of the profession largely since 1948 and the formation of the NHS, so there has not been a great deal of change in that regard; however, technical (clinical) autonomy has receded both exogenously, with the introduction of league tables and performance management systems, but also endogenously in the form of clinical audit. Allen (1995) argues that exogenous factors included the economic conditions of the 1970s, changing attitudes to the doctor-patient relationship, healthcare scandals, as well as New Public Management era reforms, which have been discussed above as part of professions and the public sector. Bilton et al. (2004) outline other factors, including the de-medicalization of health care for the elderly, with responsibility passing to social services and the marketization of the NHS as examples of changes that have threatened professional autonomy. Harrison and Ahmad (2000) capture the decline of medical autonomy at every level, from the micro, meso and macro, with, respectively, less control over treatments and work patterns, in terms of relationships with government and in terms of the biomedical model.

Other professions now carry out the roles and responsibilities that doctors used to solely do, yet there has been little shift in the hierarchy of professions within healthcare, albeit there has been the creation of the hybrid professional manager role (Ferlie et al., 1996) as “…a way of bringing an understanding from doctors to managerial issues” (Kippist and Fitzgerald, 2009: 652). However, Busfield (2000: 125), citing the work of both Navarro (1976) and Foucault (1991) discusses that more critical views of the profession and the state’s relationship would suggest less of a polarity and more of a duality, where “…professions need to be viewed
as part of the process of governmentality.” Moreover, Greener (2009) cites Klein’s (2006) view of the ‘double-bed’ relationship of mutual dependence between the state and medical profession, which would suggest a complicit reaction to changing organizational forms. In the case of English health care, one of those more prominent factors, which touches on many of these above arguments, was the introduction of New Public Management reforms in the 1980s, which will again be considered now, but specifically with regards to healthcare.

2.3.3 Managerialism and healthcare

Introduction

In UK society, the provision of medical education is organized and controlled by organizations working within the context of the public sector. The constitution of the public sector has been discussed in a previous section (chapter 2.2) and its influence on professionalism was seen to create a hybrid form of managed professionals; yet what was its impact on medical education and the medical profession?

It could be argued that NPM and English healthcare met each other formally for the first time with the publication of Griffiths’ NHS Management Inquiry (DHSS, 1983), which Timmins (2001: 407) described as “…the most important single change to the NHS since 1948.” Organizations would be subject to limited budgets and financial accountability, with increased responsibility for decision-makers, audit and benchmarking, alongside performance measurement and performance appraisal. As Timmins (2001: 407) recounts of Griffiths’ report, “…Doctors should become involved in running budgets. Cost improvement programmes should be better established. Treatments should be better evaluated to see if they were effective in both clinical and cost terms.” The proposed impact of this report on medical professionalism is clear to see. It was also a reaction in recognition of the need to update, perhaps, the rather naïve assumption that the amount of illness in England was more or less finite – achieving complete good health for all just was not simply possible – and therefore tough choices had to be made to contain costs and set priorities (Rivett, 1997). As Kirkpatrick et al. (2005) argue, medical knowledge improves all the time and so do treatments and along with the ‘technologisation’ of health care, this
creates a secure market for drugs and machinery. Therefore, standards of health 
become to be seen as conventional and societal rather than absolute, so 
increasing demand, but capped supply, are always likely to come into conflict.

Hewison (2004) argues that it is difficult to fully define NPM in the context of 
English healthcare but, drawing on the work of Ferlie et al. (1996), it could be 
argued that there are four loose types. Firstly, there is the efficiency drive, where 
targets were set to correct wasteful, bureaucratic and underperforming services, 
for example, with NHS maximum waiting times. Secondly, there is downsizing 
and decentralisation in a Post-Fordist sense, with contracting out of services, 
such as catering in hospitals, the use of the clinical directorate structure for 
decision making and resource allocation, where directorates would bid against 
each other for equipment and staff. Separation of the purchaser from the provider 
of public services, as in the case of the creation of NHS Trusts as a result of the 
NHS and Community Care Act (Great Britain, 1990), was a continuation of the 
growth of contractual and semi-contractual arrangements. The purchaser- 
provider split also allowed the partial opt-out of health authority control to become 
new ‘Trusts’ and these new organizations were free to agree pay systems and 
dispose of assets, such as property and land to manage their budgets.

Thirdly, there is a drive towards ‘excellence’, with an emphasis placed on the 
management of culture in organizations, through initiatives such as Investors in 
People (Greener and Bourner, 2005) and the Charter Mark (now Customer 
Service Excellence, Cabinet Office, 2005), both launched in 1991. This can be 
seen, specifically within the context of healthcare, in 1998, as ‘quality’ re-emerged 
as a focus in the form of clinical governance as part of A First Class Service 
(Department of Health, 1998). However, as is the NPM way, it was redefined as 
well to include a focus on greater throughput, which, whilst reducing waiting 
times, did also lead to greater differences in performance (Propper et al., 2008). 
Clinical governance also gave a statutory duty to Trust boards, placing it formally 
into the remit of chief executive officers and away from the informal arrangements 
of professionals (Donaldson, 1998). Finally, whilst there would be a fusion of 
private and public sector ideas, the ethos would remain one of a public service 
orientation, which can be seen in policy such as The New NHS: Modern,
Dependable (Department of Health, 1997) and The NHS Plan: a plan for investment, a plan for reform (Department of Health, 2000).

With the NHS being a demand-led service, purchasers could never adequately control where and when that demand would be created because of factors outside of their control; for example, in elderly care, demand in health care is heavily dependent on supply in the social care sector (Greener, 2009). Moreover, a lot of this was allowed to happen as the public, perhaps encouraged by media and politicians, became increasingly critical of the autonomy of professionals in decision-making and were content to see tighter control on how long they would have to wait for appointments and treatment (Magee et al., 2003).

Managerialism and healthcare professions

As Dent et al. (2004: 7) describe, “... the appeal of NPM lies in the claim that it delivers improved public services and that it represents an empowerment of those it employs and those it seeks to serve.” Turning to those it employs, the work of professionals and managers act as an important and stabilising function for public sector services (Exworthy and Halford, 1999). Traditional views of those key actors in the public sector saw managers as committed to bureaucracy, with conformist tendencies, yet, at the same time, self-interested and career motivated. Professionals, on the other hand, were seen as committed to the provision of expert services, with their power base dependent upon this specialist knowledge. They were creative, altruistic and ethical, in contrast to managers and administrators (Exworthy and Halford, 1999). Working within the healthcare ‘field’, they belong to a range of organizations and institutions who, together, interact to provide services.

In an institutional sense, this allows us to understand inter as well as intra-professional, managerial-professional and state-professional relationships and explain phenomena such as ‘decoupling’ (Meyer and Rowan, 1977), where the exercise of clinical judgement is one such example of behaviour. Doctors were traditionally able to follow the formal rules of the organization because they did not encroach, in any precise detail, on their autonomy within the clinical environment (Harrison, 1999). To use the language of ‘scripts’ (Barley, 1986; Barley and Tolbert, 1997), which are the “…observable, recurrent activities and
patterns of interaction characteristic of a particular setting” (Barley, 1986: 98), doctors are able to exercise their professional, specialist judgement and thus construct scripts that become established and institutionalised. NPM signalled a major revision of these scripts for professionals and organizations and Dent et al. (2004: 12-14) outline six ways in which this occurred: the creation of NHS Trusts; competition changing relationships between hospitals; increasing emphasis on discipline and parsimony in resource use; greater ‘hands-on’ management; new standards of performance, which were indicative of a decline in trust in professional expertise; and increasing use of pre-set output measures.

The outcome of NPM was that professionals in healthcare were “...subjected to the rigours of the quasi-market and managerial colonisation as outdated bureau-professional regimes became less self-serving and more accountable” (Dent et al., 2004: 14). New managerial ‘scripts’ became commonplace alongside the existing professional ones and the role of the professional was subjected to change; not a case of ‘de-professionalization’ rather one of ‘re-professionalization’ (Thorne, 2002). Abbott et al. (2008) depict the changing role of the General Practitioner against three models of separation, alliance and integration as a result of NPM-inspired reforms that brought about GP fund holding. In essence this gave GP’s a budget of their own and the freedom to negotiate the provision of certain services wherever they wished, including with private providers (Allen, 1995).

A further example of the changing role relates to Hewison (2004) above and the creation of clinical directorates with clinicians holding managerial responsibilities within the organizational framework, using their relationships with clinical colleagues to influence and cajole them into being part of the managerial decision making process (Ferlie et al., 1996; Rivett, 1997; Sutherland and Dawson, 1998). According to Willcocks (1997) and Austin and Dopson (1997), the role of the clinical director was to influence their colleagues to think about the future development of the service in the context of limited resources and a more competitive environment. Despite name changes in the form of clinical business units or divisions, clinical directorates continue to be the predominant model for involving doctors in management in today’s NHS and the scope of doctors’ role now extends beyond managing budgets to include various aspects such as
clinical governance, public and patient involvement, medical and nursing resource management and service planning (Gillam, 2011; Spurgeon et al., 2011).

However, Kitchener (1999) discusses how such organizational change in UK hospitals, which was intended as a shift away from Mintzberg’s professional bureaucratic model towards a quasi-market archetype, where professionalism was more managed, resulted in much less of the imagined transformation to a business-like model and more the co-existence of hybrid interpretive schemes, where established attitudes and values persisted (Kitchener, 1999: 198).

**Summary**

Undoubtedly, managerialism, in the form of New Public Management and beyond has had a profound impact on the medical profession. The autonomy and jurisdiction of professional practice has been seriously challenged, but at the same time, some professional roles have been extended; for example, consultant nurses and advanced practitioners (Greener, 2009). There is a greater influence of management, much to the chagrin of certain elements of the news media, in terms of both the number and power of managers responsible for the implementation of government policy. New performance management frameworks came to life, with yearly operating frameworks providing focus for the financial year and the creation of NICE (The National Institute for Health and Care Excellence) putting cost effectiveness firmly at the heart of the debate over resources and rationing (Greener, 2009). The change in emphasis between the old and new NHS can be summed up with a passing glance at the aims of the respective 1946 and 1990 acts. In the 1946 NHS Act (Great Britain, 1946), there was a focus on comprehensive health services but by the 1990 NHS and Community Care Act (Great Britain, 1990) ensuring financial objectives was the prime objective. Under NPM, healthcare had become as much a business, with customers, as a public service, for patients.

Modern public governance continues, involving numerous actors: government (the “public sector”), whose role can involve purchasing, providing and regulating; the “private sector” and third sector, who, despite having different financial models, can invest and research as well as provide services; agents in the
economy, who provide the labour to deliver the services; and citizens, who represent the general interest of the public. Flynn (2007) captures their interactions on a spectrum of consumer and citizen control, citing the work of Skelcher (1993): can some or all public services continue to be subject to bureaucratic paternalism by agency, or will citizens increasingly be provided with information, their opinions sought and proposals discussed with them, as we can see in the public and patient involvement agenda (NIHR, 2012)? Might it be that further strides are made, away from traditional models towards citizens becoming joint decision makers in the process? As consumers, exploring the various issues, goals and choices they have, might decisions ultimately be devolved to them, as in the case of personalised budgets (Forder et al., 2012)?

2.3.4 The future of medical professionalism: partnership and leadership?
Where does that leave medical professionalism in the present era in the English context? Research by Waring and Bishop (2013: 153) offers up two contrasting responses from the medical profession in light of exogenous changes such as marketization. They argue that the medical profession has been compelled into: firstly, a form of ‘McMedicine’ (after Ritzer’s (1993) notion of McDonaldization), whereby “…global bureaucratic and market logics are transforming the social organization of expert work leading to rationalised and standardised practices and identities”; and secondly, a new form of commercial restratification, whereby the profession aligns itself with the new marketized world. This supports Bucher and Strauss’ (1961) view that medicine is not a unified profession and is therefore not subject to uniform change in the context of wider change. Work by Hafferty and Castellani (2010: 293) also supports this differential medical professionalism, contending that “…different types of professionalism have been self-organized into an emergent system.” Their seven-part model expands on the two directions outlined by Waring and Bishop (2013), from nostalgic professionalism, through entrepreneurial, academic, lifestyle, empirical, unreflective to activist professionalism. Hafferty and Castellani’s (2010) model, by the nature of its seven rather than Waring and Bishop’s (2010) dual representations of modern professionalism, leaves room for a modern medical professional who is altruistic, as well as self-interested.
However, concern remains for that particular virtue of altruism (Jones, 2002), although research by Wicks et al. (2011) suggests it remains “...an important aspect of a doctor's professional responsibilities and attitudes.” Noordegraaf (2011) believes that, despite such creeping organizationalism, it is still professional associations that have the greatest influence over professional roles and behaviours. Influential reports from the King’s Fund (Rosen and Dewar, 2004) and the Royal College of Physicians (2005) have attempted to stir the debate with redefining medical professionalism to better serve today’s patients and O’Sullivan et al. (2012) argue that the formation of professionalism in the doctor’s mind must reflect societal values, rather than stand alone to be decided upon by the profession. To pick up on that and the theme of medical engagement from the previous chapter, one of the possible futures for medical professionalism is to continue to adapt and respond to the efforts and attempts of the state and society to engage with them. Adopting more managerial roles is certainly one response that has been seen and played out. The introduction of the MLCF at the end of the EEML project was a continuation of the engagement story, which builds also on Darzi’s (Department of Health, 2008: 60) work in encouraging doctors to become not only practitioners and partners, but also leaders, with an expectation that they will:

“...offer leadership and, where they have appropriate skills, take senior leadership and management posts in research, education and service delivery...It requires a new obligation to step up, work with other leaders, both clinical and managerial, and change the system where it would benefit patients.”

This would mean leaving behind notions of doctors having joined the “dark side” of managerialism (Dickinson et al., 2013; Spurgeon et al., 2011) and adopting more of a ‘co-produced’ model of care delivery, working more in line with “…notions of systems thinking and of how complex adaptive systems function” (Hunter, 2008: 191). The NHS Quality, Innovation, Productivity and Prevention (QIPP) programme (Department of Health, 2009) and subsequent white paper Equity and excellence: Liberating the NHS (Department of Health, 2010) were examples of policy that followed on from High Quality Care for All (Department of Health, 2008).

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1 Use of this term is more popularly related to the Star Wars franchise of films, with ‘good forces’ of the Jedi Rebel Alliance as opposed to the ‘dark side’ Galactic Empire forces of Darth Vader.
Health, 2008), placing medical and clinical leadership at the heart of future change in the NHS. Overseas, medical practitioners in countries such as Denmark and the United States already play a significant role in shaping service design as medical leaders (Ham and Dickinson, 2008), although experience from elsewhere in Europe and Australasia is more akin to the UK’s historical position (Ham and Dickinson, 2008).

Moreover, a new wave of texts on medical and clinical leadership written for doctors by doctors and medical educationalists (Gillam, 2011; Spurgeon and Klaber, 2011; Stanton et al., 2009; Swanwick and McKimm, 2011) all discuss the need for doctors to have a greater awareness of self and of the contemporary context of managing and leading as part of teams of both clinical professionals and others. This concurs with the aforementioned guidance from the General Medical Council. Whether this is a passing phase in the development of medical professionalism can only be seen with a more distant future view, but there is certainly an emerging zeitgeist of doctors undertaking more significant roles beyond the bounds of the medical curriculum. Martin and Learmonth (2012: 287) note that the term ‘leadership’, in particular, makes it “…more attractive for doctors to take on particular roles in organizations, and make[s] them more sympathetic to policy changes of the kind traditionally opposed by the medical profession” and this might be a significant factor in making this happen.

2.4 Medical education and curriculum development

2.4.1 Introduction

Having considered the changing nature of professionalism and medical professionalism, this chapter continues by considering the evolution and development of medical education as a means of understanding the background and historical context for the research study into the case of the EEML project.

In the British Medical Journal of the 5th January 1895, amongst concerns for the finances of the London hospitals, fleas, mountain sickness and dirty railway carriages, the issue of altruism in medicine was raised. The author wrote, “We have it on the highest authority that medicine is the most altruistic of professions. It is doubtful whether such a statement is nowadays correct” (British Medical Journal, 1895: 37). This brief section within a series of news items continues by
discussing the declining role of the teacher of medicine and how medical schools should do more to support these teachers.

This excerpt was written less than forty years after the introduction of the Medical Act (1858). This Act created the General Medical Council to regulate doctors and ensured that only qualified practitioners would be able to practise medicine. Many centuries before that Hippocrates, the father of western medicine, first wrote his eponymous oath that governs the behaviour and conduct of healthcare professionals (Horstmanshoff, 2010). Although doctors are now governed by the relatively recent Medical Act (1983), which regulates their profession, it is this combination of ethical standards, altruism and regulation that helps to capture the essence of the role of a doctor in modern society and more importantly imparts some responsibility on those who are charged with the provision of medical education (Sarkar and Adshead, 2003).

2.4.2 Influences on medical training

The 1858 Medical Act restricted access into the medical profession and required practitioners to have a licence in order to safeguard genuine professionals, protect patients and, as Flexner (1910: 22) set it out in his seminal report into medical school education, put off “…casual strollers from the highway.”

Written for the Carnegie Foundation for the Advancement of Teaching, Flexner’s (1910) report aimed to “…ascertain the facts concerning medical education and the medical schools themselves at the present time” (Pritchett, 1910: viii). This report was commissioned in response to changing demands on practitioners and educational establishments alike, as well as concerns over the proprietary profit-driven school model that existed at the time (Ludmerer, 2010). Flexner’s report led to the closure of many medical schools and its effects were not limited to North America. Whilst there had been curriculum evolution and change in the UK since the 1858 act, matters to which the General Medical Council has returned on numerous occasions (General Medical Council, 1993), the standardised model of the medical school institution had been promoted based on firm links to university and research in the mould of the John Hopkins University School of Medicine in Baltimore (Ludmerer, 2010). Long established UK medical schools from Cambridge and Oxford through to the 19th Century incarnations of
Birmingham, Leeds, Liverpool, Manchester and Newcastle were all influenced by the Flexner model.

Thus, the origins of modern medical school and curriculum development, as outlined by Flexner (1910) and following the vision of Johns Hopkins and a Germanic model are:

"...the provision of a strong foundation in the basic medical sciences, followed by the study of clinical medicine in an atmosphere of critical thinking in departments that afforded adequate time and facilities for research." (Weatherall, 2011: 45)

Flexner's work had a lasting effect on medical schools and resulted in welding together the giant institutions of hospitals and universities in the way they taught medicine. However, what is not mentioned here is the experience of ‘hands-on’ practice, which, although encouraged from the late 18th century, was still considered a “…voluntary, informal facet of medical education in which students were merely passive spectators and listeners” (Furst, 2000: 18). This was to change in the years leading up to Flexner’s report, as it had become much more accepted that “…medical students were active participants in clinical care, learning to use diagnostic instruments as well as to decide on the best therapeutics” (Furst, 2000: 18), as typified by Somerset Maugham’s (1915/2000) semi-autobiographical account of being a young doctor in the celebrated Of Human Bondage.

In the 1940s, newly qualified doctors were instructed to undertake post-medical school training through the Goodenough Report (Ministry of Health, 1944), which had a significant impact on the make-up, management and distribution of medical schools as the country set about preparing for the new National Health Service (Rivett, 1997). The 1968 Royal Commission on Medical Education (The Todd Report) (Report of the Royal Commission on Medical Education, 1968) considered the medical school curriculum inadequate for preparing doctors for the immediate practice of medicine. Indeed, this report recommended medical training continued throughout the professional life of doctors. Although many reports were to follow and iterations to the professional training of doctors continue to be of interest to the profession, public and policy-makers alike, by
1968 a broad agreement existed for medical education at three different levels: undergraduate, postgraduate and continuing professional development.

Grant (2010) describes how the curriculum has passed through the last fifty years of evolution and design by focusing on different aspects for the training of doctors. This has shifted from the 1960s, when instructional skills were to the fore, through the 1970s, when behavioural aspects were emphasized and into the 1980s, when systems approaches and facilitative learning environments were core characteristics. An example of medical curricula having already moved beyond the didactic, teacher-centred programmes familiar for rote learning is demonstrated notably at McMaster University in the 1960s. Here they adopted a problem-based learning approach. Others have embraced curricula built around themes or strands or tried to produce doctors to serve the health needs of their local, contextualised populations (see Wilkes et al., 1998; Lowe, 1969). The redesigned curricula of Case Western, Harvard and other UK medical schools, as well as the aforementioned McMaster, offered their own particular perspective on how medical education should be delivered in the latter half of the twentieth century. Such themes have included population health, communication skills and human sexuality (Newcastle University, NSW, Australia in 1978) and resulted in doctors better able to work with colleagues from other disciplines (Gordon, 2011).

The UK medical education ‘revolution’, if indeed it can be called as such, began in 1993 with the publication of *Tomorrow’s Doctors* (General Medical Council, 1993). This report placed greater emphasis on "...communication skills, ethics, social sciences and the humanities" (Weatherall, 2011: 45). The intention was to focus on more humane and pastoral skills that may have become lost in the midst of the advancement of technology, genetics, pharmaceutics and molecular and cell biology. Holmboe et al. (2011) also note this shift towards competency-based education and training (CBET) in the 1990s as a means of guiding curricula and assessment (Carraccio et al., 2002; Harden, 2006; Harden, 2007), but which is at odds with a Flexner-inspired system that favours structure and process.

2.4.3 The curriculum

The key tool for training doctors is the curriculum. A curriculum can be defined as “...a statement of the intended aims and objectives, content, experiences, outcomes and processes of an educational programme, including ...a description
of the training structure [and] a description of expected methods of learning, teaching, feedback and supervision” (Grant, 2010: 3). However, the curriculum at undergraduate medical school differs from those at postgraduate and continuing professional development level largely due to the different type of student, organization responsible, learning environment and, for those in the latter group, factoring in a number of years of on-the-job experience.

At undergraduate level, the broad requirements have changed over time from encompassing knowledge and understanding of disease and illness as well as the structures and functions of the major systems of the human body. Osler’s almost exhaustive Principles and Practices of Medicine (Osler and McCrae, 1921) itself contained 13 sections, with 278 sub-headings and multiple sub-sections and McCrae, his co-author, recognised the difficulty in classifying these given the changing nature of medicine and medical knowledge. From then to the present time, there are requirements for more transferable and critical skills and competencies as well as requirements regarding professional behaviour. At postgraduate level, the recently defunct Postgraduate Medical Education and Training Board (PMETB), which was subsumed into the General Medical Council, developed a set of eight curriculum standards that covered its rationale, content of learning, model of learning, learning experiences, supervision and feedback, managing curriculum implementation, review and updates and equality and diversity (Grant, 2010: 4).

In terms of delivering or fulfilling that curriculum, numerous short rotations through varied clinical specialties became the norm for a long time, a practice which is largely still entrenched because of Flexner (1910). Holmboe et al.’s (2011) study outlines three major strands and assumptions regarding frequent rotations: firstly, they allow for greater diversity and breadth of exposure; secondly, they effectively teach trainees how to adapt and cope and thirdly, they promote greater independence by forcing them to adapt and learn on their own (Holmboe et al., 2011: 72). For some, that was so that trainees could build up "...blocks of competency that can be ticked off, rather than a variety of aspects of the holistic concept of competence that, in the end, contribute to a coherent whole" (Ringsted, 2011: 15; emphasis in original). As a result, out went the "...individualised mentor-apprentice model and the community-oriented,
holistic...and human-paced elements" and in came "...the efficient, standardised, evidence-based, state-of-the-art, student-production demands of the new biomedical education" (Anderson, 2011: 33). Moreover, Anderson (2011: 32) believes that Flexner’s report unwittingly resulted in "...the creation of an elite class of people who had the requisite preparation and resources" to study medicine. By restricting access to minorities, women and the poor, it also created a disconnection between the profession and the public at large, but this was not limited to medical education, rather it stretched out to further and higher education as well.

However, others felt that Flexner had been misinterpreted, arguing that his emphasis on scientific medicine was not at the expense of the more human side of medical care and did encompass preventative and social elements (Ludmerer, 2010). Whilst Flexner’s (1910) work led to a substantial amount of ‘smartening up’ of medical education and schools for its delivery, that did not make Flexner an advocate solely for biomedical science. Indeed, he believed other foundations were required (Kuper and D’Eon, 2011: 37). Page 26 of Flexner’s report provides the key arguments in this vain, describing how:

“...the physician’s function is fast becoming social and preventive, rather than individual and curative. Upon him society relies to ascertain, and through measures essentially educational to enforce, the conditions that prevent disease and make positively for physical and more well-being” (Flexner, 1910: 26)

Flexner (1910) felt that doctors needed "...science, insight, sympathy and awareness of the patient's culture" (Dornan et al., 2011: 5), so establishing the expectation for doctors to balance many different skills and attributes. This view reflected beliefs held as far back as the mythical Aesclepius and his daughters Hygeia (promotion of health) and Panacea (treatment of disease) that medicine required a holistic approach to both care and cure (Dornan et al., 2011). Indeed, Calman (2010: xi) describes how “...education and learning have always been important parts of medicine”, but that these have changed over centuries from the focus on text books and observation to incorporate clinical examination, anatomy and pathology. Moreover, the practice of medicine now has to account for social and economic factors above and beyond the biomedical causes of ill health and disease. In setting out this context Calman asks some pertinent
questions, such as how is the curriculum developed, how is learning assessed, at what stage is a particular aspect of learning considered? In essence, how is all of this put together into a coherent form? He considers also the important role patients should play in determining some of the answers to those questions.

2.4.4 Change in the curriculum

The previous sections acknowledge the numerous influences on curricula and Grant (2010) lists the role of theories of learning and professional practice, of social values, of health service development and of politics in having significant effects in terms of how curricula are designed and delivered. Amongst these effects are trends for learner-centred design, team-based and ethical learning, widening participation and shorter training to produce a future workforce more quickly, all of which have become key battlegrounds for curriculum design and inclusion.

As the previous sections have indicated, it is worth noting that change has always been occurring. One of the fundamental reasons for the Flexner Report was given in its introduction:

“...the requirements of medical education have enormously increased. The fundamental sciences upon which medicine depend have been greatly extended. The laboratory has come to furnish alike to the physician and to the surgeon a new means for diagnosing and combating disease. The education of the medical practitioner under these changed conditions makes entirely different demands in respect of both preliminary and professional training.” (Pritchett, 1910: viii)

That was written over one hundred years ago and curricula continue to change and undergo transition. The pace of technological innovation has increased markedly and Grant (2010) notes how ideas develop from previous ideas. In addition, Holmboe et al. (2011) consider the issue of transition from the three perspectives of sociology, learning theory and quality and safety improvement. The authors describe the nature of rotational transition as a 'dance' with many actors: trainees, faculty, nurses and ancillary staff. Their sociological perspective considers the behaviours and values by which doctors are shaped and moulded formally, and informally, into their profession, resulting in "...new images, expectations, skills and norms as trainees define themselves and as others view them" (Holmboe et al., 2011: 72).
Mann (2011) also considers changes in terms of the very practices and learning theories that underpin medical education from their roots in Flexner and positivism to more recent considerations, given the emergence of constructivist perspectives that trainees are actively constructing knowledge by building on prior knowledge and experience. The aforementioned example of change in the delivery of medical education using problem-based learning approaches pioneered by McMaster University in the 1960s epitomises this change from content-centred instruction to trainee-centred learning (Neville, 2009).

There is, however, an inherent difficulty in broadening the curriculum sufficiently to produce well-rounded doctors, in that there are concerns that current training of doctors is already far too long and costly. This is, inevitably, a classic trade-off of the 'science' conflicting with the 'art' of medicine (Weatherall, 2011), which acknowledges that the difference between 'good' and 'bad' doctors often comes down to how well versed they are with the 'art' perspective; notably an ability to listen to and connect with patients. Weatherall (2011) notes that adding humanities and social science elements to the curriculum may endanger competence in core biomedical skills, yet Gordon (2011) believes the holy grail lies in achieving a balance between appropriate content and the best teaching and learning strategies, bearing in mind the obvious trade-offs of time and opportunity cost.

To many educators, medical education still remains rooted in the construction of a professional identity and transformation from lay person to professional and thus is preparing trainees for "...the professional roles they will enact tomorrow [...] seeking to develop professionals who are competent, self-aware, able to self-monitor and self-assess their performance and to continue learning throughout their practice lifetimes" (Mann, 2011: 62). Preference for theories focused on individual activity continues, reflecting congruence with values of medicine such as autonomy and self-reliance and reinforcing existing power structures (Bleakley, 2009). Juxtaposed to this is the view that learning can no longer be considered an individual process; moreover, it is a social and collective one that includes every interaction and influence (Dornan, 2005; Lave and Wenger, 1991; Vygotsky, 1930/1978), and which requires the focus on individual development and assessment to be widened. However, given that the vast majority of today's
educators were likely to have experienced a very different form of curriculum as they matured from trainee to specialist than trainees today, for medical schools and health care organizations, the availability and ability of medical-professional educators who can deliver such socially-contextualised syllabi is perhaps an issue.

2.4.5 The current curriculum

Kuper and D'Eon (2011) outline a number of assumptions that underpin the current challenges and thinking on undergraduate medical curriculum design, including the perspective that the current curricula are not 'normal' or 'natural' but are socially constructed phenomena. This perspective suggests that any curriculum development ends with the desired product of 'competent' doctors; that the aim of the curriculum is to teach and contextualise learning to support competent practice, rather than to train researchers. In such a view, biomedical knowledge is still a key component of being a doctor. The authors illustrate their thinking about curriculum design through a series of 'thought experiment' case studies ('vignettes') in the hope of revealing the perceptions and values of students in their role as doctors. These cover issues such as the doctor-patient relationship, the health care system, interprofessional collaboration, ethical decision making and the definition of knowledge (Kuper and D'Eon, 2011). The idea is to try and capture socio-cultural aspects of illness and their impact on delivering care. The aim is to understand the perception of the doctor in the context of power, status and hierarchy and the historical role of the hospital and other bodies and institutions in the organization of health care, as well as to capture understanding of what is 'good' or 'right'. The above illustrates how medical sociology, social psychology, sociology, history, philosophy and social theory all have an important part to play in the development of competent doctors. The learning from such a 'thought experiment' extends itself to a crucial understanding that curriculum design and delivery are "...the products of particular circumstances, power relationships and cultural contexts" that demonstrate the "...dominant and legitimated constructs of the competent doctor" (Kuper and D'Eon, 2011: 42).

Such a view suggests that current development in curriculum design and the desire to produce 'better doctors' owes much to a topical way of thinking of 're-
democratisation' of medical education (Anderson, 2011: 32). Like McMaster, Manchester adopted a problem-based learning approach with a focus on early exposure to clinical environments, rather than classrooms and interpersonal communication, where “...authentic human contact on a social or clinical context” was a driving factor, with the aim of orientating “...curricula towards the social context of practice” (Dornan, 2005: 95). This encompasses English health policy of recent decades, such as greater patient and public involvement and patient choice (Department of Health, 2000, 2002, 2006), driven by the greater availability of information and the rise of the internet, as well as a desire from certain members of the profession to reach out to their service users (Anderson, 2011: 32). Medical education tends to be self-critical and introspective when faced with tensions of how to train the next generation of doctors, at the same time, trying to ensure that those who come off the conveyor belt go about their practice "...with the ease and patience of small-town physicians" (Anderson, 2011: 34). Dornan et al. (2011: 2, 3) reflect on medical education in what they describe as an "...age of complexity, uncertainty and reflection", by hoping that future curricula designs move away from "...ticking-off competencies in portfolios", that turn "...the art of medicine into meaningless ritual."

Furthermore, Burch (2011: 23) describes the work of Bordage and Harris (2011) as to how "...educational programmes are complex systems of inextricably linked components in which change cannot be restricted to one aspect, but necessarily impacts on other components and processes." They identify five key elements of curriculum as: its learners; the assessment; the competencies and roles; the conditions for learning; and the context (Bordage and Harris, 2011), whilst advocating stakeholder input, buy-in and, ultimately, support for any changes in curriculum design. This requires medical educators to develop much-needed leadership and management skills in order to enact this (Burch, 2011). The above authors are all advocating for change to be well led and managed, informed by rigour, not anecdote and carried out by people who themselves are trained and versed in change. Prior decision making in medical education seems to have followed the PHOG (prejudices, hunches, opinions, guesses) recipe, with a large dose of 'power politics' thrown in (Gwee, 2011). That medical education has been subject to the whims and political context of key power brokers is an important historical context to understand, when looking at present attempts to adapt the
curriculum to include ‘wider’ aspects of learning, such as team working, leadership and management of others.

2.4.6 Competency frameworks and the curriculum

The previous section outlined that the current curriculum is a mediated result of cultural, social, political and economic forces (Kuper and D'Eon, 2011: 37, 38) thus defining only what it is at the present time, rather than what it must be. As previously discussed, the expectations on doctors to fulfil multiple roles concurrently are now widely accepted: to be technically and clinically excellent; to be good communicators; to work across boundaries; to take into account individual preferences and diversity and so on. As far back as the 19th century, Osler (1899) urged young doctors to demonstrate both imperturbability and equanimity, that is to say calmness and clear judgement as well as measured emotions, when practising medicine. Godlee (2007), writing more recently and citing Samuel Johnson, Des Spence and Atul Gawande respectively, discusses the need for doctors to show selflessness and modesty; the skill of doing nothing; diligence and the will to do the right thing. Chambers and Colin-Thomé’s (2009: 28) research into the role of and demands on General Practitioners concluded a need for them “…to be to be politically astute, to understand ‘the big picture’ of how health services function as a whole, but also be able to work through the detail to ensure seamless patient care.” Thus, there are multiple expectations, which reflect not only the demands of the profession but those in their trust also.

The introduction of competency frameworks is one attempt to specify and situate the multiple roles and responsibilities of doctors, whilst acknowledging that the development of professional identity is one aspect that is linked to both personal and social processes (Mann, 2011). One of the earliest attempts to capture this was the CanMEDS competency framework, a process that evolved over 20 years in Canada involving stakeholder consultations and which was published in 2000 (Frank, 2005). CanMEDS identified seven competencies required from doctors: medical expert as its ‘bud’, with communicator, collaborator, manager, health advocate, scholar and professional representing the ‘petals’ (Frank, 2005: 3). A similar process, in the English context, the GMC’s Tomorrow’s Doctors (2009), also engaged with the public to establish the requirements of the modern doctor. Such ‘blueprints’ act as a vision of what doctors, educators and the public expect
doctors to be at the end of their training, encompassing skills, knowledge and attributes that doctors must enact within "...the specific social, political and cultural contexts in which they work" (Kuper and D'Eon, 2011: 42).

Of course, balancing a busy and high-profile job role is not unique to medicine or indeed health care, but recent developments, such as the Medical Leadership Competency Framework (MLCF), have aimed to help produce 'better doctors' focussing on leadership and management skills and the ability to work interprofessionally for the good of the patient (NHSI and AoMRC, 2010). However, Dornan et al. (2011: 5) ask another important question, relevant to the job role of modern medical professionals: "why are doctors expected to be medical experts, great public communicators, leaders, managers, health advocates, educators and now perhaps education researchers all at the same time and from the start of their careers?"

Whatever its form, the final curriculum product is then left to be implemented, at a devolved level, by local healthcare workforce organizations of Health Education England (HEE) and provider organizations. Is the 'product' they are then tasked with realising likely to be a traditional solution that arose in response to previous circumstances or a transformational change brought about by a significant event (Anderson, 2011: 30)? The answer lies probably in between. The advantage that local HEE organizations may have is that they are being tasked with pushing a top-down agenda, notable for its social science foundations, into an arena which has always uncomfortably managed the two potentially incompatible paradigms of natural and social science (Anderson, 2011: 31). Medical education, by its very name and nature, is drawn more towards the social rather than the natural science, so will follow "...social and political patterns in the wider society" (Anderson, 2011: 31), which means that it opens itself up to those from a non-medical background, who are its ultimate recipients, funders and regulators. However, trying to muscle in on the world of standardisation, professionalisation and industrialisation (Anderson, 2011: 31) that underpins the biomedical world, is not without its difficulties and this owes much to the concept of professionalism, which has been considered within this chapter.
2.5 Chapter Summary

This chapter has explored, firstly in a general sense and then subsequently with reference to the medical profession, how professional role, status and behaviour has changed over time. What is evident is that the professional role is influenced by a number of factors, amongst them the medical curriculum, as well as individual and organizational beliefs about professionalism and the institutional and societal environment.

Moreover, this chapter has focused on the evolving nature of medical education, from varied beginnings, to a more tightly knit and regulated concept. At the heart of that regulation is a curriculum that is socially contested but still difficult to evolve given the multiple demands placed upon it to offer the ‘right’ training for doctors. Whatever it becomes it remains prominent in influencing the role and identity of medical professionals.

The following chapter will aim to make further sense of the context within which the case of the EEML project sits, through a number of related theoretical themes.
Chapter 3: Agency and practice in neo-institutional theory and the role of capital and social position

3.1 Introduction

So far this thesis has considered the nature of professions and medical professionalism and the evolution of medical education and curriculum development. That context is important in understanding the background against which this research aims to explore individual engagement with change, specifically agentic practices of change. The term ‘agentic practices’ has been used by Maxwell and Aggleton (2010, 2012) to describe concepts of ‘agency in practice’ and ‘agency in action’ in their research and this conceptualization works appropriately within this case study of a change initiative, albeit accepting that the term agency is much contested across sociological thinking.

This chapter will consider key guiding themes in the research, which draw on neo-institutional theory and the notion of institutionalism, as it is important to pinpoint the location in which the research is taking place. It will then consider the role of agency within institutional theory and the emerging field of institutional work, alongside consideration of practice theory, in bringing the individual explicitly back into the debate. Understanding agency and what makes an agent practise will also be considered, with reference to theoretical concepts of capital and social position. The aim of this is to draw out the links between the EEML case and the theoretical concepts that follow. As such, the literature outlined connects back to the three research questions as follows:
Table 1: Theoretical Map connecting research questions to literatures

<table>
<thead>
<tr>
<th>Background and Context</th>
<th>Research Questions</th>
<th>Theoretical Constructs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest in management and professions</td>
<td>How do opinion leaders enact and effect change within medical education?</td>
<td>Agency (institutional work / entrepreneurship)</td>
</tr>
<tr>
<td>A relevant case in the EEML project</td>
<td>What processes are involved in opinion leaders’ actions and practices that are important in effecting change? i.e. what do people do?</td>
<td>Practice Theory</td>
</tr>
<tr>
<td></td>
<td>How does this case further our understanding of strongly institutionalized environments?</td>
<td>Capital and social position</td>
</tr>
</tbody>
</table>

3.2 From Institutionalism to Neo-Institutional Theory

3.2.1 Introduction: The institution

As this research focuses on medical education and involves the study of the medical profession, amongst other actors, there is value in considering the concept of the institution, for that is how both medical education and the medical profession could be conceived.

Selznick (1957/1984) is often credited with drawing distinction between ‘organization’ and ‘institution’: the former as a technical machine function with clear and fixed goals on the one hand, and the latter, full of contested and shifting functions, deeply affected by its external context that could only be understood as the historical product of a series of ‘character-forming’ adaptations and compromises on the other (Kraatz, 2009). The institution is, in Selznick’s (1957/1984: 5) words, “...a natural product of social needs and pressures - a responsive, adaptive organism”, but that this distinction “...is a matter of analysis, not of direct description.”

Lune (2010: 2) describes an institution as “...a collective entity or any way of organizing relationships that is widely familiar and routinely practiced,” which would reflect our understanding of the organization-institution, steeped in history and folklore. Selznick (1957/1984) emphasizes that there is a need, when studying institutions, to look at their historical origins and stages of growth, to
consider them as whole entities and see how they are transformed to deal with their changing environments. Fineman et al. (2010: 406) refer to institution as “…a set of practices, a system of relations or an organization which is infused with value and recognized as part of the way of doing things.” So, it can be seen how organizations may be institutions within a system and many of those institutions are organized and defined by unwritten rules that everyone understands about some kind of organized behaviour.

This concept of an institution embedded within an environment allows the definition of institution to be extended. Lawrence et al. (2011: 53) describe institution less tangibly, as “…a mental space, way of behaving, providing a template for action, cognition and emotion.” Suddaby et al. (2010: 1235) describe that, central to this, is an understanding that institutions “…are the product of common understandings and shared interpretations of acceptable norms of collective activity.” Institutions can acquire respectability with time as they not only prove their staying power, but are endowed with special meaning. It is this special meaning of institution that allows for a lay understanding of how organizations, concepts and brands can, following the work of Fineman (2010) above, become part of the recognised fabric of a society and garner “protected species” status (Bilton et al., 2004: 375). Such examples of institutions in that sense, both tangible and not, would include the concepts of democracy and marriage, the monarchy in the UK, a popular soap opera such as Coronation Street, or a well-known brand such as Rolls-Royce. Indeed, the NHS could well be added to that list.

Scott (2014: 59) describes the three pillars of institutions as regulative, normative and cultural-cognitive systems, which together form a continuum that contributes “…in interdependent and mutually reinforcing ways, to a powerful social framework.” However, Scott (2014) also believes there is value discerning amongst the three pillars to increase our understanding of the institution concept. The regulative pillar argues that institutions constrain and regularize behaviour, where rule-setting, monitoring and sanctioning activities are prominent, where the primary mechanism of control is coercion and the rule of law provides the basis for its legitimacy. This institutional pillar is associated with institutional economists such as North (1990). Alternatively, the normative pillar provides rules that
“…introduce a prescriptive, evaluative and obligatory dimension into social life” (Scott, 2014: 64). It is values which offer what is preferable under this pillar and norms, which specify how things are done and control is attained. This institutional pillar is associated with March and Olsen (1989) as well as Parsons (1951). The third pillar, that of the cultural-cognitive understanding, stresses the “…shared conceptions that constitute the nature of social reality and create the frames through which meaning is made” (Scott, 2014: 67). Primarily adopted by the likes of Geertz (1973), Berger, Powell, DiMaggio, Meyer, Goffman (1961) and Scott himself, this pillar recognises the importance of taken-for-grantedness and shared understandings in creating compliance in social order, where “programmed actions” (Berger and Luckmann, 1966/1991: 92) of mimetic (mimicking) behaviours are the primary mechanism for control and legitimacy is provided through recognizable and culturally supported means.

3.2.2 Institutionalization

From the concept of institution, we can move to consider the concept of “institutionalization”, which Selznick (1957/1984: 16) describes as a process, something that “…happens to an organization over time, reflecting the organization’s own distinctive history, the people who have been in it, the groups it embodies and the vested interests they have created, and the way it has adapted to its environment.” Note, how it is the organization, in Selznick’s interpretation, that becomes the institution and the process it undergoes is to infuse it “…with value beyond the technical requirements of the task” (Selznick, 1957/1984: 17). Following Goffman’s (1961) work, this concept is valid if we consider the effects of institution on long-serving employees of some organizations or long-standing members of professional bodies. The behaviour of those long-term actors is affected by the institution’s history, which can control or constrain their conduct through predefined patterns of activity and action. Thus the actors begin to play specific ‘roles’, which in turn help to create and transform those very institutions that institutionalize them, as well as helping to maintain them. Moreover, Berger and Luckmann (1966/1991) define institutionalization as the construction of common meaning systems, in a three stage conceptualization comprising externalization, objectification and internalization, from where symbolic structures are firstly produced, subsequently accepted as being real and then brought into consciousness through socialization. These are concepts worth
bearing in mind in this case study with respect to the various professional actors engaged in the EEML project.

Fineman et al. (2010: 407) define the concept of institutionalization as the “...process of becoming dependent on, contained by or turning into an institution,” but this may refer to more than just organizations within the institutional field. Berger and Luckmann (1966/1991: 72) describe the occurrence of institutionalization “…whenever there is a reciprocal typification of habitualized actions by types of actors” and Suddaby et al. (2010: 1235) posit that, “...institutional pressures exist only to the degree that internal and external participants believe in them and engage in the institutional work necessary to perpetuate them.” As Bourdieu (1981: 309) put it, an institution can only become active if it, “...like a garment or a house, finds someone who finds an interest in it, feels sufficiently at home in it to take it on.” In many respects, this taken-for-granted aspect of institutionalization by its participants allows organizations to grow complete with norms, values and meanings drawn from broader society, its social discourses and institutions. What is apparent within these descriptions of institutionalization is the presence of agency, albeit implicitly recognised.

3.2.3 From old to ‘new’ institutionalism

From the rational and economic viewpoint of institutions, traditional Weberian and related arguments paid little, if any, attention to the role of human and social systems and the powerful external institutions such as the state, societal norms, traditions and conventions that affect them. As Suddaby et al. (2010) stated above, institutions draw on broader society for their meaning. McKinley and Mone (2003) capture the move from Selznick and ‘old institutionalism’ by describing neo-institutional theory’s (or ‘new institutionalism’s’) concern for such phenomena of the broader society as social institutions, organizational fields, institutional environments and societal sectors, drawing on the work of Meyer and Rowan (1977), Zucker (1977) and DiMaggio and Powell (1983). By moving from old to new, institutionalism was undergoing its own process of institutionalization. New institutionalism thinking, notably Meyer and Rowan (1977) and DiMaggio and Powell (1983), shows how other forces exert pressure on organizations to conform to accepted standards independent of rational efficiency perspectives (Handel, 2003: 227).
3.3 Change in the context of institutionalism

3.3.1 Introduction

Having considered the concept of institutionalism, it is worth exploring change within these contexts and how institutionalism attends to it. If institutions are socially constructed through the act of ‘institutionalization’, then one of those acts is to change. This may be in response to exogenous change or may be the act of changing the institution endogenously from within. Change, itself, is not a modern phenomenon (Kotter, 1996) and within an organizational context can be seen simply as moving from where an institution is currently to where it wants to be, in terms of any number of characteristics, such as market share, turnover, a response to competitive conditions, level of success and reputation. Czarniawska (2003: 135) asserts that organization studies’ interest in change comes from “...the ideological belief that change equals betterment, that is informed by a drive to supply problems with solutions.”

In terms of institution, as Dacin et al. (2002: 45) put it “...institutional theory has often been criticized as largely being used to explain both the persistence and the homogeneity of phenomena” and as a driving force for change. However, they also contend that institutions themselves change over time and are not uniformly taken-for-granted, because they are subject to the pressures of functional, political and social sources (Oliver, 1992), which can be seen in the case of medical education as outlined in chapter 2. Lawrence et al. (2002: 281) cast the collaboration and interaction of such institutions as creating a new form of “proto-institution”, from which institutional entrepreneurs (DiMaggio, 1988) can emerge.

3.3.2 Bringing the individual into institutional change

The actions of agents within the context described previously can be considered to be change work at the institutional level. Hargrave and van der Ven (2006; as cited by Greenwood et al., 2008: 27) developed a typology of four distinct types of institutional change: institutional design, institutional adaptation, institutional diffusion and collective action. The first, institutional design, focuses on individual entrepreneurs, whilst institutional adaptation considers how the organization conforms to its environment. Institutional diffusion centres on the adoption and retention of institutional arrangements, whilst the last, collective action, examines
how a multitude of actors, playing diverse and partisan roles, construct new institutions around social or technical innovations. This final type could be perceived as attempts to theorize the role of agency within institutional change, which may be relevant in a case such as that of the EEML project.

Moreover, Greenwood et al. (2002) have developed their own, albeit related, model of the stages of institutional change and depict six stages from precipitating jolts, deinstitutionalization, preinstitutionalization, theorization, diffusion and finally reinstitutionalization. In their case study of the accounting profession, the problem was framed as a profession under threat, where change was natural and inevitable as well as being progressive and normal and to resist that was unusual. It was only at the ‘theorization’ stage that the profession changed from being a force for reproduction of the status quo to one of change; by rendering ideas into understandable and compelling formats change could become legitimized and then subsequently occur. Leblebici et al. (1991; as cited in Greenwood et al., 2008: 19) theorized that organizations were a key area of focus for institutional change, where the locus of change is “…likely to be ‘fringe’ or peripheral actors because these organizations are less embedded within, and less privileged by, existing institutional arrangements.” Where “internal contradictions” (Leblebici, 1991: 337) emerge, endogenous explanations of change can be explored.

However, what is often missing from descriptions of organizations and institutions is the explicit inclusion of the individual in this debate, which is a criticism often levelled at neo-institutional thinking. Whilst the researchers above (Hargrave and van der Ven, 2006; Leblebici et al., 1991) have made attempts to address this, to further bridge the gap between macro-, meso- and micro-levels, the concept of institutional logics was developed by Friedland and Alford (1991) and extended by Thornton and Ocasio (1999, 2008). Friedland and Alford (1991) took the traditional notion of the organization-institution to conceive of institutions as supra-organizational patterns of activity, through which individuals conduct life. In addition, they also considered the institution as a symbolic system, through which individuals categorize activity and infuse meaning. They also include, in their analysis, the view that the individual is, itself, an institutionalized concept, borne out of the institutions that created and provided the categories, such as intent, rights and liberty, through which individuality is lived (Friedland and Alford,
1991: 239). Moreover, the choices and freedoms that characterize the Western experience of individuality are shaped, historically and institutionally, by the emergence of capitalism, democracy, family and religion. Individual values, of utility maximisation, 'satisficing' (Simon, 1956), income maximisation and interest are all institutionally contingent, shaped and constrained.

In support, Thornton and Ocasio (1999, 2008) view the institutional logics perspective as a framework for “...analysing the interrelationships among institutions, individuals, and organizations in social systems” (Thornton et al., 2012: 2) and by doing so are explicitly attempting to bring the individual and organizational actor back into any analytical framing, albeit through an understanding of how they are “...influenced by their situation in multiple social locations” (Thornton et al., 2012: 2), such as the family, religion, state, market, professions and corporation. Moreover, Scott et al. (2000: 20) describe institutional logics as, “...sets of material practices and symbolic constructions which constitute a field’s organizing principles and which are available to organizations and individuals to elaborate.” Importantly, they continue, “...institutional actors function both as carriers and creators of institutional logics” (Scott et al., 2000: 20), providing the guidelines for the participants within the field to act, behave and modify. Reay and Hinings (2005, 2009) amongst others have contended that different logics can co-exist but that usually one will become more dominant, and therefore institutional change can be explained as the movement from one dominant logic to another. Nevertheless, it is also possible for competing or incompatible logics to co-exist, mediated by the actions of agents in the field, as research by Goodrick and Reay (2011) and Macdonald et al. (2013) in the field of healthcare attests.

Despite the work of Meyer and Rowan (1977) and DiMaggio and Powell (1983) doing much to recognize the characteristics and behaviours of institutions, there was strong preference in their work for the dominating effect of the institution over the individual. In response to this neo-institutional stance, alongside Friedland and Alford (1991), the work of Bourdieu (1977, Bourdieu and Wacquant, 1992) and Giddens (1984) has helped to underline its limitations to explain the relationship between human action and the cultures and structures in which actors were embedded; bringing agency, as well as society, back into the debate.
Battilana and D'Aunno (2009: 45) characterize their work on structuration theory (Giddens) and the theory of practice (Bourdieu) as viewing “...individuals as being embedded in a social context and as responding to the situations that they encounter in this context; thus individual actors are not only shaped by the existing situations, by engaging in institutional work they also shape those institutions.” This will be returned to shortly.

Finally, the responding and shaping of situations, albeit embedded in and constrained by context, is counter to the neo-institutionalist stance that institutions are largely stable and permanent and is one of the reasons neo-institutionalism has been criticised for not being able to deal with processes of change. As agentic practices of change are central to this research, the next section will consider in more detail the different emphases placed on individual, organizational and institutional agents by different authors that may help to locate change within the institutional field. The role of agency within the institutional context will be examined, followed by which two related theoretical concepts, institutional work and institutional entrepreneurship, will be discussed.

3.4 Agency in the institutional context

3.4.1 Introduction

Chapter 2 outlined how the role and identity of the medical profession has changed, set against a backdrop of change in the public sector and how the state sought to engage with the medical profession. What is of wider interest is how the profession and others have changed as a result, at both collective and individual levels and how they have responded to the changes that have occurred within the organizational and institutional field, as well as how individuals engage with change at a discrete level, such as with the EEML project.

Nevertheless, discussing what was done and who did it is difficult to do at a collective level, if you take the premise that it is individuals who act, albeit constrained by organizational and institutional conditions. For that reason, we return more fully to the debate over agency and structure.
3.4.2 Agency and structure

Lawrence et al. (2009: 3) describe agency as “...the capacity of an agent/person/entity to act in a world and engage with its social structure.” This incorporates human agency as the capacity to make choices and the interplay between actors, agency and institutions is, therefore, the focus of institutional theory (Lawrence et al., 2009). Writing two years later, Lawrence et al. (2011: 55) further contemplate the role of agency as an ongoing activity where actors reflect on and strategically operate within the institutional context where they are embedded. Two key corollaries transpire: firstly, the emergence of agency leads to sensemaking and translation and secondly, agency can be viewed as a distributed phenomenon; “...how individual actors contribute to institutional change, how those contributions combine, how actors respond to others efforts and how together this leads to change and then stability.” Friesl and Larty (2013: 112) cast agency as involving the “...knowledge experience and values of organization members that influence how they interpret and make sense of situations.” In both definitions, actions by individuals lead to sensemaking, which subsequently informs future practice.

Structuration theory conceptualizes the interrelationships between actors and their institutional environments. Giddens (1984) argues that structure is both a product of and a constraint on human action, given it a dual nature. Therefore, institutions not only shape individuals’ practices but individuals’ practices constitute and reproduce institutions (Battilana and D’Aunno, 2009). Bourdieu’s (1977) theory of practice rests on the notions of ‘field’ and ‘habitus’. The first describes ‘game spaces’ that offer ‘stakes’ for individuals, offering a system for regulated improvisation (Powell and DiMaggio, 1991). As Battilana and D’Aunno (2009: 45) explain, fields are “…structured systems of social position within which struggles take place between individuals over resources, stakes and access.” In organizational life, this can mean the interactions between key suppliers, resources, product consumers and regulatory agencies amongst others (DiMaggio and Powell, 1983). The second construct, ‘habitus’ helps to explain how and why agents often reproduce and acquiesce to social structures that are not in their interest (DiMaggio and Powell, 1991). Battilana and D’Aunno (2009: 45) describe this as a “…system of temporally durable dispositions, predisposed to function as frameworks that generate and regulate practices and ideas,” so it
is through these dispositions that social structures are imprinted in an individual’s mind and body. The ‘habitus’ concept, thus, offers an alternative perspective on the rationality of individual action\(^2\).

In addition, DiMaggio and Powell (1983: 148) characterise and combine the work of Giddens and Bourdieu, by asserting that “...fields only exist to the extent that they are institutionally defined.” The process of institutional definition, or “structuration”, consists of four elements: firstly, an increase in the extent of interaction among organizations in the field; secondly, the emergence of defined inter-organizational structures of domination and patterns of coalition; thirdly, an increase in the amount of information with which organizations in a field must wrestle; and fourthly, the development of a mutual awareness among participants in a set of organizations that they are involved in a common enterprise (DiMaggio, 1982). All of these can be seen in the case of medical professionalism.

DiMaggio and Powell (1983: 148) continue by arguing that “…the emergence and structuration of an organizational field is a result of the activities of a diverse set of organizations,” which, once the field is established, cause the organizations to homogenize. With such cultural rationalization, organizations become “entrenched and routinized” (Suddaby et al., 2010: 1235) and rather than being socially determined, they are considered as “...reified social structures that exert agency and pressure on their institutional environments” (Suddaby et al., 2010: 1235). Suddaby et al. (2010: 1238) offer a further insight that much of the expanded social control in the modern world is achieved through the construction of properly tamed actors by institutions, following the work of Miller and Rose (2008) and Foucault (Lianos, 2003).

### 3.4.3 Agency, structure and change

Therefore, tensions arise centred around the degree of agency attributed to organizational actors as well as the extent to which a practice approach can adequately describe the relationship between agency and institutions, despite Gidden’s and Bourdieu’s work. Suddaby (2010) believes that the neo-institutionalist arguments of Zucker (1977), Meyer and Rowan (1977) and

\(^2\) I will return to the concepts of field and habitus in more detail in discussion of the concept of capital later on in this chapter (see chapter 3.8).
DiMaggio and Powell (1983), led to a response to correct the lack of agency in institutional thinking, starting with Oliver’s (1991) paper on how organizations respond to organizational pressures. This focus on response to change resulted in a series of empirical examples that framed “...organizations as hypermuscular supermen, single handed in their efforts to resist institutional pressure, transform organizational fields and alter institutional logics” and by creating the concept of the institutional entrepreneur “overshot the mark” (Suddaby, 2010: 15). In trying to attend to both structural and ideational elements (that is, where actors use cues to attribute meaning to events), there is a need for both positivist and interpretivist perspectives that “…pay serious attention to the subjective ways in which actors experience institutions” (Suddaby, 2010: 15). Zilber (2002) adds to the debate with research into how organizational members enact institutional agency by carrying and interpreting meaning to create, reproduce and change institutions (Karnøe, 1997) and explores how the process of institutionalization is a dynamic interrelationship between actors, actions and meanings. Her research (Zilber, 2002: 250) indicates that “…[i]n some cases, the same practices were associated with different meanings, hence reflecting and maintaining different institutions.” The role of agency in creating, maintaining and changing institutions will be returned to later on in this chapter with consideration of the emerging field of institutional work (Lawrence and Suddaby, 2006; see chapter 3.5).

Moreover, Battilana and D’Aunno (2009) discuss the tension between structure and agency, starting from Scott’s (2001) point that institutions are social structures characterized by a high degree of resilience, such that actors tend to reproduce organizational practices and seemingly comply with institutional pressures. If that is the case, Battilana and D’Aunno (2009) ask how actors can change institutions if their actions, intentions, and rationality are all conditioned by the very institution they wish to change, which follows the work of Seo and Creed (2002) in defining the concept of the paradox of embedded agency. Whilst they may emphasize the all-powerful role of institutions with regards to agency, DiMaggio and Powell (1991: 28) also remind us that “…institutions are not only constraints on human agency; they are first and foremost products of human actions.”
Taking the structure-agency debate to its extremes within institutional theory, then it can be argued either that actors’ environments determine their response to situations they encounter in the external world, which makes their experiences the products of external environments that condition them (structure), or that actors have a much more creative role, with free will and autonomy and the ability to be pro-active and self-directed (agency) (Battilana and D’Aunno, 2009). The first leaves little room for human agency and is linked to the sociology of social systems, where individual actions are its end products (Parsons, 1970). In this instance, institutions shape patterns of action and organization rather than simply existing as “...instrumental calculations aimed solely at maximizing profit or utility” (Battilana and D’Aunno, 2009: 35). This then gives us the perspective that broader social and cultural processes shape organizational action and agents’ behaviour is determined by a need to be regarded as legitimate in the institutional environment.

The second notion is linked to the sociology of social action (Weber, 1922/1978), where social systems are by-products of individual action (Battilana and D’Aunno, 2009). Taking this to its extremes, we can draw upon the framework of the rational actor model or *homo economicus* (Battilana and D’Aunno, 2009: 34), where individuals select the most efficient alternative to maximize output for a given input or alternatively minimize input for a given output under a specified set of financial constraints, where their preferences are ordered and stable. Battilana and D’Aunno (2009) argue that this view of human agency helped to influence economic theories of organization, for example, the aforementioned public choice theory (Niskanen, 1971) and new institutional economics (Coase, 1960; North, 1989), but in institutional theory, it ignores not only the societal context but also the impact the individual’s environment may have on their preferences, decisions and behaviours.

Coming away from those extreme perspective, Battilana and D’Aunno (2009) describe how agency can be interpreted as being both unidimensional and multidimensional. The unidimensional view depicts how actors operate away from the limitations of social structure, showing motivation, free will and intentionality to either dissent, by making choices that go against the constraints of social structure, or to alter the rules that govern behaviour. However, this view
does not incorporate those actions which reproduce the social structure and maintain the status quo. Furthermore, it does not account for the context in which actors are embedded which may evolve over time, rather than remain linear and constant.

For those reasons, Battilana and D’Aunno (2009), following the work of Emirbayer and Mische (1998), explore how a multidimensional view of agency, through a combination of habit, imagination and judgement, can demonstrate actors’ engagement with their social world to transform the structure of an environment. They do so through three perspectives on agency: iterative, practical-evaluative and projective. The first is represented as a “...selective reactivation ... of past patterns of thought and action” (Battilana and D’Aunno, 2009: 45); the second as responding to the emerging demands and dilemmas of present situations and the third as an “…imaginative engagement of the future and possible future trajectories of action” (Battilana and D’Aunno, 2009: 45), where, faced with problems that taken-for-granted habits cannot resolve, the individual takes a reflexive stance and projects themselves into the future.

Once again with reference to the work of Seo and Creed (2002), Battilana and D’Aunno (2009) note how individuals become more intentional and self-conscious when faced with institutional practices that contradict or conflict with each other. Such individuals are therefore not only deemed capable of different levels and types of awareness that mean they engage in institutional work but they use their social position to influence their temporal orientation toward the past, present, or future. From this debate, Battilana and D’Aunno (2009: 45) emerge not only with three dimensions, but also one perspective on agency as a “…temporally embedded process of social engagement, informed, by the past, but also oriented towards the future and toward the present.” By doing so, they challenge the notion of the all-powerful institution, which cannot deny agency, even when totally dominant.

### 3.5 Institutional work and institutional entrepreneurship

#### 3.5.1 Introduction

Bringing together the themes of institution, change and the individual, in recent years, a body of work has tried to make sense of these under the title of
institutional work (Lawrence and Suddaby, 2006). Institutional work can be seen as the “...purposive action of individuals and organizations aimed at creating, maintaining and disrupting institutions” (Lawrence and Suddaby, 2006: 215). Lawrence et al. (2009: 5) argue that institutional work helps to introduce a ‘middle ground’ of agency where institutions are products of human action and reaction, motivated by both idiosyncratic personal interests and agendas for institutional change or preservation. The distinction from other institutional theory is that institutional work is interested in the direction of action towards institutions and not the other way round. Its core focus is on highlighting the awareness, skill and reflexivity of individual and collective actors; generating an understanding of institutions as constituted in the more or less conscious action of individual and collective actors; and finally, in identifying an approach that remains firmly rooted in “action as practice” (Lawrence et al., 2009: 7). Before considering institutional work more fully, it is worth exploring the related concept of institutional entrepreneurship.

3.5.2 Institutional entrepreneurship

Institutional entrepreneurs was a term first suggested by DiMaggio (1988) and can be described as “...agents of change, who are endogenous actors with an interest in changing or transforming existing or emerging institutional configurations” (Fligstein, 1997; Rao et al., 2000, as cited by Lockett et al., 2012: 1). Lockett et al. (2012: 2) acknowledge that many organizational fields are structured by institutional forces, but that, “...struggles still occur between different stakeholders in relation to resources and social action, and these have the capacity to recreate, even change, institutionalised practices.” Institutional entrepreneurship, thus, focuses on the features and factors involved in these struggles and seeks to understand how actors influence existing and emerging institutional configurations. Often depicted ‘heroically’ and interested in changing or transforming practices, institutional entrepreneurs aim to devise “...new ways of working as a means of advancing ‘interests’ that may be suppressed within prevailing or emerging organizational practices” (Lockett et al., 2012: 2). The authors argue that these agents may occupy different locations in a field. This can be identified as their ‘subject position,’ which refers not only to “...formal, bureaucratic positions, but to all socially constructed and legitimated identities available in a field.” Moreover, their social position is considered to be relevant
as an enabling factor (Leca et al., 2008) as is their ability to work collectively within specific social contexts (Dorado, 2005).

Battilana and D’Aunno (2009: 38) contended above that, despite the existence of the ‘iron cage’ of institutions, actors within it are not always ‘prisoners’ and in certain enabling conditions, they, as entrepreneurs, can surface. The authors characterise these conditions in three ways: field-level, organizational-level and individual-level enabling conditions. Field-level enabling conditions include jolts or crises, such as social upheaval or technological disruption, environmental issues and workplace diversity, as well as institutional incompatibilities; for example, perceptions or real differences in the way people are treated. Battilana and D’Aunno’s (2009) second set of enabling conditions relate to those at an organizational level. Drawing on the example of US commercial radio broadcasting between 1920 and 1965, they argue that there was a greater likelihood of entrepreneurship, because these organizations were at the ‘margins’ of an established field where the more traditional and higher status stations, which were owned by the national television networks, fought to maintain the status quo. Finally, the authors regard individual-level enabling conditions as those where individuals undertake “…divergent organizational changes... [that] break the dominant institutional logic” (Battilana and D’Aunno, 2009: 41).

Related to this, Lockett et al. (2012) undertook a study of institutional entrepreneurs in the context of health care. This study is interesting and relevant in this research because it combines conceptualisation of institutional entrepreneurship with the context of health care, where the authors interviewed medical professionals and others involved in a case of institutional change. This work highlighted how institutional entrepreneurs work to “…engender different forms of institutional change that promote interests they value highly” (Lockett et al., 2012:6). Acknowledging that changes envisaged by policy-makers are hard to enact because of the influence of institutionalised working practices, they explain how individuals, groups and organizations shape existing institutions in the cause of promoting their own particular ‘interests,’ often maintaining their influence over service delivery through resisting change. Their work differentiates between the concepts of structural and normative legitimacy, drawing on the work of Suchman (1995). Suchman (1995: 574) described legitimacy as “…a
generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions." Located at the organizational level, Suchman’s work differentiates between two different but important sources of legitimacy: firstly, structural legitimacy, which is bestowed through formal institutional structures and relates to the power that emanates from professional hierarchy and jurisdiction; and secondly, normative or moral legitimacy, based on the ability to convince others of ‘what ought to be’, or ‘what is the right thing to do’, which requires a certain deceit by connecting to the activities and interests of other actors.

Using these contrasting terms, Lockett et al. (2012) uncovered how institutional entrepreneurs with high levels of structural legitimacy are least likely to envisage major institutional change, in the same way the US national broadcasters did in the case of radio. This is because “…they are privileged by existing institutional arrangements” (Lockett et al., 2012: 6). In contrast institutional entrepreneurs with low structural legitimacy were the ones most likely to “…envision, and have the agency to seek more radical institutional change” (Lockett et al., 2012: 6). Their rationale for doing so is to attempt to shift the balance of power and resources to different individuals and develop new ways of working, using their normative legitimacy as their source of power and drawing on rhetoric around patient representation and advocating the patient voice as their means for change. Other studies (MacGuire et al., 2004; D’Aunno et al., 2000) have suggested likewise that actors at the periphery of a field may be more likely to enact change because they are likely to be the most disadvantaged by current institutional arrangements and therefore have greater agency for change; are less embedded in current institutions and therefore can more easily discard established norms and values; and are more likely, on the outside of a field, to be part of alternative fields which work differently.

However, this does not mean they are successful, because their desire for change is often viewed by those with high structural legitimacy, and therefore those in positions of power and authority, as a challenge to their vested interests. The authors conclude that it is likely that a third group, “…who occupy subject positions characterised by medium (to high) structural legitimacy may be best
able to enact major institutional change” (Lockett et al., 2012: 6). Not already being privileged by a position of the highest structural legitimacy, they may be better placed to envisage change and reach out to relevant stakeholders to garner support, drawing on their normative legitimacy to bring about the desired change; thus the combination of some structural legitimacy, along with reaching out to those with normative legitimacy is what gives them the necessary power and agency. For example, they use the language of those with low structural and, in contrast, comparatively high normative legitimacy as a powerful tool to resonate with their audiences’ values and match their expectations of what change should arise within that particular environment (Suddaby and Greenwood, 2005). Furthermore, this use of rhetoric helps to build up relationships to support the change and to build up the credibility of normative legitimacy, although it is difficult even for this group of agents to change the balance of power attached to structural legitimacy, given how it is anchored to formal institutional structures.

In terms of the lessons for health care change and reform, Lockett et al. (2012) conclude that an understanding of institutional entrepreneurship helps to identify the different institutional forces that underpin the power and influence of those with high levels of legitimacy, such as the medical profession. The concepts of power and legitimacy may, of course, be directly relevant in this research in the context of the practices adopted by individuals during change, in particular by highlighting how some professionals may adopt distinct strategies to make and remake institutionalised ways of working.

### 3.5.3 Institutional work

Institutional work is linked to institutional entrepreneurship, although it aims to establish a broader vision of agency in relationship to institutions, somewhere between the discussions of how institutions dominate actors on the one hand and the role of heroic actors (‘entrepreneurs’) on the other. Institutional work also comes from the concept of the sociology of practice, where it is “…intelligent, situated institutional action” (Lawrence and Suddaby, 2006: 219). I will return to discuss practice in more detail later, but in trying to understand these practical actions and how they impact on institutions in terms of their creation, maintenance and disruption, it is institutional work that chooses to look at “…the
nearly invisible, often mundane, day-to-day adjustments, adaptations and compromises of actors attempting to maintain institutional arrangements” (Lawrence et al., 2009: 1).

There are three types of institutional work linked to ‘creating’: firstly, the overtly political work where actors reconstruct rules, rights and boundaries that define access to material resources; secondly, actions where actors’ belief systems are reconfigured; and thirdly, actions designed to alter abstract categorizations that alter the boundaries of individuals’ meaning systems (Lawrence and Suddaby, 2006: 221). In contrast, ‘maintaining’ institutional work “…involves supporting, repairing or recreating the social mechanisms that ensure compliance” and addresses the maintenance of institutions through ensuring adherence to rule systems, existing norms and belief systems (Lawrence and Suddaby, 2006: 230). Finally, Lawrence and Suddaby (2006: 235) identify three types of ‘disrupting’ associated with institutional work: firstly, work in which actors work through state apparatus to disconnect rewards and sanctions from practices, technologies and rules; secondly, the disassociation of practice, rule or technology from its moral foundation; and thirdly, the undermining of core assumptions and beliefs within an institution.

It is possible to see that within any change initiative or project, such as the EEML, that all of the various categories of institutional work may be at play. However, whilst the EEML was a project created to implement change into medical education, and undoubtedly caused disruption to the manner in which medical education was understood and practised, the wider focus is on a project that, through change, focussed on the medical profession’s capacity to adopt leadership and management development within the medical curriculum, which arguably helps to maintain the profession as institution. For that reason, it is the aspect of ‘maintaining’ the institution that will be considered next.

Drawing on a wide range of literatures, Lawrence and Suddaby (2006: 230) identify two forms of ‘maintaining’ institutional work, namely ‘coercive’ and ‘normative’ (see Table 3):
Table 3: Coercive and normative forms of ‘maintaining’ institutional work

<table>
<thead>
<tr>
<th>Coercive: promotes compliance with existing rules</th>
<th>Normative: promotes institutional norms and belief systems</th>
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<tbody>
<tr>
<td>• ‘enabling’; creating of rules that facilitate, supplement and support institutions (Leblebici et al., 1991);</td>
<td>• ‘valorizing/demonizing’; provides positive and negative examples that illustrates the normative foundations of an institution (Angus, 1993);</td>
</tr>
<tr>
<td>• ‘policing’; ensures compliance through enforcement, auditing and monitoring (Fox-Wolfram et al., 1998; Schuler, 1996);</td>
<td>• ‘mythologizing’ one’s history (Angus, 1993) and</td>
</tr>
<tr>
<td>• ‘deterring’, where there is the threat of coercion to inculcate the conscious obedience of institutional actors (Holm, 1995; Townley, 2002).</td>
<td>• ‘embedding and routinizing’, which infuses the normative foundations of an institution into the participants’ day-to-day routines and organizational practices (Townley, 1997; Zilber, 2002).</td>
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In contrast to creating and disrupting forms of institutional work, Quinn Trank and Washington (2009: 238) point out that “...much less is known about the processes of maintaining institutions,” despite them being “...assumed to be relatively enduring.” They go on to discuss how the institutional work of maintaining institutions, “…involves supporting, repairing or recreating the social mechanisms that ensure compliance” (Lawrence and Suddaby, 2006: 236) through enabling, embedding and routinizing work. This may involve repetition and support of existing practices in order to maintain the institution’s status and power in its organizational field, which could be seen in the case of the EEML. Dacin et al. (2010: 1394) have considered this in the context of class and formal dining at the University of Cambridge and conclude that the institution of ‘formal halls’ is maintained through ritual performances that “...legitimate the concept of social stratification through the repeated enactment of roles and boundaries.” Here, active agency is responsible for maintaining the institution, rather than its taken-for-granted reproductive mechanisms, but the connection between micro-level, localised action is not automatically linked to the maintenance of the institution at a macro-level. Quinn Trank and Washington (2009) consider two strands to this, both of which are considered to be active and strategic processes: firstly, the creation of rules and standards to uphold regulatory and legitimate authority (‘enabling’ work); and secondly, internalization, by which they mean how certain actors will repeat certain stories from the past to help represent how they wish the institution to be seen and viewed (‘mythologizing’ work). Moreover, Zilber’s
research can make an important contribution with relevance to this case study, as it is “...the continuous enactment of practices and meanings by organization members that constitutes and maintains institutions, including their appearance and experience as taken-for-granted.” In the case of EEML, practices by project members would be considered important in maintaining the medical education institution.

Reflecting further on maintaining institutional work, Currie et al. (2012: 939) argue that privileged actors work to maintain the status quo, which “…characterizes the problems associated with the paradox of embedded agency, whereby those privileged under existing institutional arrangements may have the power to enact institutional change but have limited motivation to do so.” Citing Hardy and Maguire (2008: 199), these actors are “…unlikely to come up with novel ideas or to pursue change, because they are deeply embedded in, and advantaged by, existing institutions.” Therefore, it is worth asking who practices institutional work.

**Who practises institutional work?**

If creating, maintaining and disrupting are the main actions of institutional work, who are the proponents of such action? The focus is on those who oversee the daily machinations or carry out the day-to-day functions to preserve the status of the institution. They are the administrators throughout the organization, who hold positions of some power and authority and influence decision making processes. Away from the individual level, they might be the standard-setting committees and sub-committees of larger organizations, whose boardroom decisions impact on the implementation, actions and practices of others. Key questions that may be asked of these individuals are how they represent and preserve their decision-making powers to affect and maintain institutional arrangements in a specific organizational field. Furthermore, how does institutional work preserve and promote the institutions they represent in the practices and processes of organizations within the organizational field (Quinn Trank and Washington, 2009)? In this research context, the issue of ‘non-heroic’ actors and the agency they display in their everyday work is of importance in understanding the role of institutional work in the field of policy implementation and practice, as much as their ‘heroic’ counterparts displaying feats of institutional entrepreneurship.
Critiquing institutional work

When Lawrence and Suddaby (2006: 246) first conceptualized institutional work, they were documenting a new direction in institutional research and were developing a preliminary and formative taxonomy, where they confessed to “…large gaps…in our ability to describe institutional work, let alone explain it.” In that spirit, Currie et al. (2012), in their study of institutional work carried out by elite professionals, challenged the categories defined by Lawrence and Suddaby (2006) concluding that categories such as ‘theorizing’ and ‘defining’ are as much a part of institutional maintenance as they are of institutional creation. Likewise, Herepath and Kitchener (2016: 21), in their study of institutional repair work focussing on government inquiry reports, demonstrate simultaneous “…maintenance, adapted creative and disruptive modes of institutional work”, rather than these pillars of institutional work operating independently.

Moreover, the institutional field in this case also incorporates national health policy. Whilst this was not an imposed policy change, the general conditions for change do raise questions about why the project (as an instance of change) was instigated and how the change was implemented and practised, opening up avenues for exploring the dynamics and tensions inherent in change processes. Two recent studies (Suddaby and Viale, 2011; Granqvist and Gustafsson, 2015) help to elaborate on such matters.

Suddaby and Viale (2011: 423) investigated the reciprocal dynamics between processes of institutionalization, incorporating institutional work, and processes of professionalization, “…explicat[ing] the professional project as an endogenous mechanism of institutional change.” What is particularly relevant from their research with regard to this study is the focus on both institutional work and professional agency. As it explains, Suddaby and Viale (2011: 423) observe:

“…four essential dynamics through which professionals reconfigure institutions and organizational fields. First, professionals use their expertise and legitimacy to challenge the incumbent order and to define a new, open and uncontested space. Second, professionals use their inherent social capital and skill to populate the field with new actors and new identities. Third, professionals introduce nascent new rules and standards that recreate the boundaries of the field. Fourth, professionals manage the use and reproduction of social capital within a field thereby conferring a new status hierarchy or social order within the field.”
Suddaby and Viale (2011: 429, 433) argue that “…professionals initiate institutional change as an inherent component of redefining their own professional projects” and thus “…hold considerable power to effect change not only because of their expert knowledge, but also because of their sensitivity to, and skill in manipulating, the social order within a field.” Such enactment of endogenous change, rather than just responding to any external ‘shock’, is crucial in understanding how a specific initiative of change may be initiated under general conditions of change and how actors seize upon a window of opportunity to bring it about.

Another such study into the dynamics of institutional work comes from Granqvist and Gustafsson (2015) with the identification of *temporal* institutional work. Departing from Emirbayer and Mische’s (1998: 962) view that agency is a “…temporally embedded process of social engagement”, their development of this concept demonstrates how actors engage in action despite the accepted pressures of time inherent within institutional processes to “…construct, navigate and capitalize on timing norms in their attempts to change institutions” (Granqvist and Gustafsson, 2015: 38). By doing so, they undertake three distinct processes: firstly, constructing urgency, whereby actors express “…perceptions that change was necessary” (p.17); secondly, entraining, where activities were aligned with external timing norms and finally through enacting momentum, which describes how processes are “…in motion towards future outcomes” (p.18). In describing this form of temporal institutional work, they are discussing the practices and actions of actors within a timing field.

In addition to the arguments presented in chapters 3.4 and 3.5, both the work of Suddaby and Viale (2011) and Granqvist and Gustafsson (2015) are implicitly, as well as explicitly, discussing the concept of practice and this is to where this discussion turns next.

**3.6 Practice Theory**

**3.6.1 Introduction**

An alternative and additional way of considering the concept of agency is through the lens of practice theory. The benefit of such an approach is that it does not reify the concept of institution and instead allows for a focus on practices, without
giving ontological primacy to either the institution or the individual. This section will consider how a practice theory perspective may help to explore the research area. The concept of practice will be explored, along with consideration of associated terms, such as activity, routine and process. It will draw primarily on the work of Feldman and Orlikowski (2011) and Nicolini (2012) in contrast to a focus on practice as part of the strategy-as-practice literatures (Whittington, 1996, 2002; Jarzabkowski, 2003). It will also be considered in light of institutionalism and the links between that and individual agency as a means of understanding trans-individual, contextually-bounded practice within the constraints of system- and institution-level analysis.

### 3.6.2 Conceptualising practice

Feldman and Orlikowski (2011) describe practice theory as a lens to help understand the ongoing production of social life, which emerges through people’s recurrent actions. Drawing on Weick’s (1969) distinction between organization and organizing, they describe how the nature of contemporary organizing is “…complex, dynamic, distributed, mobile, transient, and unprecedented” (Feldman and Orlikowski, 2011: 1). Practice theory, they argue, allows them to theorize these kinds of “…novel, indeterminate and emergent phenomena” because of its innate ability to focus on “…dynamics, relations and enactment” (Feldman and Orlikowski, 2011: 2). Nicolini (2012: 7) views practices as more than describing what people do, recounting the work of Chia and Holt (2006) and Nicolini (2009) that they are “…meaning-making, identity-forming and order-producing activities.” The practice view sees the organization emerge as a result of sensemaking and it is made and remade thanks to “…material and discursive work” (Nicolini, 2012: 8). Moreover, Nicolini (2012: 35) draws on Dreyfus’ (1991) notion that practice implies “…an individual’s social and historical relation to the world, where one’s own concrete practices are themselves set up and made meaningful within this wider background system of intelligibility.” Practice is therefore rooted in its common usage (Heidegger, 1929/1996) and cannot break with tradition, which is telling within the study of institutional and professional fields. Building on this, Nicolini (2012: 39) discusses Wittgenstein’s (1969) view that “…rules and meanings are grounded in social practices (or customs or institutions…)” as the latter called them.
3.6.3 Practice, process and praxis

Turning now to consider practice within a change initiative such as EEML, practice is not the same, but is related to process, which Van de Ven (1992) and Pettigrew (1997) describe as causal logic, a descriptor of activities and sequence of individual and organizational/collective events that unfold over time. Both practice and process make use of the concepts of action and activity. In contrast, ontological primacy could be given to individual agency if processes and practices are construed as purposeful activities of individuals and organizations because they are seen as the initiator of such activities and actions (Chia and Mackay, 2007). Whilst not agreeing with this perspective, Chia and Mackay (2007) are bringing to the fore a problem with perspectives on agency and practice. Their field of consideration is strategy-as-practice, which, citing Jarzabkowski (2003), concentrates its “…attention on the day-to-day activities of actors and on how these actors and their activities interact with context” (Chia and Mackay, 2007: 223). Whilst practice theory by the above definition and within a strategic context is worth considering in this research, it has less value as it makes the assumption that there is a discernible pattern emerging in a stream of actions (Mintzberg and Waters, 1985), whereas this research does not assume there was a specific strategy in play and that a planned change and outcome was expected.

Feldman and Orlikowski’s (2011) take on practice theory is perhaps closer to what strategy-as-practice theorists might call ‘praxis’, micro-daily activities, which become the focus rather than the individual agent. Two of their foci are particularly relevant in this research: firstly, the empirical focus recognizes “…the centrality of people’s actions to organizational outcomes, and reflects an increasing recognition of the importance of practices in the ongoing operations of organizations (Feldman and Orlikowski, 2011: 2); and secondly, the theoretical approach explains “…the dynamics of everyday activity, how these are generated and how they operate within different contexts and over time” (Feldman and Orlikowski, 2011: 3). Together, those two approaches answer both the ‘what’ and the ‘how’ of a practice lens, which allows for a focus not on why change might happen but what practice happens to make it occur and how those practices are enacted. Moreover, practice theory rejects dualisms in favour of dualities, notably the ability of structure and agency to co-exist, which points to a third principle of practice theory that there is relationality of mutual constitution, with no
phenomenon being independent of any other. As Feldman and Orlikowski (2011: 6) assert, “…the notion of mutual constitution implies that social orders (structures, institutions, routines, etc.) cannot be conceived without understanding the role of agency in producing them, and similarly, agency cannot be understood ‘simply’ as human action, but rather must be understood as always already configured by structural conditions.”

Practice theorists more generally, such as Bourdieu (1977), Giddens (1984) and Schatzki (2002), generally assert that these specific instances of actions take place in a social world in which they sit and thus are consequential in the production of social life. There is much to take from the work of Bourdieu (1977) and Giddens (1984) in relation to theories of practice, which have been discussed previously in relation to agency, such as Bourdieu’s concept of habitus3 as a “…form of knowing in practice akin to the ‘feel for the game’” (Nicolini, 2012: 55) and Gidden’s structuration as the study of structure, which is itself “…both the medium and the outcome of the reproduction of practice” (Nicolini, 2012: 45).

Turning to understand the work of Giddens in a little more detail, he views practices as “regularized types of acts” (Giddens, 1976: 75) with three properties. Firstly, they are produced by knowledgeable actors who draw on rules and resources; secondly, they are situated always in temporal, spatial and paradigmatic dimensions; and thirdly, they are interdependent, persisting in relationships of reciprocity. This is significant because they underline how change has its origins in the practices that continuously renew the conditions that determine them (Nicolini, 2012).

3.6.4 Practice, routines and performances

In addition, routines are closely related to practice and action and can be described “…as generative systems created through the mutually constitutive and recursive interaction between the actions people take (performative aspect of routines) and the patterns these actions create and recreate (ostensive aspects of routines)” (Feldman and Orlikowski, 2011: 11). A close comparison could be drawn between routines and what Berger and Luckmann (1966/1991: 71)

3 Bourdieu’s work on habitus and its relationship to capital will be considered shortly (see chapter 3.8).
describe as “habitualized actions” as a set of behaviours that are developed and adopted by actors to solve recurring problems (Zilber, 2002). Moreover, the study by Dacin et al. (2010) on rituals, to which this chapter previously referred, supports Feldman and Pentland’s (2003) work on the relationship between performative and ostensive aspects, demonstrating the key role of action (performative aspect) in maintaining structure (ostensive aspect) in formal dining at university, albeit with their focus on rituals, which could be likened to routines.

By theorizing routines as practices, there are two dualities that are relational and mutually constitutive: action/structure and stability/change. Pentland and Rueter (1994) describe routines as “effortful accomplishments”, which suggests that the work of reproducing a routine is full of challenge, alteration and drama. This links to Feldman’s (2000) work that routines are a source of continuous change with an “internal dynamic” (Feldman and Orlikowski, 2011: 10). Indeed, it is in the performance of routines that the ostensive aspects of routines are created, maintained and modified, whilst the ostensive aspects are used by individuals to guide, refer to and account for their performances (Feldman and Pentland, 2003). This continuous interaction between performative and ostensive aspects allows us to understand how stability (structure) and change (agency) can mutually exist.

Furthermore, Howard-Grenville’s (2005) study highlights how these performances can emerge through the negotiated actions of multiple actors, based on individual intentions and orientations, where some are more successful than others in changing routines. This may be because performances are embedded in contexts that may constrain their adaptation, or that some individuals have more power to adapt routines than others. Feldman and Pentland’s (2003) theory of stability and change in routines considers such a focus to allow for exploration of the relationship between the ostensive and performative aspects; which routines are likely to be more stable or liable to change and which conditions will promote endogenous change. It is interesting to pause for a moment and note here the parallels between the performative aspect of routines in creating, maintaining and modifying and the pillars of institutional work, whereby individuals take purposive action aimed at “creating, maintaining and disrupting institutions” (Lawrence and Suddaby, 2006: 215).
3.6.5 Summary

How does this all relate to this research? The MLCF can be cast as a mediating object (Macpherson et al., 2006) in changes to medical education as well as a final entity of the EEML project, within an institutionalized and relatively stable world of the medical profession. Mutual constitution allows us to understand how institutions, which are acclaimed for their stability and enduring nature, can be subject to change, yet remain institutions within a social world. As practices occur, individuals take action, processes change and routines are established and then subsequently reproduced, the resulting outcomes can be understood not so much as to why they happened, but in the way in which and how they occurred. As Feldman and Orlikowski (2011: 17) put it:

“In the boxes and arrows figures so prevalent in organization theory, the boxes are always labelled while the arrows are often unadorned by any text, as if they speak for themselves. Moreover, entities are often reified, considered sufficiently meaningful independent of their use or performance. In practice theory, by contrast, the emphasis is on the arrows, on the relationships and performances that produce outcomes in the world. To put it another way, practice theory theorizes the arrows so as to understand how actions produce outcomes.”

The use of practice theory allows for focus, not only on the entity that results from actions and practices and ultimately the change they create, but also on understanding the dynamic and relations between practices that constituted the entity. Considering the usefulness of a practice theory perspective, the concepts of mutual constitution and the distinction between ostensive and performative practice may help to identify and explore the levers for enabling change in practice in the EEML project. The subsequent findings and insight resulting from that can be applied to other contexts, because, as Feldman and Orlikowski (2011: 18-20) contend, “...theoretical generalizations are powerful because they travel,” and practice theory can therefore help to understand the “…ways in which agency is shaped by but also produces, reinforces and changes its structural conditions.”

Finally, in studying practice, Nicolini (2012) cites the work of Ortner (1984) with respect to practice within sociology and emphasises how attention to practice can inform us of the relationships between human action and a different phenomenon, such as the organization, institution or ‘system’; what people actually do and the role of the agent in the process of production and reproduction, which are all pertinent to this case study.
3.7 Drawing institutional work and practice theory together

Whilst institutionalism has drawn on practice theory, notably in the work of Barley and Tolbert (1997), with its emphasis on the effect of institutional fields on individual actions and cognitions (see Powell and DiMaggio, 1991; Scott, 1995; Greenwood et al., 2002, 2008), there has been little theorizing or engagement with the concept of mutual constitution, with the role of human agency only being seen as shaped by macro-institutional forces. Moreover, as Clegg (2010: 8) argues, when discussing institutional theory, “…[i]t is strangely self-referential and inattentive to the everyday reasoning of everyday people”, ignoring key concepts such as power, which is central to the understanding of society. Recently, institutional work (Lawrence and Suddaby, 2006; Lawrence et al., 2009) has attempted to correct that by addressing how individual actions create, maintain and/or disrupt institutions. However, by bringing back in individual and organizational agency, it is still constrained by the institutional field. Indeed, one of the criticisms of institutional theory that could be extended to the study of institutional work is that, by ignoring, or, at the very least, deemphasizing the role of the individual in relation to the institutional field, it has sanitised or glossed over the mundane and everyday domination and oppression by the institution over the individual (Wilmott, 2014).

In contrast, the unit of analysis of the practice perspective would bring more of a focus back onto what interactions have occurred between different actors (individuals, organizations and institutions), which may include consideration of the responses of individuals towards the context (organization, institution etc.), without falling into a similar trap of reifying either the individual or institution. Practice theory focuses on the practices themselves and the dynamics between practices, agents and the routines and processes they negotiate and (re)produce.

Nonetheless, there is still much to relate practice theory to institutional work, not least the agency inherent in both. Lounsbury and Crumley (2007: 995) have added a further useful perspective on the interchange between neo-institutional and practice theory. Drawing on the work of Jarzabkowski (2005) relating to activity, which is defined as “…the actions of and interactions between actors as they perform their daily duties and roles” and practice as “…activity patterns across actors that are infused with broader meaning and provide tools for
ordering social life and activity”, Lounsbury and Crumley (2007) provide a distinction between the activity of pounding a nail and the practice of professional carpentry. The former is generally devoid of deeper meaning, in contrast to the latter, which provides order and meaning to the activity. In that sense, practice is “...a kind of institution, ... activities that are fundamentally interpenetrated and shaped by broader cultural frameworks such as categories, classifications, frames, and other kinds of ordered belief systems” (Lounsbury and Crumley, 2007: 996). Moreover, it is interesting to reflect back here, for example, on how the language of routines, rituals and habitualized actions relates to the concept of the institution as ways of organizing that are familiar and routinely practised (Lune, 2010). This draws individual practice into the creation of the institution and helps to address the shortfall of institutional theory highlighted by Clegg (2010).

I would, therefore, argue that there is an opportunity to bring the perspectives of institutional work, with its focus on agency towards institutions, and practice theory together, particularly around how individuals perform practice to offer a more critical perspective (Jarzabkowski et al., 2009). Feldman and Pentland’s (2003) study discusses how performative practices alter ostensive aspects, despite that not being their aim. Performative aspects have three dimensions: creation, maintaining and modification, which relates closely to Lawrence and Suddaby’s (2006) institutional work through creating, maintaining and disrupting, or, as Coule and Patmore (2013) describe the latter, transforming, institutions. Indeed, the work of Lounsbury and Crumley (2007: 993-994) highlights how institutional entrepreneurship, a close cousin of institutional work, “...tends to emphasize the latter stages of practice creation where new sets of activities are theorized, facilitating their spread; bracketed are the earliest moments when the possibility of a new practice first emerges and is recognized as an opportunity for some social group.” This seems to miss a crucial part of the story of change, excluding the activities, practice and processes that occur before “theorization” efforts (Greenwood et al., 2002: 60).

The advantage of drawing on both institutional work and practice theory perspectives allows agency to be brought to the fore in a field that can be recognised as institutional – that of medical education and the medical profession. By adding in a practice theory perspective, the institution does then
not become the dominant focus and thus overshadow and institutionalize the practices that are taking place. Practices become the focus, either collectively as trans-organizational processes or individually as micro-level actions and activities. In that way, a deeper understanding of how individuals engaged with the medical profession to bring about changes to medical education can be realized.

3.8 Informing practice work: the role of capital and social position

The previous sections within this chapter have outlined how both institutional work and practice theory can help in our understanding of agentic practices of change. This section aims to explore the role of capital and social position in informing practice work.

3.8.1 Capital and practice

Nicolini (2012: 59) describes ‘capital’ in broad terms as “…anything that can be exchanged, determining as a consequence a variation in legitimacy and power.” This unequivocally locates capital and power as the end-point of all conduct (practice) and in a three-way Bourdieusian tradition is played out in previously mentioned ‘fields’ (chapter 3.4), which roughly equate to the societal spheres of politics and, in this case study, professions as well. The third of Bourdieu’s axes, after capital and fields, which informs practice is ‘habitus’, which Maton (2012) recounts as the confusingly defined “structured and structuring structure” (Bourdieu, 1994b: 170); that is to say, ‘structured’ by an individual’s past and present, ‘structuring’ in that it helps to shape the present and future and ‘a structure’ in that it is ordered and not random. Within that structure are a series of dispositions, which generate, amongst other things, our practices.

To unpick those three key terms further, capital is constituted in various forms and most relevant to this case are those of social, cultural and symbolic capital. As with all forms, depending on the academic discipline, they are much contested terms. Social capital, in this case study, follows most closely the definition provided by Lockett et al. (2014), who draw on Bourdieu (1986) and Burt (1992), as being made up of the mutual and interpersonal relationships and acquaintances and the resources embedded within those relationships, such as
belonging to a unit, group or family. Cultural capital relates to the knowledge, skills, tastes, preferences and possessions within the system of relations (Bourdieu, 1986; Lockett et al., 2014) and symbolic capital can be defined as the “…resources available to an individual on the basis of honour, prestige and recognition” (Bourdieu, 1984 as cited by Lockett et al., 2014: 1105).

Field, referred to previously by Battilana and D’Aunno (2009), relates to “…the social space [champs as in ‘battlefield’] in which interactions, transactions and events occur” (Thomson, 2012: 65), where it is “…a mutual process of influence and ongoing co-construction”, which can be seen as antagonistic sites of struggle (Thomson, 2012: 69). Together with habitus, the field constitutes a tension/conflict “…through which specific practices produce and reproduce the social world that at the same time is making them” (Thomson, 2012: 73). To consider further that concept of habitus, this allows an understanding of how to reconcile social structure and individual agency, to apprehend “…how the ‘outer’ social and ‘inner’ self help to shape each other” (Maton, 2012: 49). Habitus brings together “…both objective social structure and subjective personal experiences” (Maton, 2012: 52). It is a historically and contextually – and thus relationally – situated habit (Maton, 2012).

Therefore, to understand how actors may act, practice, work or operate within a change initiative, we can draw on Bourdieu’s formulation, that “…one’s practice results from relations between one’s dispositions (habitus) and one’s position in a field (capital), within the current state of play of that social arena (field)” (Maton, 2012: 50). Bourdieu continues, “…we need to understand both the evolving fields within which those actors are situated and the evolving habituses which those actors bring to their social fields of practice” (Maton, 2012: 52). By acquiring a sense of the tempo, rhythms and unwritten rules of the game through time and experience, actors are able to ‘practise’. The feel for the game takes prolonged immersion within a field to develop and the source of this practical logic is the habitus. Habitus is intended to make us think ‘relationally’ and “…focuses on our ways of acting, feeling, thinking, being; captures how we carry within us our history, how we bring this history into our present circumstances and how we then make choices to act in certain ways and not others” (Maton, 212: 51).
As Nicolini (2012: 60-61) outlines, “…agents’ practice is shaped both by their habitus and by their understanding of the field-specific game as it unfolds in time.” Much like the social constructionist view outlined previously, practice is a matter of regulated and improvised ‘organizing’, “…according to local, practical, and social conjectures…where the ‘regulation’ results from his or her perception of the conditions of the field generated by the habitus.” If, as Bourdieu (1990: 53) testified, practice is what people do in “…practical relation to the world”, then agents are simply responding to what makes sense and what they perceive will do them good (Nicolini, 2012). Thus practice necessarily occurs within a given time frame, with all of its “…ambiguities, indeterminacies, situated clues and feelings” (Nicolini, 2012: 63), that more theoretical perspectives cannot account for. However, Bourdieu’s contestation that the driver for practice is centred on competition for symbolic or economic advantage (Nicolini, 2012) has been critiqued by Dreyfus and Rabinow (1993), who argue that “…practices may have a different meaning for different groups of agents” (Nicolini, 2012: 65), so the assumption that accumulation of various forms of capital is done solely for personal advantage may be only one amongst many representations of the logic of a certain group’s or individual’s practice. To support this, Nicolini’s (2012) case study of telemedicine demonstrates that habitus, which informs capital and practice, was not only about power games involving different professional groups, but for some groups (nurses) was directed first and foremost towards well-being of patients, rather than professional self-interest.

3.8.2 Social position and practice

To further this debate within a professional context, and thus relevant to this case study, there is value in considering the work of Battilana (2011) and Lockett et al. (2014) who considered the role of social position within organizational change. Both studies were also carried out within the context of the NHS ‘field’, thus making them directly relevant to this case study. Battilana (2011) recounts how traditional views of who enacts change focus on low-status actors, because they are less privileged by the institutional status quo and are therefore more likely to instigate change. Related to this, Lockett et al. (2014: 1102) explored “…how actors’ unique contexts, as encapsulated by their social positions, provide the ‘raw materials’ for their sensemaking about organizational change.” Whilst social position provides the rationale for the constitution of an individual’s ‘unique
context’, this can also be thought of as a combination of an individual’s biography, motivations, experiences, jobs, time, organizations and employers. In understanding this, Lockett et al. (2014) argue that this unique context allows different individuals to sensemake and practise differently, even when confronted by a common phenomenon, such as a change initiative.

Battilana (2011) considered the case of collective actors in the form of professional groups and organizations. Governed by a model of medical professionalism, the resulting role division across health services is predicated on the dominance of the doctor over all other professionals, something that was discussed previously in chapter 2. Likewise, government attempts to “…infuse the NHS with new models for organizing [to challenge] the institutionalized model of medical professionalism” (Battilana, 2011: 819), formed part of the emergence of New Public Management and other reforms from the 1980s onwards. Battilana (2011) further argues that using this relative position of social dominance has granted the medical profession power for “positive privileges” (Weber, 1922/1978: 305) and therefore doctors were likely to defend these traditional privileges and autonomy, whilst non-doctors would be less likely to be content with this status quo.

Drawing on work by Miller and Friesen (1980) and Hambrick et al. (1993), Battilana (2011: 822) also discusses how top managers (privileged elites in their own fields), are “…more capable of initiating divergent organizational change…[but] are not necessarily more likely to initiate it”, because the institutional status quo may help to maintain their power and control. With relevance to this case study, this paints a potentially confusing picture; who, amongst managers and professionals, is more or less likely to initiate change, given the divergence in views regarding whether those in privileged positions, with the resources to very much do so, will, in practice, effect change?

The results from Battilana’s (2011: 829) study confirm that “…organizations disadvantaged by existing institutions are more likely to initiate divergent organizational change”, which would align with views that the organization of government, in the presence of the medical profession, does not occupy the privileged position when it comes to health services. This does not mean the individuals within organizations, such as the Department of Health or NHS
Institute, are themselves underprivileged; it is just that they may be privileged only in certain fields, where they are at the core and not so in those where they practise at the periphery. Therefore, a high social position is not, in itself, enough to initiate change; it depends on how that social position relates to the field in question.

In Lockett et al.’s (2014) study, social position was defined in line with Bourdieu’s (1986) thinking, based on actors’ control of capital resources that are accumulated through their lived experiences. As the concepts of capital have been discussed in more detail above, I will not recap them here; suffice to say that these capital resources offer actors’ social positions that are multidimensional in nature, also in line with Battilana’s (2011) espoused view that social positions were more complex than an elite and non-elite categorization. Moreover, Lockett et al.’s (2014: 1105) study considered the concept of dispositions, using Bourdieu and Wacquant’s (1992) definition as “…habitualized know-how, …enduring ways of seeing and believing, existing often at the unconscious and taken-for-granted level.” Influenced by an actor’s social position, dispositions will therefore vary amongst individuals and groups, but act as ‘schemata’, reproducing patterns of behaviour over time. Situating their case once more in the NHS, they focussed on the role of three actors with different social positions, but who were all faced with the same organizational change. Through their prime interest in how context influenced sensemaking, they also outlined the need to think cross-capitally and consider the interactions of the various forms of capital, demonstrating that “…actors within a professional group may sensemake in different ways, which are shaped by their individual endowments of cultural capital (Lockett et al., 2014: 1122).

Drawing on different forms of capital, individuals in their study, from the same professional group, were able to sense opportunity to change, thus recognizing that dispositions form at the level of the individual and not the group or profession, and create new emergent forms of organizations out of the legacy of old forms or ‘schemata’. The value in Lockett et al.’s (2014) work for this case study comes from the potential implications of understanding how social position informs an actor’s context and thus their ability to sensemake regarding organizational change, which then informs what they do (their practice). They conclude that
actors in high-status social positions are more likely to sensemake in a way that reproduces existing organizational patterns and structures and therefore if utilized as change agents may, in effect, be agents of stability. To promote change, Lockett et al. (2014) suggest these individuals are exposed to other organizational and professional perspectives to alter their dispositions towards institutional change.

### 3.9 Chapter Summary

This chapter has outlined the theoretical underpinnings of this thesis. Charting the journey through a discussion of the concept of institution, in light of the study’s focus on medical education and the medical profession, neo-institutional theory was then critiqued in terms of its ability to account for institutional change.

In relation to the espoused research question “How do opinion leaders enactment and effect change within medical education?”, the role of agency was also discussed to bring the individual actor into the debate. Consideration of the emerging work of Lawrence and Suddaby (2006) in the form of institutional work was a key element of this discussion, but in an attempt to consider the second research question, “What processes are involved in opinion leaders’ actions and practices that are important in effecting change?” and to move away from too strong a focus on institution, practice theory was also considered a relevant theoretical concept with its potential to help understand those processes (and indeed practices) of change. Finally, key papers that drew on the importance of capital and social position as catalysts for agentic practices of change were reflected on as a means to try and realize how change might happen within strongly institutionalized environments, in line with the third research question.

The following chapter now moves on from discussion of these theoretical concepts to consider the methodological approach taken in this research study.
Chapter 4: Methodology

4.1 Introduction

This chapter outlines the methodological orientation and design of the study, which provides justification for the chosen approach; data collection and analysis methods and discussion of evaluative elements of the study, notably the trustworthiness and authenticity of the research (Lincoln et al., 2011); ethical issues and considerations; and finally, the limitations of the methodological approach to the study.

This study investigated how individuals either within or associated with the medical profession engaged with change in medical education. The research employed a largely inductive qualitative methodology, which encompassed exploration of relevant areas of literature in medical education, then focussing on institutional work, practice theory and forms of capital. Following that, the study progressed to a secondary phase, which involved 22 fieldwork interviews alongside exploration of project documents, both published and unpublished and the subsequent in-depth analysis of both. The final phase involved returning to theoretical concepts, encompassing the creation of new ideas and constructs.

As discussed in chapter 1, the purpose of this study was to understand the work (actions, practices) of opinion leaders in effecting change in medical education through the EEML project. The central research questions were designed to explore:

- How do opinion leaders enact and effect change within medical education?
- What processes are involved in opinion leaders’ actions and practices that are important in effecting change?
- How does this case further our understanding of strongly institutionalized environments?

Furthermore, in light of the theoretical context of institutional change and the political environment of public and healthcare sector reform, this study aimed to:

- Explore how opinion leaders experience and practise change
- Understand how this is related to their social position
• Explore the processes involved in creating meaning, perspective and sense of actions, practices and change
• Critically reflect on changes within medical education and the medical profession
• Identify implications for theory and for practice

As with any research study, these objectives evolved from the study’s inception as the process of reviewing and refining relevant literatures was undertaken throughout the course of the study.

4.2 Methodological orientation

In identifying a methodological approach to this research, I referred to the work of Hiles (1999) and his model of disciplined inquiry, which outlined and informed the necessary steps required to undertake a study such as this. Beginning with identifying a relevant paradigm, this would then inform the subsequent research strategy, methods and analysis of data, as demonstrated in figure 2 below:

Figure 2: A model of disciplined inquiry (Hiles, 1999)

Denzin and Lincoln (2011: 12) recognize the same four phases, but add in an additional one at the start and at the end, those of “…researcher as a multicultural subject” and “…the art, practices and politics of interpretation and evaluation.” The former requires a consideration of history and research traditions,
conceptions of self and other and finally the ethics and politics of research, before consideration of any particular theoretical paradigm, perspective, research strategy, or data collection and sorting method. At the end of the research process, consideration must then be given to the criteria for judging and interpreting the research findings, which aligns somewhat with Hiles’ (1999) analysis phase. The following sections will outline the adopted paradigm, research strategy, methods of data collection and analysis and give consideration to the quality and rigour and ethical conduct of the research process, including reflection on my role as the researcher within this methodological process.

4.2.1 Paradigms - epistemological and ontological foundations

This study investigated how opinion leaders within the EEML project engaged with creating change in the form of leadership and management learning and development. The research employed a qualitative methodology, which encompassed the EEML project as the central case of study.

Creswell (2008) describes ontology as the nature of reality, which can be grouped or subdivided differently dependent on the perspective of the relevant prevailing paradigm within a research study, with positivism broadly at one end, moving towards participatory and then postmodernist paradigms at the other (Lincoln et al., 2011). A relativist position sits somewhere between those, accepting that multiple, constructed realities can co-exist and the tensions inherent within those form a central part of the study. In believing that there are multiple, constructed realities, rather than any single truth (a positivist position), the context of the situation, individuals’ experiences, perceptions and the social environment are influential factors (Ponterotto, 2005: 130).

Ponterotto (2005) describes a social constructionist epistemology as relating to individuals’ beliefs about how they discover knowledge. The position in this research is that the lived experiences of the participants involved and each of their ‘realities’ or ‘truths’ are relevant for consideration. In terms of epistemology, the interaction between this researcher, as a former non-clinical manager in the NHS, and the research participants, creates a social reality that is based upon a mutual frame of reference within the dialogic interaction of the research setting (Lincoln et al., 2011). Specifically within this research, my former experience as a health service manager and Department of Health economist, with time spent
learning the knowledge and practising the skills of economics and management within a health care and system context, added to those currently as a health service and management academic, cannot and should not be separated from the process of discussing with interview participants concepts around leadership, management and the medical profession, although ethical consideration must be given to it (see chapter 4.5).

Other related epistemological influences within the research process draw on Bourdieu’s (1990) work on the role of individuals’ everyday meaning making and lived experience in informing their actions and practices. This can also be linked to Garfinkel’s (1967) principles of ethnomethodology, whose work challenged assumptions about behaviour in its study of people's practices and methods. Moreover, the tradition of phenomenology, from the work of Husserl (1962), Brentano (1995), Morrison (1970), Heidegger (1929/1996) and van Manen (1990) is also deemed relevant within this research paradigm and case study, with its focus on human experiences and descriptions of those experiences by, and the meaning-making and lived experiences of, first-hand participants in a phenomenon (Creswell, 2008).

Ponterotto (2005: 128) cites Denzin and Lincoln (2000) when defining how qualitative methods “…refer to a broad class of empirical procedures designed to describe and interpret the experiences of research participants in a context-specific setting.” By its nature, qualitative research sits within a constructivist-interpretivist paradigm, in contrast to the positivist view of a single, objective external reality. This research therefore rejects the positivist tradition of a single, identifiable reality and total objectivity (Lincoln et al., 2011) because its purpose is not to predict and control the nature of knowledge embedded in this case study of institutional change, but to understand how change is practised and experienced and how meaning, perspective and sense are created as a consequence. There is no ‘one-size-fits-all’ understanding offered in terms of how change is effected and enacted, nor a single reality that can be “…studied, captured and understood” (Lincoln et al., 2011: 8) in the context and parameters of medical education and professionalism. What works in one instance of time and space cannot be replicated due to the inherent nature of subjectivity.
In terms of relating to institutional change, the work of Mead (1967), Blumer (1969) and Goffman (1959) and the concept of symbolic interactionism – how individuals give meaning to their social interactions, taking into account the role of institutions and establishments – is another potentially relevant construct. Moreover, Berger and Luckmann’s (1966/1991) seminal work on social constructionism also helps to inform the interplay between individual agents and institutional structures, which forms an instrumental part of this case study. A final influence in terms of the research paradigm and approach to this case study is Glaser and Strauss’ (1967) work on developing grounded theory, whose focus was towards inductive research and a continuous loop approach.

The approach adopted here draws from all of these traditions and can be seen as an adapted form of the grounded theory approach, which combines an overarching and starting theoretical or deductive framework with inductive search (Pettigrew, 2003); described alternatively as an inductive/deductive spiral (Kemshall, 1998) or as an abductive approach (Cunliffe, 2011). Indeed, it also draws on Layder's (1997) adaptive theory, which “…emphasises the dual influence of general theory and theory grounded in research data” (Layder, 2006: 302).

4.2.2 Research strategy

This section will consider the general orientation of the conduct of this research and in particular the tools and techniques of the research process. The above described interpretivist position informed this research approach, applied to opinion leaders and the study of change. The EEML project could be considered a single case study, within a complex institutional setting, similarly to Kallinikos et al.’s (2013) discussion of the Europeana initiative or Balogun and Johnson (2005)’s consideration of organizational change. The case study is a useful and informed approach, where it is “…important to understand how the organizational and environmental context is having an impact on or influencing social processes” (Hartley 2004: 325), as is the situation in the context of institutional change in the NHS. The rationale for choosing the EEML project as an object of empirical inquiry was threefold: it was a project of national status; change was introduced through the medical curriculum, which had not been attempted before in leadership terms in the NHS and with the medical profession; and there was
direct involvement of senior NHS stakeholders and organizations. Few previous studies had explored this combination of factors, especially with regard to change in a mature institutional field. There was also very little in the existing literature that had explored how doctors could be developed in leadership and management skills and knowledge through the curriculum and by way of competency framework (see Frank, 2005, for one example).

The case study is therefore particularly useful and relevant when studying a context dependent area or a rich problematic of research such as this (Flyvbjerg, 2006). Moreover, Weick (2007: 14), when arguing for the generative properties of richness, contends that “…if an event can happen in one place, then it likely can happen again.” This affords the case study approach the opportunity to draw on “…thick description, reflexive theorizing and conceptual slack – openness to the many new explanations that emerge when contextual detail is added to the account” (Greenhalgh et al., 2011: 539). According to Hartley (2004: 325), case studies allow for unusualness, rather than typicality, to be illuminated in the understanding of “…everyday practices and their meanings to those involved.”

What is key within the case study design is to “…disentangle what is unique to that organization from what is common to other organizations” (Hartley, 2004: 326). This case study approach therefore focuses on the particularities of the whole EEML project, but with insight into the shared and contrasting responses of individuals to the creation of change.

Due to this strategy being ideally suited to exploration of issues in depth and following new lines of enquiry as they arise, Hartley (2004: 328) argues that “…the theoretical framework at the beginning may not be the same one that survives to the end.” Therefore, whilst the research strategy will begin with recognizing the importance of a rudimentary or primitive framework (Layder, 1998; Hartley, 2004), such as institutional work or practice theory in this case, this approach is aimed at developing “…theoretical frameworks during the course of the research which inform and make sense of the data and which can be systematically examined during the case study for plausibility.” As such, case study theory building is generally inductive and through piecing together the evidence as it arises, can theories be generated or replicated for the broader interest. Indeed, case studies are at their best where there is “…rigorous thinking
[chapters 2, 3 and 4], sufficient presentation of evidence to reach appropriate conclusions [see chapters 5 and 6], and careful consideration of alternative explanations of the evidence [see chapter 7]" (Hartley, 2004: 324).

The selection of the EEML project led me to adopting an exploratory case study approach. As a historical change initiative, EEML becomes an interesting phenomenon to consider, thus making it, in Yin’s (2008) words the primary ‘unit of analysis’ at the outset. However, my approach differs from Yin’s more positivist outlook, looking to “…understand the human experience” (Stake, 1995: 38) which means that “…knowledge is constructed rather than revealed, and the researcher works towards reconstructing events and believes that humans are active in the construction of knowledge rather than being passive recipients of knowledge” (De Massis and Kotlar, 2014: 3).

As has been argued, case studies can offer rich understandings of phenomena and allow for theory testing and building (Martin et al., 2012, Martin and Finn, 2011), when applied to change processes that are taking or have taken place. Pettigrew (1997: 337) describes process as a sequence of individual and collective events, actions and activities unfolding over time in context, into which the concept of the EEML project can fit. Moreover, this approach allows for existing literature to help frame the research in the tradition of the Manchester School (Epstein, 1958; Garbett, 1970; Gluckman, 1958; Mitchell, 1956; Van Velsen, 1960) and latterly Burawoy’s (1998) extended case method, in contrast to a more purist grounded theory approach (Glaser and Strauss, 1967). However, in contrast to Burawoy (1998), this is not an ethnographic study; there was no real-time participant observation. Instead, this research relied on interventions into the lives of participants through semi-structured interviews at a point in time after all of them had moved on from this change initiative. So, whilst the EEML project is the core focus as the unit of analysis, it is also the locus of sub-units where interesting stories happened. Furthermore, it relied on the study of historical documents and interviews, which took place after the project had finished.

Sub-units that are relevant to that and contribute to the resultant change may include the stakeholders, teams, groups, meetings, practices, events, even places of work within the boundaries of the study. However, it is worth noting that
absolutely defining the case or unit is not always clear and boundaries are necessarily fuzzy, fluid and porous (Segar et al., 2015) when undertaking interpretative, qualitative research such as this. Indeed, phenomena that are encompassed within the boundaries of this research include ‘national level health policy’ and ‘professional organizational structures’, such as deaneries, colleges and other medical administration organizations. However, these could also be considered as integral parts of the cases being investigated (Segar et al., 2015). Indeed, Ragin and Becker (1992, as cited by Byrne, 2009: 2) describe cases as complex systems, recognizing that “…trajectories and transformations depend on all of the whole, the parts, the interactions among parts and whole, and the interactions of any system with other complex systems among which it is nested and with which it intersects.”

Having set out the research strategy for this case study, the following section will consider the use of appropriate research instruments through which to undertake the research study.

4.2.3 Research instruments

Braun and Clarke (2006: 96) argue that “...the theory and method need to be applied rigorously, and ‘rigour lies in devising a systematic method whose assumptions are congruent with the way one conceptualizes the subject matter’ (Reicher and Taylor, 2005: 549).” In terms of the overarching paradigm used in this study, methods appropriate to interpretivist, qualitative case study research in the domain of social science are paramount. However, social science is somewhat limited in its choice of methods for carrying out research and relies on a combination of interviews, observations and documentation (Buchanan and Bryman, 2011) as means for uncovering the truths and realities at the research site. Due to the retrospective nature of the research, observation was not viable and this research therefore concentrated on the use of interviews and documents as means to support the research question and result in the data findings. Use of two methods within a case study allows for theory to be “…supported by evidence gained in different ways, from different groups, in different situations” (Hartley, 2004: 328), even where the research team is limited to one researcher.

The research adopted semi-structured interviews as an approach, largely because it sits somewhere between the rigour of a structured approach that
allows for comparability between responses, whilst allowing for the open-endedness of a more unstructured or focussed approach (May, 2011). Semi-structured interviews allow the researcher the opportunity to seek clarification and elaboration on the response given and to probe further and deeper into answers, whilst giving the respondent the opportunity to understand the questioning as they wish, reply accordingly and as receptively as they choose to any questions. This does not mean interviews are unfocussed, as an interview schedule or guide can be used as a means to concentrate the interviews on topics that are considered relevant and arising from the initial theoretical framework. It is worth recognizing that interviews, of themselves, are not simply accurate, representative or truthful, but are a “…means of analysing the ways in which people consider events and relationships and the reasons they offer for doing so” (May, 2011: 159).

In addition, the use of documentation in case study research can offer rich, alternative insights into events that occurred as part of the project under examination. These are defined as materials that can be read, were not produced specifically for the purpose of this or any other research study, are preserved and available for analysis and are relevant to the concerns of the research (Bryman, 2008). The benefit of documentation is that it offers another account of the stories and narratives that arise from interviews that help in confirming or contrasting the various accounts of how the project was enacted. May (2011) considers them to be the sedimentsations of social practices and thus documents should not be read as simply reflecting reality, rather they are written with a distinct purpose in mind, such as record keeping of discussions and decisions made as part of the case (Bryman, 2008).

Having considered the methodological orientation of this study, including the relevant paradigm, research strategy and research instruments, the following section will consider specifically the use of the research instruments in respect of the case of the EEML project.

4.3 Data collection and analysis methods

4.3.1 Data collection

Having established the general research approach and identified relevant and appropriate research instruments; following an adaptive and iterative process, an
empirical phase was embarked upon. Embracing a ‘naturalistic design’ (Lincoln and Guba, 1985), methods appropriate to qualitative research were adopted, primarily focussed on face-to-face interviewing with relevant participants. The process of ‘case selection’ of the resulting 22 interviewees, of relevant documentation and the analysis of the interview data is outlined below.

Phase 1 - selecting participants

This research study followed this case at the completion of the project in 2010 due to circumstance and serendipity as that is when the research study began and I was made aware of this recently completed project by, amongst others, an external academic advisor to this research. In selecting the individuals for interview, I worked with the external academic advisor, someone who was known to me as a previous academic supervisor and who was also, at one point in its lifecycle, a key member of the project. This allowed me to gain intimate access to participants.

In choosing a focus for the case of the EEML project, key person interviews of members of two groups were carried out, where there was some crossover of membership. The first group was the project team, who were responsible for operationalizing the project and who worked under the remit of the second group, the project steering group. Membership of both groups was clear, making the two groups discrete, bounded entities for research, although two individuals were members of both groups. By focussing in on these two groups, accounts, stories and histories could be compared and contrasted.

There does not appear to be consensus amongst the research literature as to what is an ideal number of interviews to complete (Bryman, 2008; Layder, 1998; May, 2011) although Polkinghorne (1989) suggests that between 5 and 25 interviews offers a good range of data. Sampling was therefore carried out purposively based on trying to understand the ‘how’ of the project and aimed to engage with a broad cross-section of relevant individuals in terms of both their professional background and the project and their representation of specific organizations (Bryman, 2008). Membership across both groups accounted for no more than 50 people and from that sample, in discussion with my supervisors and academic advisor, 25 individuals were initially targeted, of whom 21
responded, with ultimately 22 eventually being interviewed (see appendix 2 for details). The participants targeted for the empirical phase were approached based on availability and ability to offer a cross-section of views across the two groups.

Drawing on the research questions, an interview guide (see appendix 3) was developed to explore how individuals engaged with the change initiative and what practices, actions, interactions and processes took place within the EEML project. This attempted to elicit participants’ perceptions of the project, from their understanding of what led to it occurring, what its intended or perceived purpose was, as well as their engagement into the project environment through their role, who they represented and what they did in practice. It explored their views on particular events or incidents that unfolded during the course of the project, as well as their views on the MLCF and other relevant outcomes from the EEML project. Whilst structured to ensure those key themes were addressed, it did allow the interviews to follow an interactive, naturalistic and fluid manner and areas were covered in an inexact order (Bryman, 2008).

Key to the interviewing process is ensuring that the language used is appropriate to the participants involved; that it is ‘translated’ and ‘connected’ to their understanding. Easterby-Smith et al. (2008) cite the work of Pike (1954) who described the ‘emic’ and ‘etic’ perspectives; these relate broadly to an understanding of language that is ‘inside out’ (emic) or ‘outside in’ (etic) and that “…better insights can be gained into management and organizations through combining insider and outsider perspectives” (Easterby-Smith et al., 2008: 95). Whilst not overtly attempting that, this research is situated broadly within a neo-institutional framework; therefore, for example, the issue of ‘legitimacy’ (Suchman, 1995) can be one of many key considered concepts; but what does legitimacy – a potentially ‘etic’ perspective – mean to participants? In carrying out interviews, I chose to talk more in the language of ‘agendas’ or someone’s ‘take’ or ‘position’ on an issue so packaging what was asked of individuals in a way that relates to them – a so-called ‘emic’ perspective. Layder (1998) develops this theme by discussing how language and key words which are relevant to developing the research question can be usefully employed here. In discussing a change initiative, consideration of the use of the word ‘implementation’ as
opposed to ‘creation’, or ‘development’; or of the word ‘involvement’ as opposed to ‘engagement’, is central to ensuring the methods used result in the capture of appropriate data.

**Phase 2 – carrying out interviews**

A series of interviews were carried out between October and December 2012, with one final interview in July 2013. In total, 22 interviews were conducted. Participants were all members of either the EEML project team (n=11) or steering group (n=13), where two participants were members of both (appendix 2). The research participants were contacted to take part in face-to-face interviews at a time and location of their choice. The interviews each lasted, on average, one hour and were audio-recorded, transcribed professionally and resulted in over 194,000 words of transcript. The decision to use a paid transcription service was one taken to save both time, reducing the ‘time cost’ to the researcher and to draw upon the experience of a professional transcriber.

In conducting the interviews, I followed Bryman’s (2008: 444) guidance to be aware of: any unexpected interviewee behaviour; the intrusion of my own biases and expectations; aiming to maintain focus in asking questions and dealing with sensitive issues. Bryman (2008) also refers to Kvale’s (1996) ten criteria for successful interviewing such as being clear, open and critical within the interview, as well as having defined introductory, probing and follow-up questions (see appendix 3). I was mindful as well that often what is of most value comes towards the end of the interview as rapport has been established by that point and was conscious of leaving the recorder running (Bryman, 2008).

The following table represents the current or most recent roles of the 22 interviewees and their membership of the project team and/or steering group:
Table 4: Roles and membership of research participants

<table>
<thead>
<tr>
<th>#</th>
<th>Role</th>
<th>Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Doctor</td>
<td>Steering group</td>
</tr>
<tr>
<td>2</td>
<td>Doctor</td>
<td>Steering group</td>
</tr>
<tr>
<td>3</td>
<td>Doctor</td>
<td>Steering group</td>
</tr>
<tr>
<td>4</td>
<td>Administrator / Manager</td>
<td>Project team / Steering group</td>
</tr>
<tr>
<td>5</td>
<td>Doctor</td>
<td>Steering group</td>
</tr>
<tr>
<td>6</td>
<td>Manager</td>
<td>Project team</td>
</tr>
<tr>
<td>7</td>
<td>Manager</td>
<td>Project team</td>
</tr>
<tr>
<td>8</td>
<td>Academic / Manager</td>
<td>Project team / Steering group</td>
</tr>
<tr>
<td>9</td>
<td>Administrator / Manager</td>
<td>Project team</td>
</tr>
<tr>
<td>10</td>
<td>Doctor</td>
<td>Project team</td>
</tr>
<tr>
<td>11</td>
<td>Academic / Manager</td>
<td>Project team</td>
</tr>
<tr>
<td>12</td>
<td>Doctor</td>
<td>Steering group</td>
</tr>
<tr>
<td>13</td>
<td>Manager</td>
<td>Project team</td>
</tr>
<tr>
<td>14</td>
<td>Manager</td>
<td>Project team</td>
</tr>
<tr>
<td>15</td>
<td>Doctor</td>
<td>Steering group</td>
</tr>
<tr>
<td>16</td>
<td>Doctor</td>
<td>Steering group</td>
</tr>
<tr>
<td>17</td>
<td>Doctor</td>
<td>Steering group</td>
</tr>
<tr>
<td>18</td>
<td>Doctor</td>
<td>Project team</td>
</tr>
<tr>
<td>19</td>
<td>Doctor</td>
<td>Project team</td>
</tr>
<tr>
<td>20</td>
<td>Doctor</td>
<td>Steering group</td>
</tr>
<tr>
<td>21</td>
<td>Manager</td>
<td>Project team / Steering group</td>
</tr>
<tr>
<td>22</td>
<td>Doctor</td>
<td>Project team</td>
</tr>
</tbody>
</table>

**Demographics:** Males = 14, Females = 8; White British = 20, White Other = 2; for more details on the research participants, see Appendix 2

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**Phase 3 – documentary evidence**

Following the selection of participants and the conducting of the interviews in the agreed settings, the next phase involved interrogating the documents. Selecting what to consider I began by drawing up a list of what was available or known about the project. Bryman (2008) outlines a number of forms, from personal documents, such as diaries and letters, to official documents deriving from government and private sources, as well as mass media outputs and virtual resources, such as those from the internet. The project team themselves kept a catalogue of official publications, such as the MLCF and MLC, as well as media and promotional pieces in trade journals such as the Health Service Journal and British Medical Journal, within an internal project document, entitled ‘Internal briefing paper on joint Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement Enhancing Engagement in Medical Leadership project’ (and known internally as ‘War and Peace’). This 67-page document
encompassed the project's initiation and background, as well as its evolving plan, goals, risks and benefits. In addition, it outlined three phases in the life of the project, from an initial phase (May 2006 to March 2008), which did not account for the project's initiation in 2005 and then for each of the subsequent financial years of the project (April 2008 to March 2009; April 2009 to March 2010). Moreover, it outlined key achievements to date as well as next stages and supporting documentation. Access to this document came via the academic advisor and project manager, who were able to provide me with an additional thousand documents pertaining to the project. These included:

- Communication plans
- Project plans
- Steering group terms of reference
- Scoping study report
- Steering group minutes
- Project team minutes
- Presentations
- Analysis
- Test site documents
- Frameworks
- Press releases
- Equality impact assessments
- Reference group notes
- Undergraduate medical school survey results
- Spread and adoption plan
- Submissions from Royal Colleges
- Progress reports
- Interviews with postgraduate deaneries

Publically available documents included those from the website of the NHS Institute for Innovation and Improvement (NHSI), such as the MLCF, first published in 2008 and summary updates on the wider EEML project. Being mindful of practical impediments (May, 2011), I focused my use of the documents as confirmatory or contrasting analysis of the interview data and restricted my consideration to the Internal Briefing Paper and its list of supporting documents (n=237), some of which included the publically available ones. I chose not to consider the trade publications as my research question was focused more on the actions and practices of individuals as outlined in their own-word accounts and the contemporaneous accounts of meeting minutes. From this list of 237 documents, I again focused in on those that offered reporting of events
and decisions made, primarily project plans and summary documents, reports from the project team to steering group and notes and actions of meetings of both groups, which numbered 90 documents (appendix 4), as they were likely to offer the most insight into the process and enactment of practice and decision-making.

**Rolling phase**

In addition to the distinct phases outlined above, I undertook a rolling phase of data collection and capture through keeping notes in a research diary. This started with notes of meetings when I was gathering ideas for the research project in 2010 through the interview phase, notably in the immediate aftermath of each of the 22 interviews to note how the interview went, where it took place in terms of setting (e.g. office, public café) and location, as well as what I learned from the interview, including opening up any potential new avenues of interest (Bryman, 2008). I kept this note taking going through all the phases of the research process, including chance encounters and supervision meetings to ensure there was a constant process of reflection.

**4.3.2 Data analysis**

In qualitative research, it is difficult to separate the collection of data from its analysis (Bryman, 2008), such is the iterative nature of this research design (Hartley, 2004). Barbour (2008: 215) describes how qualitative data analysis encourages the researcher to “...worry away at the data” as a form of rigorous interrogation of that data. In this type of analysis, the aim is to identify themes that arise from the data.

To begin this process, all of the interviews were listened to several times to remind me of how they went, what themes were covered and not; and to allow for reflection on the notes taken immediately after the interviews had occurred. Following transcription, the interviews were listened to again and checked for accuracy. The next step involved choosing a selection of interviews at random for their varying and contrasting length (#5, #16, #21) which were listened to in more depth, repeatedly stopping and restarting the recording, alongside the transcriptions. This was to start to identify if key concepts from the overarching theoretical frameworks were included within the data (*a priori* coding), as well as to see what themes might emerge from the data (*in vivo* coding) (Barbour, 2008: 215).
I also drew upon Layder's (1998: 54) imagining of the process of pre-coding, or provisional coding, with “...an openness to the discovery of new and provisional codes,” which allowed a “...search for new codes and concepts...in tandem with the use of extant theoretical assumptions and relevancies” (Layder, 1998: 55). Then began a precise process of open coding (Bryman, 2008) to yield these types of *a priori* and *in vivo* concepts and the thorough identification of themes across all 22 interviews, using NVivo 10 software (QSR International Pty Ltd., 2012), which would also allow for future data manipulation and analysis.

A sample of the coding frame (figure 3) is below (see appendix 5 for the full coding frame):

**Figure 3: Coding frame or ‘template’**

<table>
<thead>
<tr>
<th>Level 1 Node</th>
<th>Level 2 Node</th>
<th>Level 3 Node</th>
<th>Definition</th>
<th>Linked to... (code / concept)</th>
<th>Source of Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actions</td>
<td>Behaviours (Behaving)</td>
<td>Mind-set, mental approach, personalities, attributes, OR actions / practices</td>
<td>Legitimacy</td>
<td>Lofland et al. (2006); Taylor and Gibbs, 2010</td>
<td></td>
</tr>
<tr>
<td>Credibility</td>
<td>Any mention of the word OR similar</td>
<td>Legitimacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Culture</td>
<td>Working culture “getting on with others” (#16)</td>
<td>Teams Organization</td>
<td>Org/Inst. Theory literatures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enthusiasm</td>
<td>passionate, keen etc. LINKED TO motivation of individuals</td>
<td><em>In vivo</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In the figure above, codes from theoretical, methodological and emergent concepts can all be identified and links drawn to other relevant codes. In seeking out codes, a number of variables or elements could be considered, such as a participant’s role in the project; their position or job; membership of a particular group or professional body; job and work experience; as well as experience and involvement in change projects. In coding the data and drawing on constructs from the research design and literature review, codes were grouped together to
become themes, some of which you would expect to see in research into a change initiative and others that were less expected.

Creswell (2008) describes how case study analysis should be both descriptive and thematic. The process should take the researcher from many pages of text, iteratively to tens of codes and ultimately to between five and seven themes. As the analysis of all the interviews followed the same pattern as detailed in figure 3, the end result was the creation of a thematic map (see figure 4) which identified major elements of the case.

**Figure 4: Thematic Map of “The Project”**

It was from this thematic ‘project map’ above that analysis of the data could be drawn together into related notions to create meta-themes, e.g. actions, from which pertinent concepts could be elaborated upon. This also meant that some codes were reviewed and compared for similarities and differences to others, or for other distinctions and patterns, resulting in some being left outside the core data for analysis.
By constantly returning to the research questions, the focus of the interview data analysis was towards the four meta-categories of ‘actions’, ‘drivers’, ‘outcomes’ and ‘working with others’ in trying better to understand the practices and process of change within this project. The documents were then analyzed in relation to those themes, looking for contrasting and comparative themes.

### 4.4 Quality and rigour

Research findings require scrutiny and debate, especially when they are within the field of policy studies (Altheide and Johnson, 2011) and research is often considered worthwhile through the framing of its reliability and validity. The evaluation of the same concepts within qualitative research differs from similar assessments in quantitative research because of the nature of its constructivist inquiry and, in place of reliability and validity, Lincoln et al. (2011) offer the constructs of trustworthiness and authenticity. Bryman (2008: 377) elaborates on the former as constituting four criteria: credibility, as a parallel to internal validity; transferability (external validity); dependability (reliability) and confirmability, in lieu of neutrality or objectivity (Boal et al., 2003).

Use of multiple data sources to triangulate qualitative data can help support the credibility of qualitative research, such as multiple interviews or reference to contemporaneous written accounts of events and occurrences. The issue of transferability can be established through the provision of what Geertz (1973) originally described as thick descriptions, “…rich accounts of the details of a culture” (Bryman, 2008: 378), which could be seen as equivalent to the presentation of views within the study of a defined and discrete project such as EEML. Dependability can be determined through the careful collation of research sources, from initial ideas, to research participant information sheets, to transcripts of interviews, as well as coding and analytical frames and further enhanced, where possible, through the use of multiple researchers, although that was not the case in this study. Finally, confirmability can only be determined in the auditing, inspection or examination of research, given that in a social constructionist world, objectivity is impossible (Bryman, 2008).

Turning to the concept of authenticity, Bryman (2008) outlines five further characteristics: fairness; ontological authenticity; educative authenticity; catalytic
authenticity and finally, tactical authenticity, where the four specific types of authenticity are directed specifically to members of the research setting, although widespread acceptance of them as influential criteria has not been realized. On the notion of fairness, however, Bryman (2008: 379) asks “Does the research fairly represent different viewpoints among members of the social setting?” and the aim of presenting data findings should be to ensure that all research participants are given a voice within the ensuing narrative.

4.5 Ethical conduct

The conduct of research that is ethical and moral is the cornerstone of any research study and there is an expectation that social researchers approach their work in such a manner (Denscombe, 2010). The key principles underlying ethical research stem from both the Nuremberg Code (1947-49) and the Helsinki Declaration (World Medical Association, 1964), enshrining the fundamental principle that “…the ends do not justify the means in the pursuit of knowledge” (Denscombe, 2010: 331). Four principles have been adapted from those to underpin the conduct of research and they are that it should protect the interests of the participants, including doing them no harm; ensure that participation is voluntary and based on informed consent; avoid deception and operate with scientific integrity and comply with the law of the land (Denscombe, 2010: 331).

This research began its life when I was working and registered for the period of study at De Montfort University (DMU). It is bound by the Economic and Social Research Council (ESRC) Research Ethics Framework and received ethical approval from DMU at the time of formal registration and acceptance onto the doctoral programme in June 2011. As the empirical phase of the research approached in 2012, a research protocol was drawn up to reflect changes in research design and the specific nature of the intended research strategy (see appendix 6). Health and social care has its own research governance framework (Department of Health, 2005), and whilst this research did not require formal NHS approval, it was important to be aware of the requirements of that.

In line with the four principles outlined by Denscombe (2010) above, the participants in this study were granted full confidentiality and anonymity. They were informed about the nature and the purpose of the study, the nature of their
involvement and their right to withdraw from the investigation at any time. Participants were also informed of their ethical rights, and what to do if they felt these have been violated by the research process. This information was included in the participant information sheet and consent form (see appendices 7 and 8), which they completed before participating in the study and it was made clear that their participation was voluntary. If participants had wished to withdraw at any point, they were informed that they would not have had to give any reasons for their choice, but none chose to do so. Of the 25 initially identified to take part, I was unable to make contact with three of them and the fourth declined the invitation, leaving me with 21 participants. However, I was able to make contact and interview a 22nd participant the following summer (2013). The findings that follow aim to protect the anonymity of individuals in the write up of the research, whilst trying to provide some context to their role, position and biography. Direct quotes, which have been used in the write up of the research, have also been anonymised. Permission to audio-record interviews was obtained from participants. In order to ensure anonymity, confidentiality and comply with the Data Protection Act (1998), all data has been kept secure with paper data and audio-tapes being kept in a locked drawer of which the key is in my sole possession. Electronic data has been stored on a computer and is protected using electronic passwords.

A further consideration in the ethics of this research project was my role and managing my insider-outsider (emic-etic) status. Pelias (2011) describes how the researcher may contaminate the research process and be implicated in the problem being addressed. Insider status refers to membership of the group under investigation and although I was neither a member of the project team nor steering group, I did know some of the research participants professionally and by association and reputation having worked in the field of health care management and leadership since 2000. One of the research participants was known to me as a former academic supervisor and early on had been an external advisor to this research, helping to facilitate access to the research site, participants and relevant data, such as project documents. Another had been a manager I had known during my own training as a health service manager. With this, I was part insider, part outsider and was aware of how this might influence the direction of the study, not only because of my own biography, bias and
viewpoints, but also because the history of medical leadership in the NHS meant my questioning and analysis could be deemed potentially to be sensitive within this context.

I had worked with other managers and doctors delivering health care between 2000 and 2007, many of whom had been asked to act as leaders and service developers and could not disassociate those experiences from my interest in this research area. I did not reveal my background or work experience in my invitation letters (see appendix 9) but it was something I did not hide if it became relevant to the conduct of the research, especially around building rapport with participants regarding the subject matter. With some participants this was more successful than others in terms of eliciting responses and resulted in varying discussions of interest as well as varying lengths of interviews.

4.6 Chapter Summary

This chapter has considered the methodological approach to the stated research questions and discussed relevant paradigms, research strategies, methods of data collection and analysis; as well as reflecting on issues of quality, rigour and ethical concern.

In terms of methodological limitations, the purposive selection of interview participants who were integral to the EEML project is one way in which processes can be understood in their context, yet it is also evident that by restricting the sampling to them, other potentially dissenting voices outside of the EEML ‘tent’ may have been excluded. The analysis that follows attempts to address this issue and by necessity, stories of change are understood by interaction with those who managed to be part of the story. Moreover, although a narrative inquiry approach was not adopted (Boje, 2001), there are always concerns and debates about the ‘truthfulness’ of conducting one-off interviews, rather than repeated interaction with relevant participants. Due to the nature of this research design being retrospective, this is less of a concern, than it might have been had the case study been conducted prospectively. In addition, there were pragmatic considerations of gaining repeated access to participants and given the nature of modern electronic communication, I was able to negotiate the ability to check my understanding of interview responses via email. Linked to this is the cost of
conducting fieldwork in terms of both finance and time for travel and the opportunity costs of not continuing my work as an academic. Finally, a limitation in any research will always be the skill-base of the researcher and this is undoubtedly true in this study as well.

The following chapter outlines the findings from the research study beginning with the presentation of evidence in chapters 5 and 6 and followed, in chapter 7, by the thesis’ empirical and theoretical contributions, before consideration of alternative explanations of the evidence. Chapter 5 outlines the perspectives and views of participants of the environmental conditions at the time of the project that led to the change initiative, along with their perceptions of the project’s purpose. It also details their own and others’ motivations for engagement.

Chapter 6 then picks up from chapter 5 to assess how the project worked in practice, again from the viewpoints of research participants, focussing in on their practices, actions and opportunities taken to enact the change initiative. Subsequently, chapter 7 draws together the findings from chapters 5 and 6 and with reference to theoretical constructs outlined in chapters 2 and 3, offers the empirical and theoretical contributions of this research study.
Chapter 5: Findings: the prevailing conditions, purpose and motivations behind the project

5.1 Introduction

This chapter focuses on exploring and describing patterns and themes that emerged from the data collection and analysis as outlined in chapter 4, focussing on the 22 interviews with research participants and use of supporting documentary evidence. By doing so, it aims to build a logical chain of evidence (Miles and Huberman, 1994) towards the following chapters, 6 and 7, the latter of which links back to the theoretical base introduced in chapters 2 and 3 and which also offers the main contributions of the thesis. It will also draw upon elements of the theoretical constructs outlined in previous chapters to connect these empirical findings to the later contributions.

The chapter is structured in the following way. Firstly, it will explore the environmental conditions that led to the creation of the project, many of which can be seen paralleled in chapters 1 and 2, including the particular exogenous and endogenous factors that led to the project happening. From there, it will examine the purpose for the project and the motivations of individuals to become engaged with it, building on those existing environmental conditions. It will then look forward to chapter 6, which outlines the practice and approach adopted within the EEML project.

5.2 Right time, right place: the prevailing environmental conditions leading up to EEML

5.2.1 Introduction

This section will examine the reasoning, perceptions and thoughts of interview participants and outlined in project documents as to what led to this project occurring. It will describe how prevailing environmental conditions, as well as a number of events and incidents help to explain why the project took place in this particular time and space of the NHS story. It will begin by outlining the factors that participants considered to be relevant in bringing about the prevailing environmental conditions, such as the publication of a report in 2005 by the Royal College of Physicians (RCP), the early years of health sector reform which date
back to the 1983 *NHS Management Inquiry* (Griffiths Report) and the continuing resonance of various adverse events within the health service, including the cases of the Bristol Royal Infirmary and Dr. Harold Shipman.4

### 5.2.2 General conditions for change

A number of participants were unable to pinpoint an exact reason, or ‘driver’ for the inception of the EEML project but did talk about a conflation of reasons, summed up through this participant’s thoughts:

> The reason that the project was able to start at the time that it did was because there had been several things that had happened...Bristol Royal Infirmary being one of them had identified the lack of clinical leadership...And the Royal College of Physicians developed the document, ‘Doctors in Society’ [in 2005] and it clearly stated that clinical leadership was absolutely essential if doctors were to maintain and develop their sense of professionalism...but it’s taken a long time for it to be recognised and for it to dawn on people that this is important. So there is something about a growing sense of, ‘we have got to do something’ and in a broader sense, that compact between doctors and the public had started breaking down because of the number of incidents. And that led to the Doctors in Society report, it’s like, ‘as the medical profession, we’re in danger here that if we don’t do something about this, and actively demonstrate that we are making every effort to make sure we are professional, that we are safe clinically, that we’re looking for good quality outcomes, that we can regulate ourselves, then the profession’s going to be in a lot of strife’. So that set the scene. [#4, manager, Project Team (PT)]

Building on the above, the following excerpt pieces together how two of the events mentioned, namely child deaths at Bristol Royal Infirmary in the 1980s and 1990s and the subsequent Kennedy (2001) report, followed by the 2005 *Doctors in Society* report from the RCP had acted as a wake-up call to the profession to look at itself to change:

> We’re here because there are things we, as doctors, don’t do. So there was a fundamental rethink and part of that is a reality that doctors don’t engage, and what were the systems and levers that actually mitigated against that happening... when I was appointed as a [role], I felt I was the [role] for a geographical patch of about 600,000 people, and my job was

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4 The Bristol Royal Infirmary Inquiry took place in 2001 in response to higher than expected death rates in paediatric cardiac surgery between 1984-1995, where poor leadership, staff shortages and a culture of secrecy were blamed (Kennedy, 2001). The Shipman Inquiry was an independent private inquiry into the practices of Dr. Harold Shipman, a GP, which took place in 2000 after a criminal investigation into Dr. Shipman, who was found guilty of the deaths of at least 15 patients in his care (Shipman Inquiry, 2002, 2005).
to give those people the best care I could within the resources I’d been allocated, which was basically me, a ward, a few nurses and [diagnostics]. So that’s why consultants were employed before, and the shift came when we had the provider/purchaser split [in 1990] …But perhaps what we left out of that was the role that doctors give themselves in actually leading health services and trying to improve the health of the population. And now we’ve got to get back to that Muir Gray bit, which is, these are the resources we’ve got, how do we get best value health care for those resources, what evidence base are we going to use, what are the outcomes that the public wants. And perhaps that bit of engagement with the public and patients is something the medical profession never did. [#10, doctor, PT]

This description considers the role of a key policy change – the purchaser provider split from the NHS and Community Care Act (Great Britain, 1990) – as particularly relevant in changing the relationship between doctors and the public. It also describes a perspective of how to work more holistically towards achieving the aims of the NHS. Other participants continued this theme, looking back at policy initiatives from the 1980s and 1990s from which this project emerged:

…if you go back to 1985 when [there was] wide recognition that the NHS was significantly under managed and that it might be helpful to develop a management cadre, then in words of the Sainsbury’s report [Griffiths], the idea of [a] management cadre, of a board was developed and finally Trusts were developed. And so the cancer systems were set up in the late 90s because of the recognition that we didn’t measure up against European outcomes. And out of that came quite a lot of the discussion about what leadership means in terms of the delivery of outcomes…And as we reached 2000 and the Blair years, the language started to change around what you could do to do service transformation, how you could make things happen. And it became logical to have a leadership framework in the absence of anything else. So it took 15 years before it was okay to have something like this. [#15, doctor, Steering Group (SG)]

This perceived reality was also mentioned by another participant, alongside some other factors, such as clinical governance, the Shipman scandal and medical revalidation:

…management became a dirty word. We really lost it as a profession 30 years ago at the time when they introduced general management...there was almost a complete opting out and that then becomes a generational effect and almost a competition, fighting between the politicians, managers and the doctors…so that’s given anything that looks like management a bad name…. the whole way medicine has evolved over the last 15 years, clinical governance coming in as a concept in ‘97, the Bristol inquiry and responsibilities on yourself, Shipman, we all know that these have been big changes now, the introduction of revalidation. So it’s part of a culture
that is changing the role of the doctor and patients’ expectations. [#5, doctor, SG]

This last excerpt also describes how there was a perception of a need to redraw the relationship between doctors and patients around what could be expected of medicine and the NHS. The same participant also felt that the introduction of the European Working Time Directive (European Commission, 2003), which was fully implemented in 2009, became a critical factor:

…the European Working Time Directive reduced the amount of time available so we need to be much more explicit about what people need to learn and to show that they had done it with what was clearly far less patient contact time...that was one of the big drivers...and public expectation has changed and equally accountability. If your chief executive appoints a new obstetrician and they can’t do a caesarean section you might wonder what the deanery has done in order to sign them off, say they were fit for purpose and able to apply for a consultant job. Similarly now, you might feel that if they are incapable of working in a team, why didn’t you deal with that in their training… you are not just looking at what you have done in your operations but how you have functioned on the ward round. [#5, doctor, SG]

This viewpoint begins to describe how one respondent saw the role of the doctor changing alongside change in the service delivery model of health care, away from individuals towards further team-based working. This was cited by another participant as being a relevant driver for the initiation of the project at the time it began:

When I was a junior doctor on the medical rotations…you saw people dealt with pretty shabbily, nursing colleagues talked down to, and that’s progressively become more and more unacceptable, there is no area of medicine that you can deliver any care on your own. And some of the specialties were quicker off [the mark], so psychiatry, general practice, you have to work in good teams, if you don’t get on with your district nurses it just doesn’t happen, your palliative care, diabetes care, it’s all team based care. And you’ll ring someone to ask for advice and it actually won’t bother you if it’s a nurse or a doctor, you ring the best person…So I think it was an evolution. I do think if you go to other areas, in Scandinavia, the Netherlands, where you have population based care, you are more likely to find it as an ethos…So I don’t think it was 2005-2006, I don’t think that was particular at that time, I think it was just evolution. [#19, doctor, PT]

This excerpt picks up on a conflation of factors and cultures changing elsewhere in Europe. More broadly, efforts were under way to introduce leadership and management development as training for doctors:
There were some ancillary things happening at the same time which supported all of this. So the King’s Fund and the British Medical Association and the Academy of Royal Medical Colleges prompted by things like Shipman were running a series of programmes that involved every medical school in England around understanding professionalism and there were publications from both the King’s Fund and the Royal College of Physicians about this broader more intangible aspect of medical practice that is often summarised as professionalism within which management and leadership is one component. [#22, doctor, SG]

What these excerpts are describing is a change in the societal ‘temperature’ created by a gradual evolution of events and health care delivery practices, that could all be summarised as ‘general conditions for change’, rather than the project being borne out of one ‘big bang’ or exogenous shock. Indeed, the Scoping Study report of May 2007 (appendix 4: document 3) also discussed the impact of the Kennedy Report (2001), as well as the requirement of the role of doctors to widen to encompass newer models of working, including more focus on team-based working. Previous governments had attempted initiatives to engage or involve doctors in the management agenda, as discussed in chapter 1, but somehow any lasting change had not been sustained. However, as with others, these respondents felt something was changing:

… leadership was not just about NHS management, every doctor has a role in leading a small team of people or students or whoever else around them, he will be leading patients sometimes and therefore everybody needs to know how to do that, not just people who are about to become consultants and the only way you are going to get things learnt by all doctors of all levels is by exposing them all to it relatively early on in their life… there was work going on in various colleges around leadership…I don’t think any of the things that happened around that stage particularly made this imperative, it was just a natural evolution that people were concerned as to what was happening to and in the profession and that we needed to get something done about it. [#20, doctor, SG]

There was much more of a universal as opposed to sectional acceptance that these skills [were] essential for us to tackle what everybody saw was coming. Nobody saw the credit crunch but everybody knew that we couldn’t carry on expecting to see the service develop in the way that it had done in the past…There is more acceptance that this is legitimate activity. What would have happened ten years before would be some colleges in particular would have said this is nothing to do with us and not something we are interested in. And now none were saying that. Some were much more active in their engagement than others but none were saying this is not legitimate activity and it’s something we don’t want to get involved in. [#22, doctor, SG]
These are describing a certain acceptability or tolerance by a number of key organizations, responsible for the policy and strategy of medical education and professionalism to be involved with change. Indeed, medical professional and regulatory organizations were amongst those to recognize this along with the wider profession.

This section has attempted to outline the various factors that respondents gave as reasons for why the EEML project was able to take place when it did. No one single factor was identified as the prime cause of the project’s inception. However, whilst some of these events included responses and reactions from within the medical profession, notably the RCP report of 2005, the next section will outline many more factors that were identified as coming from within the profession to bring about the opportunity for change.

5.2.3 Changing professional attitudes?

Introduction

Whilst chapter 2 has already outlined the changing nature of professionalism and the impact on the medical profession, participants corroborated this sense of a changing of professional support for greater engagement from within the profession itself. A number of themes emerged from the interviews, amongst them a growing acceptance and, in some cases, enthusiasm amongst younger doctors for greater engagement and development, acceptance from the medical ‘establishment’, specifically the recognition by the Postgraduate Medical Training and Education Board (PMETB) and the British Medical Association (BMA) of the need for management and leadership development, as well as a move away from the traditional ‘resistance’ of the profession to management as an accepted concept and occupation. This evidence was confirmed by the documentary data analysis, notably the enthusiasm from medical school and junior doctor feedback for the development of leadership skills (appendix 4: steering group minutes and progress reports, documents 83 and 97). Much of the recognition for change from within the profession was linked to initiatives from the Department of Health in concert with medical leaders, such as Modernising Medical Careers (Department of Health, 2004b) – a factor that was also cited in Project Summary of May 2006 (appendix 4: document 1) – thus also making these partly exogenous changes.
The role of doctors

The ‘traditional story’ of medical involvement in management, be that medical professional views towards government policy initiatives or day-to-day operations with managers in health care organizations, talks of attempts to control on one side and efforts to resist on the other (Allen, 1995; Marnoch, 1996; Willcocks, 1998; Degeling, et al., 2003). This was something that was grasped by participants, as outlined in the following excerpt:

And I think there was a lot of struggle going on about maintaining status quo and people’s reluctance to change, personal and organisational...it was acknowledgement that doctors couldn’t sit outside the tent any longer, because a lot of the barriers to organisational change were coming from the medical card being played saying, we don't agree with you...So part of it was a recognition about... ‘going to the dark side’ that people quote. So it was much more around a recognition [that] we need doctors to be very much in the driving seat. And this was ahead of reform agenda, of course, but recognising that doctors had an absolute essential role to play, and a responsibility actually... [it was] always recognised that this could be working so much better if you didn’t sideline and exclude probably one of the, if not the most, influential professional grouping within the system... [#13, former senior manager, PT]

The notion of the ‘dark side’ is about giving up sole dedication to one’s medical career to work in a management and leadership role, which had been something doctors had been historically reluctant to do (Spurgeon et al., 2011). One particular participant recounted their efforts in trying to engage doctors in training as a doctor:

I gave a series of lectures on how money came into the health service, how decisions were made within the National Health Service. And I got the very worst ratings from the students on those lectures of any I’d ever given. The students had absolutely no interest or involvement in this and yet within a year or two they were going to become quite significant players within the health service. And [they] had really no understanding of how decisions were made and how money passed down from Parliament to patient care...they were much more interested in how to take the blood pressure, how to treat patients with conditions. And I think that’s a significant priority but knowing how the organisation that employs you works is also quite important...the profession was diffident about it and not quite sure whether they were crossing the line and working with the enemy. [#16, doctor, SG]

One of the reasons that the profession may have been unsure as to where or how to position itself, and hence be seen to be reluctant or resistant, was
described by one participant as an uncertainty as to the merit of involvement in medical management, as it was seen to lack credibility amongst professional peers:

…well certainly when I was training, and long after that, it was considered the dark side. And if you were any good in academia or any good even as a very good clinician, because that’s what we respected, then to do this was because you weren’t good enough to do either very good teaching, very good academia, or very good research. And so when I became [role] at [organization] people thought I had really lost my marbles, what is the matter, has [name] really gone over to the dark side? So it wasn’t a credible thing to do in some circles, not all circles and therefore it wasn’t what you did if you really valued your colleagues’ opinion…it didn’t have kudos at that time. [#17, doctor, SG]

This participant then describes how there was the beginning of a shift in professional attitudes:

I think that has changed considerably and it’s been helped by all sorts of things like the CMO [Chief Medical Officer] had his young fellows shadowing him, who had a year off to develop this sort of skill. We had the Darzi fellows, we had the schemes that the Health Foundation had for supporting people to go abroad, there’s the Harkness fellowships. A lot of things have happened since then that have made it perfectly reasonable for doctors to be engaged in management, improvement issues. So I think it’s completely different…I think it was a growing thing, I don’t think there was any one time when this happened. But I think when you started to get people like myself and other people who had been good at other things, starting to say this is a good thing to do, then it started to get momentum…it just took time and also of course the changes in the health service. You know, really once Griffiths had got into action it was almost inevitable that you could either put your head in the sand, which was a really daft thing to do, or you could start to see that high quality health care needed all of these things. [#17, doctor, SG]

Like many others, this excerpt describes a combination of factors – this time, including the role this individual saw themselves playing – in helping to create the conditions for acceptance by the profession to change. Aligned to this, the participant also saw that the profession reacted to perceived increases in power towards managers:

Most doctors, I hope it’s changing, always saw the person in front of them, not the population, not the life of the hospital as a financial or managerial entity. And this project was really testing them to move beyond the direct patient therapeutic intervention and that was challenging…life was moving on and they were seeing that managers were getting increasing powers.
and the old regime was not going to work anymore, at least the more intelligent ones saw that... [#17, doctor, SG]

What these excerpts describe is a change in professional attitudes, triggered by a number of different causes and a gradual letting go of 'old' ways and adapting to a new reality. One related theme that emerged from the interviews that may have hastened this change was the mind-set shown by younger medical professionals, those typically in training posts, towards management, leadership and service improvement issues. That particular shift in attitude is exemplified by this example:

*We talk a lot about the hidden curricula, which, a lot of what a student or a junior doctor learns, is from the person immediately above them or two or three levels above them, who may well have been trained in medicine forty years ago, they're still practising medicine, hopefully they're still reasonably good at it, but the world has, in every speciality, changed beyond belief...it takes a hell of a long time to train a doctor, even the ones who are about to finish their training, what we call, CCT level, ST8. Well that implies, probably they entered medical school fifteen years ago, which is still quite a long time ago. So that sixty-year-old will probably still talk about hospital administrators and be fairly dismissive about the whole thing, whereas someone in their second or third year at medical school probably is seeing this framework as part of their curriculum, is starting to think, actually this is very interesting almost irrespective of what might happen. [#6, manager, SG]*

This upturn in interest was not limited to training doctors, as this participant describes:

*...we had some pilot medical schools who had little groups of enthusiasts up and around doing it...a whole load of medical students going to do a BSc in Medical Management linked to the Business School, something like 60, so large numbers and they absolutely love it, they get really enthused. [#18, doctor, PT]*

This specific shift in professional attitudes amongst the newer generation of doctors appears to be one of the contributing factors towards an impetus for formal changes within the profession. To this point in their understanding of the factors that were changing from within the medical profession, whilst attitudes were largely still entrenched in particular ways of thinking that government was at odds with the profession, participants felt there was a growing sense of optimism, amongst trainee doctors in particular, and a realization from the wider profession of the role doctors had to play in the reform agenda. In many respects,
this typifies the sense that professional thinking continues to evolve, much like the arguments of Abbott (1988) and Freidson (1986) with respect to professionalization projects.

Influences on professional change

Further events were seen as important driving forces for the project, at the time of its inception. Participants mentioned the impact of Agenda for Change, introduced into the NHS in 2004 (Department of Health, 2004a) as a new pay deal for staff, excluding doctors, but which caused the NHS to reflect on roles and responsibilities, especially after the introduction of a new medical consultant contract the previous year. The Postgraduate Medical Training and Education Board (PMETB) had also carried out its own work into what medical training should include and this was described by one participant:

…it was a time of investment and a time of ability to do; you know, your back’s not against the wall but equally performance did matter. But it was more about the profession. PMETB were doing the surveys that said there was no leadership development…the big message was, most of them were leaders in their own right, even the junior docs were, they were heads of BMA groups, they had got where they got to by opportunistic means and that they had had no preparation to do that in any way whatsoever. And the group felt that wasn’t right, that it should be more open…that their training they had experienced was lamentable in terms of actually preparing them for the whole gamut of their work. [#14, former senior manager, PT]

Such work was described in the EEML’s Scoping Study (May 2007), referencing PMETB’s Strategy (2006-10), which cited communication and leadership skills, multi-disciplinary team working, quality assurance, review and evaluation, amongst other factors, as relevant for the modern medical professional (appendix 4: document 3). On top of that, there was a growing sense that this was important for not only PMETB and the British Medical Association (BMA), but also the General Medical Council (GMC):

I think largely it was because the [GMC] were getting a sense from their membership that it was something that they wanted and were interested in…especially with the GMC that was the main reason there was a bit of a shift, because initially doctors weren’t really asking for it, but then as time went on it was, ‘well, hang on other professions are doing this, why aren’t we doing this?’ So the GMC as an organisation woke up to that a bit and said, ‘right, well we need to help provide this.’… And the BMA as well and
even some of the publications, BMJ and HSJ, we noticed a bit of a trend...people were actually willing and wanted to talk about leadership and management. [#9, administrator, PT]

One participant deemed the setting up of the Medical Training Application System (MTAS)⁵ in 2007 as part of Modernising Medical Careers (MMC, Department of Health, 2004b) as another contributing factor to change. MMC was an initiative that came from government and medical leaders to reform medical training for all grades up to Consultant and was driven by the following narrative:

“Reform had been long overdue and was driven by the need for care based in more effective teamwork, a multi-disciplinary approach and more flexible training pathways tailored to meet service and personal development needs. It also foresaw more care being provided by trained doctors and recognised that existing training systems fell short of modern needs. Training also needed to be brought more in line with best practice in other countries. Above all the driver for change was the need for better care systems for patients” (Modernising Medical Careers, Department of Health, 2004b: 1)

Whilst the MMC initiative could be seen as an exogenous factor, the way in which medical leaders acted in respect of MTAS, which became heavily criticized by the wider profession, was seen as crucial by the same participant, who described it as a ‘debacle’ due to a lack of unified leadership:

The profession got badly hit with the MTAS debacle in 2006-07...It wasn’t speaking with a unified voice, it was disjointed, there was marching in the streets because people thought that doctors were going to lose their jobs. That was a turning point for quite a few people in higher places, who felt that we needed to be much more coherent in our leadership messages and therefore we needed to be able to develop leaders. And we had no mechanism at all, it really was Biggins’ turn...the presidents of royal colleges felt they had taken the eye off the ball...the reality is, that was a turning point for them and they did feel that what the profession lacked was leadership and it was a big issue. There were two big faults, one communication...and the other was leadership and no leadership was shown at the time or not sufficient leadership and what was, was too late. So I think that toned people up to thinking, well, we need to have people who can rightly do that. [#3, doctor, SG]

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⁵ This was an online application system, set up as part of Modernising Medical Careers, through which doctors in training were required to apply for posts. It asked questions of candidates which would be used for shortlisting them for interviews and gave greater weighting to their short answers rather than prior experiences or qualifications, which was criticized by the medical profession. The profession’s lack of support ultimately led to its failure.
The significance of the problems encountered with MTAS was one of the factors that led to the inquiry by Sir John Tooke into Modernising Medical Careers (Tooke Report, Tooke, 2008). Following the publication of the Tooke Report, the organization responsible for postgraduate medical training, PMETB, was formally subsumed into the GMC, who were responsible for undergraduate education and medical regulation, in 2010. Early discussions of this merger had started back in 2007 and this would become relevant as the project started to look to embed changes through the GMC after 2008 (appendix 4: documents 85-87, steering group minutes).

Another key event that acted as a driving force to sustain the momentum of the project during its lifecycle was Lord Darzi’s Next Stage Review and subsequent report, High Quality Care for All (Department of Health, 2008). This was mentioned by a number of participants:

… Darzi’s what are we going to do to make this all work was often framed in, we’ve got to have clinical leaders if we are going to transform health services, shrink hospitals, get care out into the community, develop, the translation of academic medicine into care at the bedside and so on and we need leaders to do all of that. [#15, doctor, SG]

And then Darzi came along…recognising that things don’t just happen that everybody has to take responsibility and leadership…that everybody had to be a practitioner, partner and a leader…And again showed that culturally the time was right. [#19, doctor, PT]

Darzi by 2008 was very much then banging that drum…his whole reforms really are around greater clinical engagement and greater clinical leadership, that was the reform. [#21, academic/senior manager, PT/SG]

What participants are describing is how a number of factors, in this case, the work by Lord Darzi on behalf of the government into the state of the NHS, contributed to the momentum of the EEML project. As with MMC and MTAS, it is difficult to draw a precise line between these as exogenous factors of change and those that came from within the medical profession, given the intertwined nature of professional policy development.

5.2.4 Summary

In the excerpts outlined above, there was a realization that leadership development for doctors was not just something recognized by one profession or organization, but was something that was generally seen to be the ‘right’ thing or
simply a good thing to do. However, the history of medical engagement that dates back to the early years of the NHS, as outlined in chapter 1, tells us that there had been many previous attempts to integrate and engage doctors into the management, administration and leadership of the health service, but without long term sustainability or success. This could be attributed to long-standing conflicts of logic (Reay and Hinings, 2005) within the NHS field.

However, through the excerpts above, a number of reasons were given to describe why the EEML project occurred when it did. Questions regarding the current and future role of doctors were being asked, whilst there were other influences, external and then internal to the profession, that provided the prevailing field-level conditions to allow the EEML project to happen. As summarized by this participant, an argument could be made that it was a culmination of these aforementioned events that led to the project:

*Well I know people talked about appraisal and revalidation as push factors. And maybe it was that, the old force field analysis, there were just at that point enough push factors around, together with pull factors the other side, to make something happen on that occasion whereas previously it hadn’t.* [#11, academic/manager, PT]

What was becoming clear was the interest of a number of key actors within the medical profession and realm of medical education and medical leadership, combining with each other, at a time of particular environmental conditions:

*…compared to the decade before, the thought that you would get all of the colleges and faculties, being not only comfortable but actually wanting to be involved in the process to codify the skills associated with medical leadership was a really good thing.* [#22, doctor, SG]

As Battilana and D’Aunno (2009) recount, these individuals are demonstrating an awareness of the prevailing environmental conditions discussed above, which can be summarized as follows:
Figure 5: Prevailing conditions

<table>
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<tr>
<th>1980s/90s</th>
<th>2000s</th>
<th>2010s</th>
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Whilst these conditions help to explain the project’s arrival in 2005 they do not inform us as to how the project was able to successfully integrate leadership development into medical education with the publication of the MLCF in 2008. However, through the awareness of a collective of individuals, informed by their past, but also oriented towards the future and toward the present (Battilana and D’Aunno, 2009) and building on the environmental conditions which acted as driving factors, individuals were able to conceive of a purpose and link it to the changes above.

The next section will consider in more detail that purpose, how it was linked to these changes and what motivated individuals to join the project.
5.3 Right people, right project: purpose and motivations

5.3.1 Introduction

In light of the conditions that existed in the NHS leading up to 2005, the next topic that was explored with participants aimed to establish a better understanding of the purpose of the project and their motivation for engaging with it.

5.3.2 The project purpose

The background to the project was spelt out in the aforementioned Scoping Study report entitled *Improving the effectiveness of health services: the importance of generating greater medical engagement in leadership* (NHSI, 2006: 1 – appendix 4: document 3). This was written around six months into the project:

> Medical training has traditionally focused on the clinical skills necessary to be a safe and competent clinician, but with the move to more team based practice, delivered within a managed system, it is increasingly important that doctors are not only competent clinicians but also have a wider set of skills to enable them to function efficiently and effectively within a complex health care system.

At that time, six project goals were espoused (NHSI, 2006: 2):

1. Create a culture of managerial competence amongst doctors
2. Secure greater medical engagement in management and leadership with all doctors at every level
3. Inclusion of appropriate management skills into “fitness to practice” requirements at both undergraduate and CCT levels
4. Identify and disseminate examples of best practice of medical engagement in management and leadership
5. Develop a holistic medical management and leadership framework from undergraduate education through postgraduate training to specialist roles
6. Create clearer links with management and leadership in other health professions and social care through inter-professional activity and work being done on competency frameworks by the two sector skills councils.

These did evolve as the project went on so that by 2008 and through to the end of the project, there was one central goal (NHSI, 2010: 1 – appendix 4: document 6):

> Create a culture of greater medical engagement in management and leadership with all doctors at every level.
The original project summary document (appendix 4, document 1) describes how initial scoping studies were carried out between November 2005 and March 2006 to assess the current extent of medical leadership development provision. A key player in the inception of the project was the Department of Health. Individuals within that organization facilitated the approach to the NHS Institute and together took the opportunity that arose from the environmental conditions for change to initiate the project, with the Department acting as the funder and sponsor. This was picked up by a number of participants and helps to explain some of the purpose behind their involvement with the project:

*I think there was recognition that the system was heading for major difficulties...we were half way through a ten year NHS Plan and at Department level, it was, ‘are we going to get to where we need to get to?’ Because that ten-year plan was about investment but it was also about a huge transformation.* [#8, academic, PT/SG]

*I think the Department of Health became frustrated by the inability to bring about change as quickly as they wanted to and they realised that if doctors were driving the change it was likely to happen more quickly. So therefore why don’t we skill up the doctors to deliver the change?* [#12, doctor, SG]

*A lot of the language changed at the time of the Labour Government in 97...there were indicators that people weren’t going to get to where they thought they were going to with that ten-year plan...* [#13, former senior manager, PT]

Triggered by some concern that the reform agenda would not be met and the prevailing conditions outlined in the previous section, some participants elaborated as to how particular actors took a leading role:

*So you had [X] as the President of [organization], which is obviously one of the largest colleges and quite influential as well and also chair of [organization]. You had [Y] who was the head of [organization]. You had the Department of Health starting to take an interest in this and NHS Employers. So you had both the medical profession and you also had the health service at the same time both saying, ‘this is an issue, we need to do something about this’. And having those very influential people all agreeing to get something happening and get something started, it just made it work... And actually when they came together and said we are going to focus on this, things changed within 12-24 months...it creates that momentum. And all the blockages get removed so something can actually happen...when you have got the right people in the right place at the right time with a shared sense of something has got to be done about this, and we want to do something about this, and we will do our utmost to make sure something happens, then things happen....* [#4, manager, PT]
...the atmosphere had changed and a lot of that is down to some individuals, [X] very much so, the CMO probably, subsequently Bruce Keogh. Nigel Crisp was very positive about a lot of the leadership agenda...[and] he was the first person to try and begin a process to look at talent management for these kinds of things. Andrew Foster got really enthused by the health improvement movement...people had been at this for 20 odd years, they were coming towards the latter end of their careers [and] saw this as an opportunity to get this to a point where things simply couldn’t go back to the way they were before. [#22, doctor, SG]

The excerpts above describe how the changing conditions had encouraged the Department of Health more generally and a few organizations and individuals specifically to come together in response to the prevailing conditions to bring about the project. Whilst these may help in understanding the ‘official’ reasons for the project, participants also described their varying views regarding the purpose at the heart of the project. These can be summarised as concerns about the quality of medical leadership training in the NHS and so the project was borne out of a need to instil knowledge, skills, behaviours and attitudes and embed those ultimately through a form of competences into medical training. This purpose is also supported and confirmed in a number of project documents, notably plans and progress reports (appendix 4: documents 4-6, 97). As one participant described it:

So it wasn’t an optional extra, it wasn’t something that you chose to do a module on, but when you were doing your clinical work on, say, diabetes, that communication, working in the team, developing the service, were all part and parcel of being a doctor. They weren’t additional things. [#7, former senior manager, PT]

Working with medical colleges and through their specialty medical curricula, this project was deemed by participants to be about more firmly basing leadership within the profession and giving the profession a specialty-wide consistency.

*Linking purpose to change and letting the project emerge*

In addition to the above, there were two other themes that emanated from asking participants about the purpose of the project: firstly, there was an emphasis that the sort of fundamental change in working practice described above was important to link into:
This was not another set of boxes they were meant to be ticking; this is about how you work in a changing environment. So I started off talking about the environment, how it had changed...Doctors are older, many married, dominantly female. So you have a whole group dynamic change. And we have to fit ourselves to manage...So where is the leadership, where is the change, it's about working within the teams you are in and getting to understand how they function, being able to move to different settings and be flexible throughout your career...understanding yourself, just recognising it's a changing world and you have got to be fit for it. [#1, doctor, SG]

If you looked at where innovation was going to come from in the future, it's never going to come from uni-dimensional teams anymore, it's multidisciplinary teams. And if you look at some of the most amazing research being done in the clinical field, it's true partnerships with engineers and material scientists and IT specialists, and it's all of their skills together, which make the breakthroughs now. And not one discipline can do it alone. So that concept of teams being led by the right people to lead the team at that particular moment. And sometimes it might be the doctors, sometimes it might be the nurse; it can sometimes be the patient who will give you some of those breakthroughs. [#7, former senior manager, PT]

Both of these excerpts have emphasized a further change towards multidisciplinary team-based working; moreover, it was something that applied to every doctor, because of the inherent nature of their roles:

We had to make it abundantly clear that while relatively few doctors would occupy formal management positions, all doctors had a real management issue, not least because they were managing patients, therefore whether they liked it or not, they were managing resources. [#16, doctor, SG]

The patient group were astounded, ‘how much do you pay doctors and you don’t give them any management training?’ The groups are full of quite high flying people and they just couldn’t understand what the NHS was doing in asking the most expensive people, who through prescribing ability cost the NHS so much, to have so little training - that was a real wake up call. [#19, doctor, PT]

What is being described here is how every doctor’s practice needed to be affected and influenced by this project and that it was not just for a select few.

Secondly, there was a theme that linked to the purpose with a certain amount of ease as to how the project would operate:

I think there was a germ of an idea, but I don’t think anyone thought that we would get where we got [to]... because it really was action research, it wasn’t, here’s a piece of thinking now let me go and prove it. It was action
research of [how] this thing developed; it got legs as we went through it.  [#7, former senior manager, PT]

Well it depends what success looks like, we were quite pragmatic about how it would go. We knew that some colleges were really trying to adopt this and embed it into their curriculum which is what we were trying to achieve... And there’s also that bottom up stuff, well let’s just get out and start using it and try it and see how it resonates with people… [#18, doctor, PT]

This emergent view aimed at being dependent on the process and contingent on what ideas materialized as the project unfolded:

[There] was quite a deliberate strategy…saying we won’t just draw up the framework, we need to go and find out what’s currently happening. What is it that others would like to see happen and then for us to begin to test out some of our thoughts and get reactions to [them]…particularly as we were talking about medical engagement. And I also didn’t think that we had the answers. I personally thought the answers are out there. So I would regularly say, what we’ve got to do is constantly pick up the nuggets because part of our role is aggregating the nuggets. [#21, academic/senior manager, PT/SG]

What I did have was a very clear sort of compass point around this work and where it needed to get to and was very determined that we would end up with this embedded in the way we have described, …so it moved out of the arena where one strike of the minister’s pen and the whole thing could fall apart into a different kind of world. Other people absolutely shared that vision. And so in thinking about that, provided your compass point is okay then the map along the way can take some turns or slow down a bit if necessary. So a contingent approach to the obstacles as they occurred along the way but clear where we needed to get to. [#22, doctor, SG]

These excerpts describe that there was an explicit purpose (or ‘compass point’) that was being developed by individual organizations in some instances that the project could link to, but that the central team was not too concerned at the start about a specific project course or outcome; rather they were looking to work collaboratively with the profession in order to effect change, acknowledging both the events that had impacted on the professional role and the changing nature of professionalism (Evetts, 2005). This general direction was supported at the outset as evidenced in the project’s Scoping Study Report of May 2007 in a number of sections entitled “Context – the case for greater clinical engagement”, “Changes to the Medical profession – Motivating for engagement” and “Emerging Thoughts”, which outlined a number of avenues to explore as the project unfolded.
In order to turn that purpose and loose sense of direction into a reality, individuals would be required to join the project team and steering group. The next section explores the motivations of individuals for doing so.

5.3.3 Motivation for involvement

Introduction

The participants carried out many different roles alongside their work on the project. Thirteen had backgrounds in medicine, having trained as doctors, even though not all of them were actively practising medicine as their major career. The remaining nine came from managerial and academic backgrounds, from individuals who had held chief executive positions in the NHS to project managers and administrators from non-health backgrounds and encompassing varying degrees between those two positions.

Amongst the 22 participants, motivation for joining the project was varied. Table 5 provides a summary of the reasons participants gave for becoming involved along four themes: professional interest; knowledge; vision; and other personal reasons.
<table>
<thead>
<tr>
<th>Theme</th>
<th>Mentioned by number of participants</th>
<th>Description(s)</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Interest (40)</td>
<td>22</td>
<td>clinical leadership/interest in CL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>interest in change/management CH</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>“how stuff works is interesting to me”; innovation; challenging</td>
<td></td>
</tr>
<tr>
<td>Knowledge (31)</td>
<td>22</td>
<td>prior clinical leadership development (14) and prior knowledge (8)</td>
<td>PD</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>leadership in the UK; you had to be a good doctor first before being a good leader; understanding leadership abroad</td>
<td></td>
</tr>
<tr>
<td>Vision (55)</td>
<td>15</td>
<td>values/vision</td>
<td>V</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>&quot;needed to do this&quot; / “it was important&quot;</td>
<td>N</td>
</tr>
<tr>
<td></td>
<td>28</td>
<td>succession planning and development; the psychological compact; curriculum; response to scandals; ensuring this wasn’t a vanity project for the great and good; greater control over the profession</td>
<td></td>
</tr>
<tr>
<td>Personal Reasons (35)</td>
<td>8</td>
<td>working with a good team/people</td>
<td>T</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>opportunity for career development / progression</td>
<td>CA</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>satisfying/fun; fell into it / coincidence / luck; family; representing organizations / interests; personal relationship, e.g. X asked me to be involved; needed the money</td>
<td></td>
</tr>
</tbody>
</table>

The remainder of this section breaks down the themes further and explores the main ones discussed by participants (codes CL, CH, PD, V, N). Regarding ‘professional interest’, participants discussed how they had an interest in clinical leadership and change management (codes CL, CH), whilst within the theme of ‘vision’, there was a stated desire for the project, with phrases such as “we needed to do this” and “it was important” (code N) and this was often linked to the values expressed by participants (code V). With regard to ‘knowledge’ all twenty-two participants described how they had had prior knowledge of clinical leadership development (code PD) and against ‘personal interest’ reasons for involvement in the project ranged from working with a good team and having the opportunity for career development and progression to being involved because family members were doctors. What this describes at one level is a juxtaposition of reasons from those that might be considered altruistic in the sense of having
concern for others, such as the medical profession, to those who became involved for reasons that were more self-interested.

Professional interest

The most often cited reason was an interest in clinical or medical leadership (CL):

Initially I saw it as an interesting project management opportunity and an opportunity for me to develop my knowledge of the health care system and in particular medical education and training. To put the skills that I already had around project management to good use and to develop those further. And to develop my networks further as well…the health service has been my background and it’s what I find really interesting. [#4, manager, PT]

I think human nature says that if you’re given something that you’re broadly interested in, you will get a bit more involved. Had this been given to someone else to do, who had no interest in it whatsoever, there may have been even less [organization] engagement. [#6, manager, SG]

This formed part of a wider group of codes including an interest in change and management (CH) and challenging and innovative projects, which also linked to their own knowledge of clinical leadership development initiatives.

Knowledge

Prior involvement in clinical or medical leadership development (PD) was also a common reason given for wanting to be involved within the project. Several participants from within the project cited this and the following excerpt is an example of this typical response:

So historically I had done quite a lot of small scale work around medical, clinical directors…And what they found difficult basically was the absence of a lot of the skill sets that were in, what ultimately became the Medical Leadership Competency Framework… So what I became exposed to and then slightly committed to, is you have to get this into the training process. As long as we wait until people get into jobs and they haven’t been trained you are always going to be on a remedial programme of, ‘oh I have now got the job for which I am untrained, can I go and do some courses on it?’ And I thought the real way to get these people coming along and moving into these jobs is (a) they are equipped for them and (b) they want them. So we have a quality of clinical director applicant, medical director applicant that raises the whole standard. [#8, academic, PT/SG]

Through this excerpt as an exemplar of wider views, participants were describing how they had spent, in some cases, considerable time trying to get others
engaged with medical leadership much earlier on in their careers, often because they had had prior involvement or had carried out research with postgraduate trainees in this area. In the example above, it relays one example of how prior knowledge and active participation in clinical leadership development was important to individuals and what they were trying to achieve through the EEML project, which links to the following theme around their values and visions for medical leaders.

Vision and a need for the project

Espoused visions or values that aligned with the project (V) and a stated 'need' for the project to happen (N) were among the other highest-mentioned factors for joining the project. This narrative captures the combination of these factors as motivation for one participant being part of the project:

...the performance for the MLCF was very much about getting the newly qualified doctor right through the whole spectrum up to consultant level, engaged in understanding and developing, in the broader sense, their leadership skills. And you talk to a doctor about the word leadership and they think 'being in charge' which it clearly isn't. So I have to say my initial thought was, 'what's this all about?', worried that it was about leadership in the commonly understood 'being in charge' sense. And then I rapidly discovered it was a much more positive and helpful process. So I was there because the MLCF has to be implemented, it’s implemented in places like this, by people like me, persuading my colleagues, who are delivering the training that they need to somehow put components of these professional behaviours, the leadership activities, into their training [#1, doctor, SG]

In terms of values specifically, a number of participants talked passionately about their own values and vision (V) for the development of medical leaders through and out with the project:

I just thought it was important. I do believe that clinical leadership is really important. What do we mean by clinical leadership? And we define that locally certainly, as the ability to influence others to improve patient care. So it's a very simple definition which can apply to any doctor in any role. This isn't about heroic leadership or anything else. It's about how you use the non-clinical bits of your job to make the clinical bits as effective as possible. [#5, doctor, SG]

I would say the values that appeal to me are ones of greater openness, transparency, greater democratisation so that people have a better say in what happens to them, and issues of wanting to see more fairness
generally in society, more equity for all, greater equality… those values are actually very important for medical leadership because they underpin everything you want to do, because what you are trying to do is ultimately get better health for people, and [that] is quite a political achievement as well. So the phrase I use to people is, ‘it’s not just the patient in front of you, it’s about how you make a contribution to health in general, and your behaviour with that one patient has a significant impact on what others are trying to do elsewhere. So you’ve got to see yourself as part of an interconnected system.’ And just simple things like we know that inequality in society is the key cause of inequality in health. So these are important things that need to be core to medical leadership. [#10, doctor, PT]

I believed you could deliver more efficient and high quality health care if you really did understand management, delivery, improvement technology. It was about how did you get doctors to really take some responsibility for and understand management and communication skills. [#17, doctor, SG]

Over half the participants interviewed talked of a ‘need’ (N) for the project to happen, citing how important it was in developing medical leadership. Many spoke of how the NHS had moved on from isolated hospitals to much more integrated care, with a focus on creating numerous leadership opportunities for individuals as a member of potentially several different teams. One participant related how the idea of psychological compacts (Kornacki, 2015) rather than a contract (Rousseau, 1989) became relevant for him in bringing medicine and the understanding of engagement together to effect big change within the NHS, such as reduced lengths of stay, different treatment modalities and much greater patient involvement. Another participant talked about trying to make the aims a normal part of medical practice:

So there is a view, the classic phrase is ‘you have joined the dark side’, you are one of them. And it’s a very counter-productive attitude and a very counter-intuitive one given that the group who accuse you of having joined the dark side also very often say, ‘look we have got no power, what are we going to do, how are we going to get those guys and all of that?’ And the obvious answer is to join them in a productive way and not just as a criticism. So why did I join this, it struck me that it was an important thing for there to be a national offering. Given that the National Health Service is a national health service, then having something that was much more obviously sponsored by the NHS seemed to me to be a really important statement to those slightly grumpy colleagues who say it’s all bad and getting worse. And so it’s a way of normalising the ambitions and aspirations of doctors to lead the service. [#15, doctor, SG]
This concept of the ‘dark side’ (Spurgeon et al., 2011) has been discussed previously and was seen clearly by this participant as an inhibiting factor for making management and leadership a normal part of practice. For another participant, they emphasized that engaging in medical leadership was a new way of leading the health service:

I think it comes from pride in working for a service which delivers health care for all, regardless of background…it's non-discriminatory. And it’s a terrible privilege; you travel around the world and have a look at other health care systems, and to be able to see a peer of the realm, followed by someone who’s been unemployed, someone who is just out of prison, or someone who is a bank manager, and you don’t know who is going to walk in through your room but actually it doesn’t matter. And it’s a chance really to keep that going and to keep the medical profession recognising the need to change and that it’s also about their leadership and their management…It’s also cultural, everyone is talking about leadership…Radio 4 for the last seven years, they ask any government minister about why something has been changed or [has gone] wrong and somewhere in that short paragraph of the answer will be the word leadership, so culturally it’s there. And I think we’re moving away from the Chief-Executive-Officer-Billy-Graham…one-person type of leadership, certainly within the UK, to shared leadership. So it’s leadership at every level, personal leadership. [#19, doctor, PT]

The major reasons outlined above for participants to become involved in the project centre not solely, therefore, on an underlying interest in a change initiative within medical education, but also more deep rooted personal values about the future for medical leadership, experience of having been involved in or developed medical leadership programmes previously as well as a view that there was a wider need and purpose for the project. In contrast are the views that may be considered less benevolent and which were reported on by others rather than being self-reported.

5.3.4 What were others’ motivations – or agendas, if any?

Whilst the above narrative has concentrated on individuals’ own expressions of their engagement, participants also shared their views and perceptions of why others may have been interested in the EEML project. These are potentially important motivations to understand and capture within this change initiative, certainly in terms of explicitly challenging the various shared assumptions espoused above in the analysis of this case. Participants disclosed that the project faced challenges relating to what should go into the framework, as
colleagues from their home organizations identified the opportunity that came from the EEML project team to work more closely with the medical profession. One example of this relates to patient safety:

...in some ways we were in the enviable position of working so closely with the colleges, with the academy, with the GMC and people were paying attention that others in the Institute really wanted their stuff in the framework ...The challenge was to keep bringing that back to, this is about management and leadership. This isn’t for you to put in every single thing that you can come across about patient safety. We can include that as part of the learning material but people wanted an entire domain dedicated to patient safety. And we were never saying this isn’t important; it is important, it’s in the framework, but it’s in the framework at [a] high level...But people wanted things very prominently and we had to keep saying, no it’s there, but this is [a] management and leadership competency framework. [#4, manager, PT]

Other challenges included how the project may have interfered with agendas of power, positioning and money as outlined, respectively, by these excerpts:

...it was probably petty, it was ‘my organisation could do this, we’re frightened this is being set up by the Department. The Department wants to get a grip of this.’ And the fact that this cut across all existing medical colleges made it difficult to get specific ownership for it. In a sense that could be regarded as a strength but at the time it was seen as a weakness but there were concerns that one [college] might grab it. [#16, doctor, SG]

...undoubtedly there was positioning going on about where power lay within the medical profession, I’m sure that was there...did you have more of a voice and more of an entitlement if you were a President of a Royal College or if you were the person who actually had to get on and implement? In terms of endorsement you needed that very high level and in fairness, some of the medics who were at the table, genuinely, mostly were there because they were interested and were supportive, otherwise they wouldn’t have given up their time...I may be being really cynical now, but perhaps some of them could see a bit of an opportunity here, that if this is the next best thing that’s coming out, we’d like to be on that train and be seen to be the voice. [#13, senior manager, PT]

So there was an agenda at that time and some of the colleges, the GPs for example thought they could just do all this themselves and didn’t need anybody else’s input. Partly because they saw money in it, they thought, if we get this sorted out and we are going to be teaching all these programmes then we will make a lot of money out of this. [#5, doctor, SG]

The excerpts are describing concerns over who might control the direction of the project and whether its ownership might sit with one royal college, thus giving them a position of strength, or be controlled by the Department of Health. The
second excerpt also suggests there was a mixed rationale for engagement, of being associated with the ‘next best thing’, but also of genuine interest in the aims of the project. Additionally, the following excerpt raises the issue that motivation for involvement may well have come from a related desire to protect one’s own professional standing and interests:

And then there was an aside, a statement that went beside all, which was if we don't do it ourselves somebody else will do it to us, so if you want to be in control of your own destiny then you have to get up there and do something. [#2, doctor, SG]

Furthermore, some participants described how there was latent concern about the project, even from those who were engaged in the project, because of a perceived future impact on the profession regarding who would control medical workloads or that the project was a diversion from the core business of providing care. A number of participants reflected on this, one offering some suggestions as to why the project may not have been universally accepted:

Status quo, not for us, diverts us from the important thing of understanding more in-depth about our medical speciality, part of a bureaucracy, don’t want doctors to get sucked into it; the best thing a doctor can do is become a Senior Consultant in the speciality treating patients, not getting involved in budgets and resourcing… [#6, manager, SG]

The same participant also understood that some doctors would want to concentrate solely on the clinical aspect of their role and not take on more management and leadership responsibilities:

…it would be very hard for anyone to say, actually this has no place at all in the doctors’ training and understanding… the argument is about degrees and about how people feel about it. I’m quite sympathetic to the doctor who says, ‘actually I just want to treat patients and have the resources to do it and that’s my primary motivation and I don’t really care whether I’m working for a Trust, a board, a hospital.’ That’s probably one end of the spectrum and then there will be others who say, ‘actually, I’d really like to get involved in being a leader in medicine, leading a Trust, getting involved in the resource balancing decisions.’ [#6, manager, SG]

In addition, when discussing the project with medical colleagues, participants reported that they had concerns over being managed by other doctors, which they saw as only going to increase with the advent of the project:
...a lot of doctors still do not want to be managed and one of the major problems that we have is that there is still a group of consultants, who believe once they are appointed as a consultant they can have complete autonomy. Now that attitude has changed over the years and there is now recognition they have got to work in a managed environment. But the one thing that a lot of doctors still find incredibly difficult is being managed by other doctors, and that attitude is quite pervasive within [organization]. They saw the project as further enhancing the power of doctors in management to then manage them...and often [they are] colleagues who they don’t respect or acknowledge as having the skills in order to achieve that... [#12, doctor, SG]

Participants also offered views on what the motivations of organizations like the GMC may have been:

...I don’t think the GMC was ever going to really say, mandate this, embrace this, be a flag waver for it really...at any time there are dozens and dozens of initiatives and projects, ...it was well intentioned, it had good antecedents, it was approaching it in a fairly sensible way... [but] it’s not at the heart of what the GMC is about really. Ultimately [that’s] about protecting the public, protecting patients, setting standards, dealing with fitness to practice...but if you’re a medical doctor who’s got involved in an organisation like the GMC, you’re probably going to be reasonably well disposed to saying that doctors should have a bit more understanding and involvement in managerial and administrative type issues. [#6, manager, SG]

This describes a reticence to be a proponent of the project, which was picked up on by this participant when describing the GMC’s approach to regulating the profession:

...a consistent issue with GMC and other regulators [is] that they are ultra-cautious, because they will [say], in a slightly mythical way, when we feel that the profession has reached a stage where they feel that medical leadership is part of their role then we regulate for it. [#8, academic, PT/SG]

This short section has focussed on perceptions of others’ motivations for their degree of involvement in the EEML project, which varied from participating to influence their own agendas, to being concerned about being managed by doctors, to not taking a role as a fervent supporter of the project, whilst still remaining engaged with it.
5.4 Chapter Summary

In this chapter, participants have described how the project was set up in light of changing environmental conditions which enveloped the NHS and the medical profession. This particular time and space and the ensuing field-level conditions allowed for the opportunity and a purpose that was subsequently agreed but without a specific and defined end goal in mind, yet understood to be about greater medical engagement in management and leadership.

This general direction towards greater engagement was supported by individuals who were motivated to become involved along four self-described lines. Professional interest was one driver and along with espoused visions and values became prominent reasons for engagement. Those with knowledge of and prior involvement in medical leadership development engaged with the project as they felt this was another part of a longstanding commitment to their work in this field and some further participants cited personal interest and reasons for involvement. These motivations can be seen to emanate directly from individuals’ backgrounds and experiences or ‘habitus’ (Bourdieu, 1977). Previously, chapter 3 has discussed how social position and capital informed practice within an institutional context (Bourdieu, 1986; Battilana, 2011; Lockett et al., 2014) and the narrative presented above typifies the various motivations of individuals in making sense of the prevailing conditions and acting in response to them (Nicolini, 2012).

Moreover, participants offered their views on why others may have engaged, which encompassed reasons related to power, positioning and money (Bourdieu, 1986). Others felt medical professionals had no choice but to engage given the changing NHS conditions, although accepted that some of this engagement may have been to understand the implications for the management and organization of professional development (Muzio and Kirkpatrick, 2011).

The following chapter considers how those individuals were recruited and their organizations represented; how key stakeholders were subsequently engaged and how the project’s outcomes, notably the production of the MLCF and MLC, were achieved in practice.
Chapter 6: Findings: the project in practice

6.1 Introduction

As outlined in chapter 5 and its description and analysis of the environmental conditions, purpose and motivations behind the project, this chapter will consider how those factors led to an explicit ethos and emergent approach to enacting the project; from how it was structured, how relationships were managed and how its outputs were achieved. In outlining the practices, collaborations, timing opportunities and use of particular choices of process and action, it will also draw briefly on previously discussed theoretical concepts relating to practice, social position and capital.

Throughout it will aim to elucidate how members of the project team, notably opinion leaders, enacted and effected change within medical education. This will then be picked up in chapter 7, where the first contribution of this thesis will be proposed. Chapter 7 will also offer the second and third contributions, notably the concepts of system capital and system centrism, which explore how this case furthers understanding of strongly institutionalized environments, such as medical education and the medical profession, as well as the processes involved in opinion leaders’ actions and practices that are important in effecting change.

6.2 Right people, right approach: enacting the EEML project

6.2.1 Introduction

This section explores how the project worked in practice: how it was set up; how relationships were managed; what role different groups had; and how members of those groups (the project team and steering group) carried out their roles and developed the Medical Leadership Competency Framework (MLCF).

6.2.2 The set-up: structure and recruitment of key individuals

When asked about what they did and how they went about their work, many participants began by talking about the structure and recruitment process that facilitated working with the medical profession. One participant explained the project’s set-up and shape formed around groups looking at three distinct stages.
in the training process; undergraduate, postgraduate and post-certificate of completion of training (CCT):

We initially identified what we needed for the project, we’d needed academic advice. And then we would need three leads for the undergraduate work stream, a postgraduate work stream and a post-CCT work stream. We had difficulty recruiting to two posts, because people needed to have a certain level of credibility to be able to work with the medical profession… who had that gravitas, that kudos and that had worked with doctors before. So it was partly through networks that we were able to recruit to the two positions… Then we formed reference groups because we had these three different work streams [and] those people varied because they needed to have different levels of knowledge. So on the undergraduate work stream we needed medical school deans or people that were involved in the education of medical students... medical student representatives on there but we also had people from the service involved. Then at postgraduate level we needed to have people like postgraduate deans involved. And then once you got to the post-CCT stage you needed to have people that were working in the health service so it was medical directors. So people who knew the national workforce impact of what we were doing, which was important. [#4, manager, PT]

These work streams each formed a reference group, which were constituted of a broad range of experience and expertise from the profession and sat under the auspices of a core project team, above which sat a steering group. This was further evidenced in a number of key project documents, notably Overview of Project (appendix 4: document 2) and Project Team Minutes (appendix 4: document 14). Individuals were recruited who had knowledge of the system, expertise in certain aspects and worked in pairs, with one project manager and one doctor in each work stream. How the medically-qualified members came to join the project work streams is recounted by this participant:

…the names would have come from all of us… And, obviously, it’s a pretty biased sample because we were tapping into people who we knew had got an interest. So a number of the medical leaders that were in each of those three work streams, many of those would have been medical leaders that [we] would have known. So we would have tapped a few of our friends, and said, ‘would you be interested in [joining]?’ We also wanted to make sure we got good representation across the home countries. [#21, academic/senior manager, PT/SG]

The rationale behind recruiting doctors was because one of the project’s foci was around having people that understood the education and training framework that existed in the UK at that time and those individuals would be able to advise how
to navigate around those different structures. With respect to the project team, some individuals were asked through formal interview processes, some others through prior knowledge of what skills and attributes they could bring to the project and others who were known prior to the project by its director. In asking each participant if they knew how others had become involved, one participant summed up a general ethos of bringing together a group with varied interests, backgrounds and experiences, being ‘hand-picked’ for their involvement:

...four or five of us were clinically trained and then the others had been chief executives so held a senior role. One of its greatest strengths was this mixture of managerial and clinicians with an input. Because we all come with our perceptions and we all see the world through our own glasses really so that was one of its strengths. And the others, certainly a couple of them had been involved in management training for their colleges and had probably been put forward because of that. [#19, doctor, PT]

Linking back to the project’s purpose, it was seen as important that the project drew on a wide variety of professional backgrounds and skills. Recruitment to both the project team, which was responsible for the mechanics and ‘operationalizing’ of the project, and to the steering group, whose role it was to oversee and provide governance to the project, appeared purposive, based on the judgement, selection and subjectivity of the core project leaders and sponsors.

One key aspect of the recruitment to the steering group was aimed at bringing in individuals and organizations who could offer value through expert knowledge and opinions as to how to progress the project and its purpose. This was described by a number of participants, for example:

The steering group was interesting because that was initially led by [X] and she was supportive...if you are not used to working in the college environment or understanding some of the politics that goes on then there’s a bit of a learning curve there...and it was a mixed group, there were people like [Y] who was then the chief executive of [organization] who were really one hundred percent behind this, and really banging the drum that this is really important. And... [Z] with [organization], when he’d go out to talk to people he would talk about the project and what it was trying to achieve. So that was important in providing more of the high level political advice. [#4, manager, PT]

At the very beginning it [the steering group] was set up right, the right people were asked. There were several things about being the right
person, one is you know what you are doing and you are good at your job. The second one is politically you are the right person so you have come from the right organisation and you have the appropriate voice within that organisation. And you recognise all of the different agencies … that need to be involved, so it’s not just the medical royal colleges, it was the GMC and the BMA…it’s the intelligence and knowing the right people in terms of influence as well as acknowledging ability. [#19, doctor, PT]

Part of this included being receptive to individuals asking to join if they were seen to be important in terms of influencing the project’s path, as explained by this participant:

*We began to include one or two representatives of Colleges. There were a few occasions when other eminent people said they’d like to join the steering group and we’d have this discussion around, well if [we] say yes to [X], then we really ought to be saying that to ten other people. But at the same time, here’s somebody who’s got a lot of enthusiasm. And so the Vice President of the Royal College of [organization] wanted to be involved, and we said, actually to get [specialty] inside the tent on this is really important. So having the [organization] represented, did mean that we could say, ‘well look, all the main Colleges here are absolutely signed up to this.’* [#21, academic/senior manager, PT/SG]

The above extracts describe how getting individuals on board who could add legitimacy and credibility to the project was important, testifying to the value of those with positions of influence within key organizations (Battilana, 2011). This was a factor that was picked up by other research participants:

*I think there’s an interesting dynamic between the individual and the institution…we had some crucial individuals coming out of certain institutions. Of course, some of those were hand-picked so we knew what they represented and I am not ever sure that their institution blessed them as their representative. But once they had become inside the project they became the institution’s representative whether the institution knew about it or not. [#8, academic, PT/SG]*

*[The BMA] did help the sign up and awareness of the project largely because of [X] coming to the medical managers’ committee…Now I think that might be a benefit which wasn’t realised at the time but now this is appearing in various curricula, consultants can connect with that presentation at the BMA meeting. And I know it helped [X] considerably to know that he had support of the BMA…Because at the end of the day the BMA is seen as a very influential organisation in terms of the public face of doctors. And if the BMA had said, ‘hang on a minute we are not getting involved in this’, I think that would have done morale and credibility to the project a lot of harm. [#12, doctor, SG]*
We needed it from day one to the end of professional lifetime, and maybe the GMC contributed to that overview. Put it the other way round, if the GMC had walked away from it and had not been involved it would have made it more difficult to complete the project and would have had less impact. [#16, doctor, SG]

The examples above describe not only how organizations, but also individuals, were deemed useful in supporting the project to give it enough credibility and legitimacy within the wider profession.

**Steering Group – oversight and governance**

Participants also described the role played by the individuals and the steering group in providing support to the project team and ensuring that current medical education guidance and practice were aligned with the project’s direction and purpose, which was also in evidence in key project documents such as summaries, plans and terms of reference (appendix 4: documents 1-2, 5-8). In practical terms, this was described by individual members as follows:

> So it was limited to going to meetings, hearing the discussion and the presentations, and putting my oar in and trying to shape the way the project was developing. [#15, doctor, SG]

> …the group I was involved with was probably 15-20 people. Not everybody arrived at all the meetings, I think I was a fairly assiduous attender, largely because [we] produce booklets, guidance for doctors on management issues, and I was keen to make sure we were up to speed with current thought so that our advice to doctors was compatible with whatever was coming out. And if it wasn’t then we needed to change it. [#16, doctor, SG]

How it was perceived to have worked was described by a member of the project team, looking in from the outside:

> The steering group was also interesting in that it was again not so much diverse views but they all came from diverse stakeholder groups and again worked properly as a steering group. Sometimes you see a steering group be a wishy washy, wouldn’t it be nice if we did this, and then they all bugger off again. They didn’t, they were good, they were focused, they could see they had a part to play in implementation and they were serious about wanting to see it work. [#14, former senior manager, PT]

Beyond the overall structure of and recruitment to the project, participants also described how they went about their work, what strategies, practices or
approaches they saw themselves undertaking and enacting. Building inter- and intra-organizational alliances was one theme that emerged.

6.2.3 Key alliances

AoMRC and NHS Institute

One of the key partnerships was that between the two main project organizations – the Academy of Medical Royal Colleges (AoMRC) and the NHS Institute for Innovation and Improvement (NHSI). One of the key ways the project would operate would be in joint ownership of the delivery and publication of any outputs, as can be seen with the MLCF, even if the work was carried out by one partner or the other. For some individuals, this was key:

> One of the reasons the Institute was chosen to be involved was [X] had been working in this space for a long time, a huge amount of credibility...having an organisation that was outside of the medical profession and...that was very committed to innovation and improvement and leadership and sharing best practice. I can't think of another organisation that existed at the time that would have been better placed to do it...But also being very clear that [it] was working in conjunction with the Academy of Medical Royal Colleges was important so everything was co-badged. [#8, academic, PT/SG]

> It was often sold as this is what we feel it should be; they were fairly collegiate about it. They weren't saying we have produced this, they weren't saying we have done all the work but we are happy to joint badge it, it was presented as a joint badged operation from the word go. [#20, doctor, SG]

The rationale outlined in the above excerpts relate to how individuals saw the need for the EEML project to be embedded into the medical profession through a joint project approach between the NHSI and the AoMRC.

The steering group and project team

Another aspect that was deemed important was the working relationship between the project team and steering group in achieving the project’s goals:

> We had probably monthly meetings with whoever was the Chair of the steering group and they became really important meetings because they did monitor the progress we’d made and if we’d said that we were going to go and do A, B and C, they would be challenging, ‘well have you done A, B and C and if not, why not?’ And then the steering group itself was
where, at one level, we were demonstrating to them that this project is in good hands. [#21, academic/senior manager, PT/SG]

The same participant also described how the role of a prior existing relationship was crucial, as it enabled a certain freedom in which to manage the project:

We had so much autonomy, but we would keep the steering group informed…[it] came from [X] trusting me…the steering group pretty rapidly trusting us…so without a doubt there was that autonomy…I think some of it is around personal relationships, personal friendships, …[X] and I have known each other for a number of years … and a sort of confidence in me and then a confidence in the team. [#21, academic/senior manager, PT/SG]

These excerpts describe the relevance and importance of good working and prior relationships respectively in ensuring the project was carried out well, which can be related to the role of capital in informing practice as discussed in chapter 3 (Lockett et al., 2014; Bourdieu, 1986). The role and practice of the project team was another one of these critical factors.

6.2.4 Project team: collective decision making and creative tension

As described in the previous section, there was a close working relationship between the steering group and project team, with the latter providing the practical work of engaging and testing out the ideas of the project. A number of participants described how the members would work together and agree the direction of the project, so whilst some individuals would lead on certain strands, collective decisions were taken to the overall direction of the project. Part of the strength of that approach was the diversity of experiences and backgrounds amongst project team members, as described by these participants:

It’s one of the few projects I’ve ever worked on that has worked incredibly well. I don’t think there was a huge amount of planning of who [W] would have but one of the reasons it worked really well is that we were very different, so diverse… So [people] were probably the academics and have that perspective around leadership in a theoretical sense as well as in a clinical sense. [X] had an HR focus and an organisational development focus. [Y] originally came through the social work or probation route so had a very different clinical practice background, which was strategic and was a Chief Exec of [organization]. The medical advisors were all different, [W] came from a management background and [Z] also from a management background but obviously from another country as well…We didn’t do groupthink and I think that’s partly because we were all vociferous enough to challenge. [#14, former senior manager, PT]
Lots of diversity and lots of different perspectives but a common purpose… there was dissent around things but everyone felt very comfortable around that. We didn’t have a feeling of a strong hierarchy… probably above all the people were really, really stellar. [#18, doctor, PT]

The last two excerpts talk about the diversity of perspectives and backgrounds which led to dissent and challenge. Whilst individuals were supportive of the general principles of the project, a certain tension existed, which was considered to be a positive aspect of diverse experiences:

Ninety-eight percent would have been democratic, a good consensus. There were sometimes a few little tensions between members of the project team; somebody felt that somebody was intruding into their territory, just like in any team. But that’s healthy, I mean I suspect at the time it probably irked me, but I would always rationalise, isn’t that a good space to be in, that you’ve actually got a bit of creative tension. [#21, academic/senior manager, PT/SG]

Managing relationships ‘inside’ the project environment, comprising the project team and steering group, was a core practice that underpinned the project, but equally relationships outside of that environment were also important, notably building wider awareness and support for the project, its purpose and products.

6.2.5 Using peer influence and relationships to build support

One of the themes that emerged when discussing the recruitment of the steering group and project team was to ensure they were comprised of individuals who, collectively, had a combination of knowledge, expertise and credibility to add legitimacy to working with the medical profession. The following extracts expand on how steering group members acted as both governors of the project but also enablers and influencers for access to discuss specific aspects of the project with other stakeholders, such as medical colleges.

The steering group was chaired by [X], influential, very powerful, incredibly well networked, and a real gift to the project, because within the medical world at that time who [X] didn’t know could be counted on one set of fingers, [X] was very central, very well networked. And [X] managed at times when we couldn’t get certain individuals to respond there would be a call to [X], could you just have a word. And [X] would facilitate that...So somebody in the [organization] at one stage said, we could put this under generic outcomes and it will just be part of that. And we desperately didn’t want that because it would have lost its focus as a new product. And this guy was pursuing this because frankly he had another agenda and he thought it would be better for him. And it was [X] who said, ‘I don’t think
you want it to go down that route’, and it moved away quietly and he left it. [#8, academic, PT/SG]

…we would use the steering group to get endorsement on various things, to open some doors for us. So there would be times when somebody might say, ‘Okay leave that with me, I will talk that through with other colleagues in the [organization]’ or times where I might say, ‘can one of us come and talk to you [X] because this potentially could be a barrier?’ And we’d always from the start had this anxiety around it has to be mandatory because if it’s not, then how do you get this to therefore be embedded into a doctor’s education and training? …that’s where [X] said very early on, ‘if you get this to a point where you’ve got widespread support, then we will endorse that and we’ll make sure that it does become embedded.’ [#21, academic/senior manager, PT/SG]

A number of steering group participants, when asked to describe what they did, spoke of their part in aiding project awareness, buy-in and facilitation within their networks:

…my contribution was around identifying the sales pitch in a way; if you want to make this work you have got to do it in this particular way, it was very much ‘what are the practicalities of this?’ We were able to get every director of medical education in Britain aware that it was coming out and what it was. So we were a help with the publicity side of things. [#1, doctor, SG]

The same participant continued to describe the impact this had on the wider network:

It might well have been launched differently because we were able to send it round to all our members saying this is a bloody good idea chaps, it’s what you’ve been waiting for, read it. That probably is the most significant contribution we made. As opposed to it being something launched by the great and the good as yet another thing to do. So I think if we can claim any credit that would probably be it. [#1, doctor, SG]

This was also picked up by other members of the steering group:

I was involved in all the committee work which of course is the tedious bit of it all…really my role was in trying to get others bought into what we were trying to do. So I guess I was a facilitator between the main project and everything else that was going on. [#2, doctor, SG]

I think a lot of my role is facilitating to ensure something happens, the actual, me writing or me physically doing, isn’t it. I exist to make things happen in that respect. [#3, doctor, SG]
I had been around the postgraduate educational world for quite a long time, had a track record, and can get along with most folk, those sorts of things all help without a doubt. [#20, doctor, SG]

This was not only the case for steering group members, but also for some of the project team:

I think the advantage of having me was the network and the ability to say we’ll get this through [organization]. And so I was able to discuss how to do this with people at [organization] and it was harder for [organization] to reject me, they could have rejected some guy they didn’t know...but then as is the way of things generally in medicine, it’s often about network and contacts, so I think I was probably the right person. [#10, doctor, PT]

In particular, some participants talked about how some of that work that facilitated the project’s path was also about securing commitment from individuals or groups who were either unsure of their role in approving the project’s purpose or had been diffident to past changes along this line:

Of course, my biggest job was to keep all the colleges on side, engaged, participating, wanting them to trial this out in their own environment, test it out in committees, in meetings, improve it and fit it into their own. My job was not to let anybody throw their toys out the pram...whatever topic it was in [organization] you just had to keep going back quietly, time after time, listen, see what their unhappiness might be. They will all tell you probably to start with that they were doing a lot of this so did they need it. Well they were doing bits, well almost every college had thought about this area…but my job was really to keep them altogether. [#17, doctor, SG]

[X] did lots of the footwork of meeting stakeholders. And they were important stakeholders like [Y] for example who we needed to work with over quite a long period. And if you look at the kind of trajectory of the project overall there is a period of about 18 months to two years at the front end of the project which was securing alignment and agreement about what it was we were trying to do here. I did some small key bits of that at key points when something needed to be unblocked, but [X] did most of the work. [#22, doctor, SG]

Alongside the securing alignment or ‘smoothing’ role that these participants undertook, what was also described was a sense of listening to pushback regarding the project and continuing to adapt as a consequence, which starts to explain how the project was enacted in a collective manner (Dorado, 2005). Moreover, what these participants are describing is how ideas were broached with key people and organizations, many of which they belonged to, as well as those who would be stakeholders in embedding leadership and management.
concepts into medical training. This happened at various stages throughout the project, from its inception, to testing ideas out once the project had delivered some ideas, to the first competency framework and curriculum. The evidence for this is also supported in project team and steering group minutes that were made from the beginning of the project in 2006 through to its conclusion in 2010 (appendix 4: documents 12-60, 81-90).

Another key factor that participants identified as being crucial was the prior and existing relationships with other members of the steering group, and how this helped decision making processes to be accomplished:

[X] was the chief exec of [organization] at that point and [X] and I grew up in [place] together and I wrote my very first paper with [X], so these things matter oddly enough. So we would go out for dinner and discuss what it was all about and he would get others of his team out and I would take others of my team in. So a lot of it was done off line as ever is the case with these things… whether you like it or not these things matter. I mean you try your best not to make them matter but if you are wanting something done you use all your contacts you can…that’s important, that’s how you get things done. Nothing is ever done in a committee, a committee ratifies all the decisions you have made beforehand, does it not? And you make all those decisions beforehand in a whole variety of environments… So you know, whether that is good or bad it’s just how it happened… my strength in [organization] was my contact list, because I could get anybody because I was a medical doctor, and it opens doors. [#2, doctor, SG]

Prior knowledge of other members of the steering group was also common to other participants:

Most of the people in the room I knew already and that is a really important thing about all these groups…you get there because no matter what it is it’s the same suspects everywhere… So I had most of the relationships with people in the room already. [#1, doctor, SG]

On the whole I suppose I would have known reasonably well always half of the people there, and then there were people I would have either known by name or met once or twice and had some contact with. [#15, doctor, SG]

It would appear that the leaders within the project had a clear vision of how individuals from relevant organizations, with a rich mix of experience, contacts and networks, as well as prior relationships, might work on their behalf to achieve the aims of the project. This again helps us to relate the importance of social
position and forms of capital in informing practice and effecting change (Lockett et al., 2014; Nicolini, 2012).

6.2.6 Hitting the mark: getting the MLCF into curricula and Tomorrow’s Doctors

Having recruited significant individuals and influential organizations to the project and subsequently employing them to build key alliances within and out with the project, a further important stage of the project was aligning to key events that would help to embed the learning and the framework into medical education. In order to do that, relationships were built in particular with two key organizations: PMETB and the GMC.

Both PMETB and the GMC were stakeholders in the EEML project from 2006 (as evidenced in Project Summary May 2006, appendix 4: document 1) and one of the key factors in gaining their support was how the project’s aims and purpose related to issues of poor medical practice, as explained by this participant:

…part of the winning argument is if you say to them, ‘look at NCAS, the majority of doctors who turn up at NCAS don’t have problems with which way the heart valve opens. It’s, they don’t function effectively in teams, they don’t communicate well, they are rude to patients. And they agree, they nod when you say this, it is these wider range of skills that they don’t have that end up being problems… That’s quite a winning argument with the GMC. [#8, academic, PT/SG]

Soon after, PMETB took the decision to scrutinize and approve the MLCF in 2008/9 and this was felt by some participants to be a crucial moment in formalizing the purpose and aims of the EEML project within medical curricula. One participant recounted this:

It must have been after about a year, PMETB insisted it should be a straight addendum to every curriculum and eventually everyone went away to write it into their curriculum… with specific curriculum, there is stuff that everyone expects everybody should know. [#5, doctor, SG]

NCAS (National Clinical Assessment Service) is part of the NHS Litigation Authority, whose role it is to help resolve concerns about the professional practice of doctors, dentists and pharmacists. More details can be found at: www.ncas.nhs.uk
Likewise, this excerpt describes how important it was for the success of the project:

When PMETB recognised medical leadership as a specific competency that could be tested using the MLCF, and could therefore become part of curriculum. Now that, you know, if there is a driver, that’s a driver. [#2, doctor, SG]

PMETB’s decision to become a project member and support the inclusion of the MLCF into specialty curricula was part of a growing realization, which included changing times, concerns over poor medical practice, as well as other factors described in previous chapters, to ensure leadership development was a part of all doctors’ training, rather than an exception.

Building on the PMETB decision, an associated stage of the project was to link this potential shift in attitudes and get the MLCF adopted in forthcoming renewed guidance for undergraduate education, Tomorrow’s Doctors (General Medical Council, 2009). This was because, with PMETB’s move into the General Medical Council (GMC), it gave the latter oversight and control over the curriculum throughout medical training. Members of the project team described how important this process was:

There were stages where, for example, we needed it [MLCF] to get into Tomorrow’s Doctors, where we needed it to be embedded in the specialty curricula that each of the medical royal colleges produced. Those were a lot of waiting periods where there wasn’t a lot we could do until we knew that it was going to be included in Tomorrow’s Doctors…we created guidance to help medical schools integrate the competency framework into their curriculum. But there was a bit of, ‘well we have done what we can do, we need to wait, and see what the GMC says now’. Or we need to get the approval or the endorsement from PMETB, when that was to say, ‘yes we support this and the colleges should definitely be including these competencies in their curricula…’ [#4, manager, PT]

The following excerpt describes the significance of that:

One absolute critical stage was in 2009 when the GMC incorporated the framework into Tomorrow’s Doctors. Because that is a prescriptive document that tells undergrad schools what they most cover…So that inclusion was essential because what it also means is that if you introduced it at undergraduate level it really made no sense to stop that process at the postgraduate level …So the fact that PMETB became part of GMC was also crucial, because PMETB agreed with us that they would ask all colleges to incorporate the framework into their postgraduate
medical training curricula. And that meant that we now had the undergraduate and the postgraduate world covered. We are still working through with the GMC how it’s built into revalidation. Because that gets us all the way through the system, that gets the undergrads, the postgrads and the consultants up to that first revalidation period… and the lobbying was about getting them to incorporate it into Tomorrow’s Doctors. So that was a pretty big win actually to get them to do it. [#8, academic, PT/SG]

Not only was this a significant victory for the project team in relation to PMETB and the GMC, it had a wider effect in terms of gaining broader support for the project from other relevant organizations, such as medical royal colleges, as described by these examples:

… there were some things which felt really important, so particularly around the GMC and PMETB who have got an umbrella over it all, getting their support and assent to incorporate this felt really important and once you had them on board you could start to lever the colleges and medical schools… So had the GMC or PMETB said, ‘look, you guys are going at this wrong’, maybe it would have got parked if there was too much else going on, that would have been hard. [#18, doctor, SG]

…the way doctors behave is so governed by what the regulator says. And ultimately [the GMC] have their licence to practice, [to] approve all the postgraduate curricula. So if you’re seeking, as this project was, to embed management and the framework in postgraduate curricula, it probably does make sense to have the GMC involved… people thought it was a good thing to have the GMC involved, as they often do in medicine, because a lot of it’s about getting alliances and getting supporters…knowing that every college will at some stage have to submit its curriculum to the GMC for approval…You can have a college completely ignore it if you like, but don’t forget the acknowledgement of the GMC on the back page just gives it a little more credibility in the medical firmament… not having [the GMC] involved would have made it difficult. [#6, manager, SG]

The interaction and engagement with PMETB and ultimately the GMC was intended as a way of ensuring that changes would be sustained over the longer term, rather than be quick fixes to this issue. By linking into the timing of reviews of medical education curricula (Granqvist and Gustafsson, 2015), the project was able to work with the GMC and ensure the framework was embedded in refreshed specialty curricula. By taking such an approach to change, working within and to a defined period of change, and with these organizations, was imperative:

...we knew what we were doing was taking a decision that would bear fruit in the long term…over a generation rather than a quick set of new Masters programmes for medical directors, which would be the alternative way of
thinking about all this. But what that meant was we had to know when the GMC were going to reissue Tomorrow’s Doctors. We had to work with the Council of Deans of medical schools...because there is a window to affect the redefinition of the curriculum for specialist training which the colleges do with PMETB and the GMC, an opportunity to influence Tomorrow’s Doctors because it goes through a quinquennial review process. There were windows that would close quite quickly and we had to be in a position to influence people so that those opportunities were taken to underpin all of this... we knew some key points and some opportunities emerged as we went along. [#22, doctor, SG]

This details quite significantly the thinking behind the approach taken and how the intended effort was constrained within a window of time. In the words of one participant, the reason the project was pursued via the curriculum route was because:

…it’s getting to the nub of how you develop as a doctor. And if you want to engage doctors you’ve got to engage with the way they become doctors and try to influence that in some way. [#13, former senior manager, PT]

Through curricula, medical students and doctors in training are taught the knowledge, skills, attributes and behaviours that are required of any practising doctor, as outlined in chapter 2, and this was recognized as crucial to ensuring leadership competencies were embedded in practice:

Well I think if you want young people to take notice of anything, get it into the curriculum and then taught properly. 'Cause it’s really a two stage process, the curricula are very crowded but if you can actually get the right people in the colleges to put this module, or this sort of programme, into the curriculum sequentially...as it goes in year by year and it gets more advanced, you only give a little bit and by the time you have produced a fully trained doctor you hope you have given them a lot more. Therefore, they will take notice of it, if it’s in the curriculum you think you need to know about it. [#17, doctor, SG]

But technically, no postgrad doctors should be able to get their CCT unless they’ve demonstrated the postgraduate management leadership service improvement competencies, in the same way that no medical student should graduate unless they can demonstrate [clinical competency]. [#21, academic/manager, PT/SG]

The above excerpts have described how the project aimed to embed leadership development through competencies into the curriculum and the importance of getting the GMC, PMETB and other relevant medical organizations, such as the BMA, on board in giving the project credibility and legitimacy. Whilst this process
was ongoing, another approach was being employed by the project team and steering group to understand how the MLCF might be used in practice.

6.2.7 Testing out the MLCF: co-production and collaboration

In carrying out the project, key individuals were recruited and important alliances formed that were then used to build wider support. Part of this process of building support involved the approach to engagement employed by these individuals in testing out the MLCF. It began through a process of listening to what stakeholders thought might work:

They just heard what I had to say about it in a way, if I did anything it was say ‘great idea, carry it on, please do it’. Because it wasn’t for to me to say you are missing something because the leadership curriculum was via the colleges. The blue print books I distributed, the circle [MLCF], all the nice diagrams as it were, we put out. And we reviewed and we tried to check that’s what we were offering here too…. we were looking to develop people’s understanding in the academic sense of the leadership roles and change management and how that’s best achieved. [#3, doctor, SG]

We wanted to make sure it wasn’t just what are you going to do for us, it was what can we do for you. And understanding their motivations and what would get them on board and happy to take part in what we were doing. [#9, administrator, PT]

Both of these perspectives describe that the engagement approach was not a ‘hard sell’ of the content and purpose but one that aimed to check understanding and test out ideas. One of the ways in which ideas were tested out was by trying to speak with people who were leading key organizations, but also those responsible for the mechanics of integration and implementation:

The other part of the project, once the colleges have set the training curricula they’re not really responsible, so they think, for actually delivering it. So that’s a responsibility of the Deans and I think we met with the Deans frequently, I used to go to the English Deans and CoPMED [Conference of Postgraduate Medical Education Deans] … So there was a lot of high level engagement and that worked pretty well, but it was that bit down the bottom there, the foot soldier bit, so how do you actually turn that curriculum competency base into something that means something to doctors on the ward… and then I think there was something about the personal approach of engaging with the people I knew… [others] were using much more of a sort of engaging, mentoring style and hoping that you know the snowball would build. [#10, doctor, PT]

One of the things that I did on my own was visit every UK Medical School and interview every Dean of the Medical School. And if I couldn’t get the
Dean, I got the person who was responsible for management and leadership, as far as the curriculum was concerned. [#13, former senior manager, PT]

In particular, a lot of the success of the acceptance of the MLCF and the EEML project came from running workshops with stakeholders. Again the approach taken was one that was centred on mutual benefit and being interested in hearing diverse voices:

...we had these different focus groups, undergraduate, postgraduate, continuing practice and we said, 'right, what are the things that you do that you might call management and leadership?' And so we got these lists of activities that people did and we took them away...and once we'd got the basic framework, we tested it back out with reference groups and beyond and then we refined it further. So it was quite an iterative process over quite a long period of time, probably a year, 18 months until we got to something that we published. Because what we needed to do then was put some meat on the bones of that. So we had our domains, we had our elements and we had some descriptions, and then we needed to compile some case studies that were illustrative and from the field. So we got the doctors to write those at undergraduate, postgraduate, continuing practice [levels]. [#11, academic/manager, PT]

So we had lots of people and they came together as a reference group about three times, maybe more than that, and then we had conversations beyond that...the reference groups were very egalitarian, we want contributions, we don't want grandstanding... [they were run] as functional workshops that got a lot of information and a lot of listening to each other and seeing things differently... [#14, former senior manager, PT]

One participant described how this began to break down barriers and bring about some consensus:

And this big group would be made up of doctors in training, medical managers, tutors from secondary and primary care, all specialties. Often some good discussions around, 'well surely a doctor should do what the chief executive said', to the doctor saying 'well actually we have got dual loyalties, one is to the NHS, the organisation, but also to the GMC and the ethics the GMC had'. And that was never a sticking point...but it did identify the ethics for which the profession has to go forward. And for some of the non-medical people it was just interesting for them to talk it through. They were all well aware of it, they've worked with doctors all their lives...it's always difficult to answer the needs of a financial operating system but you've got a human being in front of you. [#19, doctor, PT]
So, alongside valuing contribution, actively getting doctors to write case studies and encouraging debate, the ethos of engagement was underpinned by being open about the process:

…the main thing is to make sure that people know why they are being asked and if you are going to listen to them you really are going to listen to them. And that any report following will reflect the fact that you are not just going through a tick box exercise, so that you reflect what was genuinely said. And that wasn’t always necessarily in support of [the project], but would often show you future pitfalls or barriers, so you wanted everything. For people to give up [time] and we had people very busy delivering care on the ward and practices, and they don’t have much time…So you have to make sure it is worthwhile that they come down and that you capture it…it was just that intelligence gathering and that is very important in leadership, it’s being able to see the world through other people’s eyes, to understand the influences on them, a particular response to something you are doing. [#19, doctor, PT]

Now just getting people together on a regular basis and showing them, well actually, why reinvent the wheel every time, there are common elements which they can share…it was relatively easy once you got them into the room and realising that you weren’t in any way threatening them, you were just trying to help them come up with a better product and better patient outcomes. [#20, doctor, SG]

The experiences described above are examples of how participants approached their work with a consideration for the views of stakeholders, supporting them to elicit an understanding of what might work or not, and were done in a way that did not foreground any expertise or knowledge the project members had in the content of the competency framework and curriculum. Indeed, much of the iteration involved using the groups to help produce materials and case studies that were relevant and grounded in practice. The approach described above through these various excerpts matches that described at the outset of the project around making the process of engagement meaningful and collaborative and can be related to Dorado’s (2005) notion that those seeking to change within an institutional context cannot succeed alone.

6.2.8 Refining the product: the role of language in developing the MLCF and MLC

Previous sections have alluded to the work undertaken to engage stakeholders with the EEML project. Part of that was the role project team members took in testing out and facilitating the embedding of the main product of the EEML project
the Medical Leadership Competency Framework (MLCF) – into stakeholder organizations in the form of the Medical Leadership Curriculum (AoMRC and NHSI, 2009). This was done using the approach, evidence, expertise and experience of its members building on research undertaken internationally, as well as through developing the Medical Engagement Scale (Spurgeon et al., 2008), which demonstrated a link between medical engagement and clinical performance and outcomes. Furthermore, part of that approach was the use of language that chimed with professional thinking, as picked up in project team minutes from 19th June 2007 (AoMRC and NHSI, 2007, appendix 4: document 21), where the following points were noted:

*Critical Friend / Conversation phase*

**Purpose:**
- To test language
- To test levels and ensure understanding
- To obtain contextual examples to support the levels
- To ensure individuals/organisations can work with the document and translation into curriculum and assessment is possible

This was also described by this participant:

> So, we had done a fair bit of research around what other frameworks actually existed…and we got to a point where let’s all of us as the project team just look at these frameworks. So we decided what the different domains would be, primarily basing what we were doing on the Leadership Qualities Framework because that existed at the time and was well regarded and well accepted. So the structure emerged from that. But the big thing for us was around the language and what would be the language that would be most acceptable to doctors in the medical profession…So the challenges were in particular in ‘managing the service’ or in ‘setting direction’ of something. [4, manager, PT]

The above evidence demonstrates that project team members were conscious of issues of relating to language around and of leadership. What emerges from other accounts is how the project created a common language around which leadership could be discussed and ideas and concepts challenged. Ensuring the language was appropriate continued to be something of a focus even after the first edition of the MLCF had been published:

> So I was more involved in the undergraduate piece we worked on, with a consortia of curriculum designers in various universities, to produce the guidance on how you might integrate the MLCF within the curriculum… at that point the first edition had been out already but we had had quite a bit of feedback on it, so gathering together all the different feedback and
simulating that and working out, ‘we can take on board this, this isn’t quite appropriate’, working out who we needed, who else we needed to consult with. And then working with a few of the project team members, working out what language we needed to get changed, go off for a plain English review, working with the designers to get together the look and feel of it. 

[#9, administrator, PT]

In the excerpts above, the participants reported the attention paid to language and wording, as well as to engagement with internal (steering group, project team) and external (reference group) stakeholders.

What the above extracts demonstrate is the iterative, inclusive approach to engagement, undertaken by participants, linked to the core project purpose and particular windows of opportunity. These were underpinned by a style of engagement that used peer relationships and influence, employing values and language that considered and understood stakeholder perspectives (Suchman, 1995), supported by evidence, experience and expertise of the project team and steering group.

6.2.9 Summary: A ‘no surprise’ curriculum offer

Feedback had been sought following the publication of the first version of the MLCF, to adapt its language, tone and case studies and the time and effort put into working with the profession resulted in products that were of little surprise, as described by this participant:

…it was one of those elegant pieces of work…We did so much seed investment in saying what we were doing, when we came to publish people went, ‘we know all that’. It wasn’t a big bang because actually we had prepared everyone so well, that it was just, ‘yeah, well we’re doing that already’…what they were saying was they had seen the model, because when we had produced the model we had shared it with everybody. We made everyone feel they were part of its development, so from young medical students, all the way through to the Presidents of the Royal Colleges, so it was who was the audience that we’re going to have to sell the final project to? And actually, we didn’t have to do a sales job because it was just so evident. [#7, former senior manager, PT]

In another example, a participant discussed how five pilot sites agreed to test out the work and in one experience discovered that the framework was already being used in practice, given its availability on the internet, without anyone feeling the need to inform the EEML project of their use of it. Feedback from a further pilot site recounted an episode with a focus group of students who were able to give
examples of how they could take the framework and apply it for themselves, that educationalists and the project team could not begin to see. Likewise, when subsequent versions were produced, they too were of little surprise to the profession, due to the manner in which the project had carried out its work:

And then of course you go from a listening part into the delivering and if you like, marketing and selling of it and that was quite interesting, going along to the [college] Annual Conference. And because the project had been integrative from the very start by the time you were marketing it, it wasn’t a surprise to anybody. People knew about it, it had been written about enough. I made sure I put things as soon as we were able to, in the [journal] for instance so that people will have seen that wheel with the five domains, it went viral...by the time it comes out suddenly people aren’t saying, well ’what’s this all about and who are you to tell us what to do.’ Because the whole process was open they’d understood it wasn’t just us sitting in an office in the centre of London having a good idea...actually the idea came from a community of people...so it was the fact that you were forever integrating and developing the ideas and making sure that was known about so you didn’t say, we are now doing the listening and we are now going to market, you were doing it all the way through. [#19, doctor, PT]

The excerpts describe in particular how the project was able to latch on to existing work that was happening around developing and embedding leadership competencies into training, through the iterative, consultative approach outlined above and develop a number of products that were acceptable to and accepted by all levels of the profession from the outset and which did not appear as an unwarranted surprise.

6.3 Chapter Summary

This chapter has highlighted the practices and general approach undertaken within the project from the setting up of the project and recruiting to its two key fora; the key alliances and relationships that allowed it to function and proceed; the opportunities taken to tie in with wider developments in medical education around Tomorrow’s Doctors and the work done to test out the MLCF and its language with external stakeholders, amongst them doctors working in the NHS. This resulted in a product launch that was of little surprise to the medical profession. It has highlighted how the approach taken and practices enacted can be framed within the literatures introduced earlier on, notably around the role of social position, capital, relationships and collective action (Battilana, 2011;
Dorado, 2005; Lockett et al., 2014; Nicolini, 2012) and that these processes focussed around engaging with others using routine practices (Feldman and Pentland, 2003).

The next chapter will attempt to draw together the threads developed in chapters 5 and 6 – of environmental conditions, of purpose and motivations and of approaches to and practices within the project – to offer both empirical and theoretical contributions as to how to work with professional groups to enact institutional change.
Chapter 7: Practising change in medical education; ‘mirroring’, system capital and system centrism

7.1 Introduction

This chapter presents the interpretation of the major themes arising from the analysis of data in the previous two chapters and offers some suggested contributions: firstly, to understand the processes or phases involved in opinion leaders’ actions and practices that are important in effecting change through the introduction of a four-phase process of Contemplating-Preparing-Mirroring-Revealing.

Subsequently this chapter will explore how this case furthers understanding of strongly institutionalized environments through the emerging concepts of system capital and then system centrism. It will argue that concepts of system capital and system centrism are refinements and extensions of Lockett et al.’s (2014) model on the influence of social position and the nature of dispositions within organizational change, by demonstrating how professionals can use their collective capital assets as a stimulus to act collectively towards wider dispositions than their own professions (see figure 6 below).

Figure 6: Adapted Model of Influence of Social Position and the Nature of Dispositions within Organizational Change (Lockett et al., 2014: 1119):
The chapter begins by outlining the empirical contribution to this research, namely how opinion leaders enacted and effected change within medical education (chapter 7.2). It then continues by discussing the concepts of system capital (chapter 7.3) and system centrism (chapter 7.4), which make up the final contributions of this thesis, before giving some consideration to alternative theoretical interpretations of the data presented in chapters 5 and 6 (chapter 7.5).

7.2 How do opinion leaders enact and effect change within medical education?

From the analysis in chapters 5 and 6, four key phases can be determined, in terms of understanding how to work with professionals to bring about change. This can be conceptualised as the following four-phase process:

7.2.1 Phase 1: Understand Prevailing Conditions

There was a particular time and space – a policy window – that allowed the project to happen

As we saw in chapter 5.2, although a few participants did identify a key event in the NHS ‘story’ as a driver for the change initiative, there was little consensus around one event. Both project documents, such as the scoping study and steering group minutes (appendix 4: documents 3, 81-90), in mentioning factors such as Bristol (Kennedy, 2001) and the RCP (2005) report, as well as interviews, indicated that a number of events as well as general conditions for change were seen as creating an enabling environment for this change. Feldman and Orlikowski (2011) argue that the nature of contemporary organizing is complex, distributed, mobile and transient and this relates well to the prevailing conditions during the mid-2000s of the NHS.

Opinion leaders were able to identify prevailing conditions, key policy thinking and the societal ‘temperature’ towards the medical profession and respond to the emerging demands and dilemmas, thus demonstrating a practical-evaluative sense of agency (Battilana and D’Aunno, 2009). Earlier, referencing Dreyfus (1991), Nicolini (2012: 35) explained this by describing how “…an individual’s social and historical relation to the world” informs their practice and it was the case that multiple events in each opinion leader’s context informed their
understanding of the climate for change. Moreover, Granqvist and Gustafsson (2015) described in chapter 3 how actors engage in such action within institutional processes to “…construct, navigate and capitalize on timing norms in their attempts to change institutions” (Granqvist and Gustafsson, 2015: 38), which can be seen with how opinion leaders linked to the window of opportunity created by exogenous and endogenous factors identified in figure 5 towards their purpose.

The argument from participants was that doctors had a role and responsibility to be engaged and only opinion leaders, as individuals or a group from inside the system, with their particular perspectives and ability to draw upon each other to engage with the social structures around them (Lawrence et al., 2009), could sense the opportunity and use it. This can also be seen to relate broadly to the direction of travel that emerged as part of the Health and Social Care Act (2012) around medical leadership, with an emerging focus on outcomes that reflect patient experience as well as clinical and financial measures.

7.2.2 Phase 2: Identify Purpose and Motivation

There was an accepted purpose that the project was beneficial for the profession and there was motivation to engage with the profession

As we saw in chapter 5.3 (for example, Table 5), all of the interview participants spoke of a need for the project, as a way of ensuring the profession was in the best possible state to carry out its role as care givers and system leaders within the NHS. How the medical profession were trained, organized and managed within that system was at a point of particular scrutiny and therefore subject to general conditions for change. The analysis above has revealed that the medical profession had a choice: be part of influencing and leading that change if it decided to or choose to allow the change to happen to it. Key opinion leaders conceived a project infrastructure around that purpose and engaged individuals within and beyond that structure towards a possible future trajectory of action, thus demonstrating a projective form of agency (Emirbayer and Mische, 1998; Battilana and D’Aunno, 2009).

Far from being solely heroic ‘entrepreneurs’, these individuals worked with others in “…intelligent, situated institutional action” (Lawrence and Suddaby, 2006: 219), whilst using discursive strategies to mobilise resources (Leca et al., 2008), acting
more in a manner of collective or distributed institutional entrepreneurship (Dorado, 2005; Lounsbury and Crumley, 2007; Garud et al., 2007; Qureshi et al., 2016). Active agency created the project, through recruiting individuals to both the steering group and the project team and subsequently connecting to their professional interests, knowledge and mutual visions. Collectively, opinion leaders and other project members took part in various simultaneous aspects of creative, maintaining and disruptive institutional work (Lawrence and Suddaby, 2006), advocating, defining, educating, enabling, embedding and routinizing the project’s purpose through its processes, mechanisms and practices, whilst also disassociating some of the moral foundations of arguments that had previously existed that doctors, leadership and management did not go together (Lawrence and Suddaby, 2006). This can be evidenced in project documents, such as steering group minutes (AoMRC and NHSI, 2008, appendix 4: document 87), where it is noted that project work had enabled the MLCF to become part of the discussions around the update for Tomorrow’s Doctors (GMC, 2009):

*The consultation version of Tomorrow’s Doctors will include a discussion paper on leadership... GMC are planning to talk with medical schools in summer around curriculum implementation.*

The particular infrastructure and membership positioned the project as legitimate in the eyes of the profession and using their previously earned legitimacy collectively, in order to appeal to a broad and diverse constituency (Leca et al., 2008), opinion leaders were able to create the project team and steering group and source funding and high-level sponsorship. Part of the set-up was about ensuring that within the project itself, there were organizations and individuals who could act as influencers and enablers within the wider process of engagement (for example, see chapter 6.2.2, pp.159-161). This was also noted in the scoping study report of May 2007 (NHSI, 2006: 5):

*Building relationships - The initial scoping phase of the project was specifically designed to provide time to build relationships with leaders of many of the medical professional and regulatory bodies. It also provided opportunities to meet a number of individuals with particular perspectives on, and interest and involvement in, medical management and leadership.*

As well as getting them on board with the project, individuals from key organizations were important in enacting and embedding the project within the profession itself, resulting in a form of dynamic institutional maintenance that
“…enables the institution to evolve in order to endure” (Giddens, 1984: 24, as cited by Herepath and Kitchener, 2016).

7.2.3 Phase 3: Commit to Practice

*Working with all levels of the profession by adopting a “mirroring” approach*

This project adopted a particular approach in engaging with stakeholders, which can be conceptualised as ‘mirroring’. Having a ‘feel for the game’ (Bourdieu, 1977; Nicolini, 2012), project members practised a facilitative and consultative style, testing out ideas iteratively with wider stakeholders through reference groups, deaneries and providing assistance for implementing the MLCF into specialty curricula, much like in a co-productive manner (Reeves and Knell, 2006; Hunter, 2008). As can be seen from the evidence provided in chapter 6.2, ‘Mirroring’ describes an approach that not only ‘reflects’ but accurately represents and matches where the profession was in terms of its thinking and not to be ahead of or behind that thinking; for example, appropriate language was adopted that was refined by the profession for the profession, through the various engagement fora (see chapters 6.2.7 and 6.2.8, pp.172-176). Understanding the language required for the appropriate audience, project members were drawing on normative legitimacy, alongside the structural legitimacy that was displayed in the forming, positioning and ‘badging’ of the project (Suchman, 1995). This enabled the profession to gain greater ownership of the project and its aims. This meant that when the project produced its initial outcomes, they were accepted by the wider medical profession.

Conceptually, mirroring connects structural factors such as a prevailing environmental condition to particular interventions, like those adopted by project members, and like Lawrence and Suddaby’s (2006) institutional work notion of ‘mimicry’, is situated in existing sets and schemas of understanding as a way of easing in the passage of new practices and ideas. This juxtaposition of ‘old’ and ‘new’ (or ‘present’ and ‘emerging’) makes the new ideas “…understandable and acceptable, while pointing to potential problems or shortcomings of past practices” (Lawrence and Suddaby, 2006: 226).

Mirroring involves meticulous, iterative and constant effort to understand where the profession is, working with it sensitively to consider and understand various
perspectives, employing evidence, experience and expertise of the system and its drivers for change, as outlined in chapter 6.2. It required an intellectual flexibility not to predetermine how the means for embedding medical leadership might look, rather to let them emerge from consensus and through building key alliances across all levels of the profession. One of the key facilitating actions of this was to consult genuinely through the various groups and let the ‘answers’ emerge; to ‘aggregate the nuggets’, to borrow a phrase from one of the research participants. Alongside this, members were able to connect the project to key events such as the consultation on the GMC’s (2009) Tomorrow’s Doctors, as a means of embedding leadership development within medical training (see chapter 6.2.6, p.168-172). By doing so, they were undertaking the three distinct processes described by Granqvist and Gustafsson (2015). Firstly, they ‘constructed urgency’, expressing “…perceptions that change was necessary” (p.17); secondly, ‘entraining’ was displayed, where project activities were aligned with the external timing norms of Tomorrow’s Doctors and finally through ‘enacting momentum’, they were working with the profession “…in motion towards future outcomes” (p.18).

7.2.4 Phase 4: Outline Outcomes

Leadership development in the curriculum and a new discourse of the doctor-leader

In foreseeing and recognising the prevailing conditions [Phase 1, which we could conceptualize as “Contemplating”], the data describes the purpose behind and the need for this project and the motivations and values that underpinned that [Phase 2 – “Preparing”]. Through an approach to engagement that was considered and in step with the profession’s thinking [Phase 3 – “Mirroring”], the project was able to launch ‘unsurprising’ products and outputs, notably the MLCF and MLC documents, as well as creating, in the minds of many of the research participants, a new, emergent discourse [Phase 4 – “Revealing”]. This is incorporated and embedded through curricula into medical training and also enacts momentum towards a future discourse (Granqvist and Gustafsson, 2015), in this case, of the doctor-as-leader.

Aside from the tangible products, such as the MLCF, MLC and Medical Engagement Scale (MES), some of the findings reported by project members in
terms of outcomes were a greater awareness of leadership and management for doctors (as evidenced in the Project Plan 2008-09, appendix 4: document 4); changes to curriculum and training; changes to practice, with some evidence of improved outcomes and a nascent language of leadership, common to all doctors in training. Whilst this research study cannot attest to the long-term nature of the EEML’s project outcomes, given the short time since the project was completed, participants spoke about a changing culture with the overt doctor-as-leader, the formation of the Faculty of Medical Leadership and Management and growing interest in leadership and service improvement notably amongst younger doctors and those in training as evidence of that (Spurgeon et al., 2011).

7.2.5 Summary
This finding offers the first contribution of this thesis, a four-phase process of Contemplating-Preparing-Mirroring-Revealing. It considered the process by which individuals engaged in the project undertook their roles and helps us to understand how change was initially considered, pioneered and created. It has briefly established how a combination of values-based intentions and a vision of the future of leadership development within medical education were vital in adopting an approach that mirrored the behaviours and thinking of the wider medical profession to enact a key moment of NHS organizational, institutional and system change. Key to this effort were the relationships established amongst like-minded people motivated to work on the project, alongside crucial existing relationships to allow a number of the key phases of the project to unfold and occur. All of this was summed up by this participant:

…what felt new and different was looking at engagement rather than expectation. So you look at the doctor’s role in leadership positions, you then start talking about power, the organisation, the hierarchy, professionalism and tribalism. And a lot of doctors had got told, you’ve got to become the next Clinical Director, you’ve got to become the next Clinical Lead, it’s your turn next, whether they had any skills or not. For us the newness was about having the conversations, which said that all doctors have a role to play, but also that doctors need to acquire the competence to do the job. And they haven’t all got that, they’re not all born with it and up until now, Buggin’s turn has been okay but actually in this world it’s not okay…part of a doctor’s responsibility should be about looking at themselves, holding a mirror up and saying, how do I develop the skills around this, if I haven’t already got them…so it felt as though it was new territory because doctors have always had a role to play, but the dynamic and the context and the environment had shifted… [#8, academic, PT/SG]
Furthermore, this process, with ‘mirroring’ at its heart, allowed participants to adopt a genuinely consultative approach to engagement with the medical profession, rather than one that was ‘done to’ the profession. In terms of its relationship to agency and practice theory, it helps to demonstrate the dynamics and tensions inherent in change processes and the micro-level practices of individuals engaged in ongoing actions of institutional change.

This chapter will now turn towards consideration of further contributions of this research study, notably theoretical extensions to the work of Lockett et al. (2014).

### 7.3 The development and use of system capital

#### 7.3.1 Introduction

This section develops an argument that individuals, and particularly opinion leaders, acted in a way that drew on each other’s skills and resources, using a concept called system capital. In doing so, it helps to demonstrate how this case furthers understanding of change in strongly institutionalized environments through the use of system capital – a shared, collective form – as a resource to take advantage of the particular prevailing conditions and enact the project through working with and influencing others.

In respect of the four phases of the project outlined at the start of this chapter, particular narratives can be demonstrated as summarized in table 6. These will be discussed within the context of this section and demonstrate the role system capital played in practising change:
Table 6: Project phases at a conceptual level

<table>
<thead>
<tr>
<th>Phase of Project</th>
<th>Conceptual Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand Prevailing Conditions</td>
<td>Contemplating</td>
<td>Understanding of the prevailing conditions in the NHS at this time transposed different fields/habitus, e.g. medical field, managerial field and how to use them to create change</td>
</tr>
<tr>
<td>Identify Purpose and Motivation</td>
<td>Preparing</td>
<td>Drawing on own symbolic, social and cultural capital, linked to maintenance of the medical profession as institution; including those already known (prior relationships) as a resource (additional sources of capital)</td>
</tr>
<tr>
<td>Commit to Practice</td>
<td>Mirroring</td>
<td>This is about understanding where the profession is and thus understanding the habitus/field in which they operate</td>
</tr>
<tr>
<td>Outline Outcomes</td>
<td>Revealing</td>
<td>Seeing motivations and purpose realized that are accepted by the profession (legitimized)</td>
</tr>
</tbody>
</table>

7.3.2 The role of existing relationships

During the ‘contemplating’ and ‘preparing’ phases, participants were engaged in the process of either setting up or joining the EEML project. As chapter 6 has demonstrated (for example, see chapter 6.2.5, p.167), a number of pre-existing relationships were apparent. During the interviews, in order to understand how the project unfolded from the perspective of those engaged with it, I had asked participants about any key relationships that they had during the project (appendix 3). What arose from that was mention of relationships not only during the project, but also, those that had existed prior to it commencing. In understanding what was crucial in the enactment of the outcomes, participants spoke of drawing on these existing relationships.

As a consequence of the frequency with which this was being mentioned, I began to explore which participants were connected to each other to see if there was anything significant in these relationships. Subsequently, a map of prior relationships and connections was drawn (appendix 10) to indicate the key links that existed prior to the project. At this stage, some consideration may be given to the relevance of social network analysis (Scott, 1988) but this was not felt to be necessary due to the size of the cohort interviewed and this research’s focus.
on meaning and not the number of relationships. Nonetheless, the map highlighted relationships that were particularly between opinion leaders and others within the project team and steering group and the particularly important roles played by certain individuals. This allowed for analysis of how existing relationships and capital resources influenced the process and practice of the project.

7.3.3 Relationships, social position and capital

The nature of the relationships between certain stakeholders had developed over a number of years, largely because of their shared interests in medical leadership and management. However, this does not mean that all of these participants shared a common understanding of how the project should unfold and what its outcomes should be. Differences of opinion, vision and views existed amongst those who had known each other from their time and service within the NHS and it could be argued that they were therefore a coalition of opinion leaders, with diverse motivations, values and interests (Leca et al., 2008). Nonetheless, all were in senior positions within NHS-related organizations and had been involved in previous change initiatives within either the medical profession, medical education and in relation to organizational development, leadership, management and service improvements.

The analytical turn employed here was to focus on how the relative characteristics of participants had managed to effect and enact change. By focusing on that, I considered the attributes of these individuals and was able to further elucidate Battilana’s (2011) work, which examined the relationship between social position and organizational change in diverging from the institutional status quo. In the two types of change that diverged from the expected institutionalized template of role division both among organizations and professional groups, her study found that actors with different social position profiles were likely to undertake the different types. Significantly, actors at the centre of one field (e.g. medical education) were at the periphery of another (e.g. leadership and management development and change) and my findings confirmed that opinion leaders were the ones to initiate organizational change. Moreover, Lockett et al. (2014) examined the influence of actors’ unique context, as characterized by their social position, on their sensemaking about organizational change. They concluded that
“...actors within a professional group may sensemake in different ways which are shaped by their individual endowments of cultural capital” (Lockett et al., 2014: 1122), which was the case here.

Prior relationships were critical in getting things done within the realm of the project, ensuring its purpose and aims were not derailed. Moreover, this coming together of individuals from influential organizations, as evidenced in both interviews and project documents (in chapters 6.2.2 and 6.2.3, pp.157-163), happened at a particular time, when a window of opportunity arose for the convergence of these connected opinion leaders. Drawing on their own backgrounds, biographies, identities and motivations and sensing the opportunity to act, all were then saying that the issue of greater medical engagement was a concern that needed to be addressed and there was agreement to get something, such as the EEML project, started (for example, the evidence presented on the project's purpose and motivations in chapter 5.3.1-5.3.3, pp.142-152). As has been discussed earlier in chapter 3, one of the key contributions to an actor’s practice is their capital endowment or resources (Bourdieu, 1986), made up of varying degrees of overlapping types and elements (e.g. economic, social, cultural, individual, informational, intellectual and symbolic). Likewise, an actor’s social position is defined by their use and control of these varying elements (Bourdieu, 1986): hence a direct relationship can be drawn between practice, capital and social position. In the context of this project, social, cultural and symbolic capital were the elements most drawn upon.

In the case of this project, opinion leaders who were medical professionals had a Bourdieusian ‘feel for the game’ of medical education; whilst their counterparts from non-medical professional backgrounds, immersed in non-clinical and administrative functions of policy development and change management, had an equally good ‘feel for the game’ in their field. Each could demonstrate practical command in their own ‘game’ but struggle in games and fields where their own dispositions were less well developed and their capital resources in shorter supply. Only a few opinion leaders may have had enough understanding and resources within all fields, but not enough on their own to initiate and successfully conclude the project. They relied on reaching out to others with their own dispositions and capital resources, who had a ‘better’ feel for the series of intricate
games involved in enacting, managing and embedding change in medical education, such as building the competency framework, securing alignment from medical education organizations, facilitating workshops and testing out the language of the framework.

In the medical profession, social, cultural and symbolic capital shape an actor’s position within that grouping and the opinion leaders had sufficiently high levels of all three forms of capital. In Lockett et al.’s (2014) study, the professional with the highest status cultural capital and most profession-centric social capital was more likely to orientate towards the primacy of knowledge creation, in contrast to those with lower status cultural capital who were more likely to focus on the importance of practice and improving service delivery. Their relative positions determined their actions in the distinct directions of knowledge creation and service improvement. In contrast, in this study, opinion leaders possessed high enough levels of cultural capital yet had social capital dispositions that were more systemic and focussed on delivering service improvement through the EEML project, which was a project of collecting together existing knowledge from the profession and abroad, rather than necessarily and solely creating new knowledge (see chapter 5.3.2 for the aims established at the outset, p.142). To explain that difference, the findings from this research offer a second contribution and offer a ‘new gaze’ (Bourdieu and Wacquant, 1992: 251) by developing the concept of an extension to the model of capital: that of system capital.

7.3.4 System capital

System capital is a cross-field collective form of capital. System capital incorporates knowledge, skills, tastes and preferences from cultural capital as well as the mutual relationships and acquaintances of social capital and the honour, prestige and recognition of symbolic capital. The preeminent argument arising from these separate but mutually dependent forms of capital is that they are employed to reinforce or advance an actor’s relative field position: to secure individual benefit and reward and enhance individual status and esteem (Bourdieu, 1986), whereby the more ‘credit’ they have of these forms of capital, the more they can advance and be advantaged in terms of societal status. What system capital offers as an extension to these concepts is the notion that opinion leaders drew collectively on their own endowments of capital for cross-field or
system benefits that would accrue more widely and in the future for others, and not solely for themselves. Pressure from outside their own fields were viewed to be increasingly relevant; for example, the expectations of the public and the taxpayer about the role and purpose of the doctor in the modern health service, such as towards patient experience (as noted in chapter 5.2.2 regarding general conditions for change). For so long, the dominant actors in the medical and health field have been doctors; now there was a challenge to that status, through the form of that changing public expectation, brought about by general conditions for change and expedited by changing professional attitudes. This culminated in a response in the form of the EEML project and dispositions towards a new role for doctors and medicine more generally in the twenty-first century NHS, as outlined in previous chapters.

Individuals who are able to use their own capital resources and draw upon existing relationships (and others’ capital), to then collectively sense a window of opportunity afforded by the field-level conditions in which to carry out the project, can gain access to the collective pool of system capital. Therefore, opinion leaders, as structurally significant actors within their field, possessing sufficient social, symbolic and cultural capital, can collectively access one another’s capital within a given meta-field. The concept of system capital is more than the sum of its constituent capital parts, extending beyond multiple localized forms of social, symbolic and cultural capital. Concepts of capital explain how individuals are able to understand field-level conditions, prepare for change and act as a result. Within a complex field such as medical education, which is mutually embedded alongside medical professionalism within the NHS, individuals used system capital as a means of enacting their motivations, which arose from professional interest, knowledge and their values and visions to bring about the possibility of change (as noted in Table 5, p.148), where a sole form of capital would not be able to.

This form of capital is collective but it can also be deemed to be of the person and acquired over time, fitting with the concepts of embodiment and duration (Bourdieu, 2006). It could be conceived of as being accessed as a ‘timeshare’, where multiple parties have the rights to it, thus diffusing individual power and ownership. In terms of its formation, only individuals who have had prolonged
exposure to the field-level conditions are able then to utilize the capital. Doctors are agents whose cognitive structures are comparable to the structure of the field and consequently adjusted to the expectations inscribed in that field (Bourdieu, 2004). The medical opinion leaders inhabited the medical field for a long period of time, acquiring and cultivating the sensibilities of that field but alone would not have been able to harness the system capital in the project field, such was their disposition to the medical field. Furthermore, their capital endowments did not possess the necessary transposability to other fields to bring about this change on their own. Through working across different fields, in relationships with non-medical opinion leaders who had their own resources of capital within their given fields, and collectively employing their agency, they were able to initiate the project, drawing on resources of mutual system capital. Therefore, system capital, whilst embodied by an individual, is not owned by one particular individual, but belongs to the collective, network or, indeed, system.

Nonetheless, as chapter 5 attested, it is possible to argue that actors participate in change for different reasons, some of which could be considered self-interested, whilst others more altruistic. Are self-interest and altruism (defined here as the practice of concern or consideration of others), as singular motivations, exclusive of each other? In an empirical example of clinical excellence awards, Exworthy et al. (2016), building on the work of Le Grand (2003), concluded that motivations existed that were both ‘knightly’ (altruistic) and ‘knavish’ (self-interested) and there was an interdependence between them, which could also be seen to be the case in this project. Likewise, Nicolini’s (2012) case study of telemedicine, as discussed in chapter 3, demonstrated that habitus, which informs capital and practice, was not only about power games involving different professional groups, but for some groups (nurses) was directed first and foremost towards well-being of patients, rather than professional self-interest. Individual actors may therefore strategically improvise, but not to maximise their own position as the primary driver of their actions. This is where system capital helps to explain how these opinion leaders acted, which cannot be explained solely through motivations of self-interest but must encompass something of a
return to professional values of social responsibility, public spiritedness and benefit\(^7\).

Moreover, system capital can therefore be seen to play a role regarding the dynamics through which professionals reconfigure institutions and fields. Within Suddaby and Viale’s (2011: 434) conceptualization that would make this project a medical professional change project of largely endogenous origin enacted by a few opinion leaders, drawing on “…their unique access to a wide range of different forms of capital within an organizational field as well as their facility in moving between different forms of capital.” Firstly, the EEML’s opinion leaders used their expertise and legitimacy to challenge the incumbent order – the one in which many of them were the privileged incumbents – to define a new, open and uncontested space for medical professional identity. Secondly, they used a related form of their inherent social capital – which I have called system capital – and skill to populate the field with new ideas and entities. For example, by creating and then utilizing the artefact that is the Medical Leadership Competency Framework (MLCF) itself, they were able “…to facilitate the transition between past habits and the elaboration of new habits for the future” (Lawrence et al., 2013: 1028; Raviola and Norbäck, 2013; Callon, 2009) and bring about a new discourse of medical leadership.

Thirdly, and again through the introduction of the MLCF, these opinion leaders introduced nascent rules and standards that recreated the boundaries of the field, as MLCF competencies became newly embedded into curriculum standards (as detailed in Project Achievements within the Project Plan 2008-09, appendix 4: document 4). Finally, they used and reproduced their system capital to confer a new status hierarchy or social order within the field, which was the emerging cultural acceptance of doctors as leaders within the health system. In doing so, system capital helps to explain not only how opinion leaders enacted and effected change in medical education but also how strongly institutionalized environments may be subject to change. What this case also adds to Suddaby and Viale’s (2011) analysis is that this was a change project about medical professionals, but

\(^7\) However, the issue of self-interest will be returned to and considered again in chapter 7.5.
which also required non-medical professionals, with their own forms of capital, in order to effect change.

7.3.5 Summary
System capital is a partly embodied, collective form of capital acquired over time through systematic exposure to processes of inculcation in cross-field activities. Like other forms of capital, it differs in its transposability across fields and in the fields of medical education, health policy and service improvement it was used within this case study to achieve the outcomes of the EEML project.

However, the existence of system capital only helps to explain how it was possible for this collective of opinion leaders to use this stock of resources to enact a project of this type across contested fields. It does not explain the direction in which the project headed, and for whose benefit it was intended, and that will be developed in the following section.

7.4 System centrism as an orientation and disposition to approach practice

7.4.1 Introduction
As explained in previous sections (notably chapter 5.2), the NHS 'field' (Bourdieu, 1977; DiMaggio and Powell, 1983; Battilana, 2011) of the mid-2000s was created by general conditions for change over the previous decades. It became the fertile ground in which system capital resources to engage with the project were 'propagated', informed by individuals' biographies, experiences and their previous and current roles. Weick (1995: 18) has argued how individuals' contexts endow them with a “…manual or set of raw materials for disciplined imagination” that constitute the characteristics that explain their motivation.

The concept of system capital developed above would fall partly into Weick’s analysis, as individuals' biographies, professional training and contexts made up their motivations and led them to engage with the EEML project, where they were able to draw on the resources of others with whom they had prior social and professional relationships. However, the opinion leaders discussed in the previous section deviated from the well-worn paths of the status quo in bringing the EEML project to fruition in a much less deterministic manner to that described
by authors such as Battilana (2011) and Currie et al. (2012). Lockett et al. (2014: 1004) explain how “…change actors in different groups, in different functional areas, or at different hierarchical statuses or levels often see the same event in very different ways, as they draw on different schemata for sensemaking and the development of new schemata to support change.”

This section develops the argument that individuals, and particularly opinion leaders, used system capital as a resource to enact the EEML project. In employing those resources, they were motivated to direct the project beyond the exclusive benefit of the medical and other professions, as has been noted in chapter 5.3.3. In doing so, the processes involved in opinion leaders’ actions and practices that were important in effecting change can be explained through the concept of system centrism.

As before, in linking to the four phases outlined in chapter 7.2, particular narratives can be described as summarized in Table 7. These will be discussed within the context of this section and demonstrate how system centrism plays a part in practising change:
Table 7: Project phases at a practice level

<table>
<thead>
<tr>
<th>Phase of Project</th>
<th>Conceptual Stage</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understand Prevailing Conditions</td>
<td>Contemplating</td>
<td>Understanding of the prevailing conditions in the NHS at this time and societal temperature to create change</td>
</tr>
<tr>
<td>Identify Purpose and Motivation</td>
<td>Preparing</td>
<td>Drawing on own visions of future medical education/workforce, which, crucially, are oriented towards those beyond the profession, i.e. patients, public, taxpayers due to the changing psychological compact between doctors and the public/patients</td>
</tr>
<tr>
<td>Commit to Practice</td>
<td>Mirroring</td>
<td>Through the set up and structure of reference groups and lay groups. Achieved by linking to key alliances; project team ethos of collective decision making; use of peer influence; getting MLCF into curricula; testing out MLCF; role of language (understanding the particular habitus/field of medical education)</td>
</tr>
<tr>
<td>Outline Outcomes</td>
<td>Revealing</td>
<td>Seeing motivations and purpose realized in practice. Doctors don’t just provide care, BUT also improve system care (Sven-Olof Karlsson, former CEO of Jönköping County Council, Sweden; King’s Fund, 2011)</td>
</tr>
</tbody>
</table>

Within the EEML, individuals from medical professional and non-medical professional groups and different hierarchical levels drew on different and distinct readings of the field-level conditions to explain their reason for engagement (see figure 5 below), as outlined in chapter 5. This helps support Lockett et al.’s (2014) argument that actors’ unique positions shape their sensemaking but also outlines the multidimensional and interactive nature of actors’ contexts. Martin (2003:1) also talks of forces that impinge “…from the inside”, in addition to the forces exerted externally due to an individual’s position within a social field. Individuals responded not only to external events but also to changes from the inside of the profession that ultimately led to the project happening; for example, the RCP report of 2005 followed three inquiries into medical practice (Alder Hey (The Royal Liverpool Children’s Inquiry, 2001), Bristol (Kennedy, 2001) and Shipman (2002)).
A combination of different field-level conditions were recognized as some of the important motivators for various actors amongst the medical professionals involved in the project, such as the European Working Time Directive (EWTD) and Medical Training Application Service (MTAS) (see chapter 5.2, p.131 and p.138). In addition, many more project members spoke of their interest in change projects and clinical or medical leadership development as inherent parts of the motivation for joining the project. Moreover, many talked about a wider purpose – not one of personal gain, self-interest or satisfaction – but rather that the project was needed ‘for the good of the medical profession’. Although difficult to define precisely, ‘for the good of the profession’ could be seen critically as a way of ensuring the medical profession’s ability to operate autonomously, set their own standards and control their own performance (Kitchener, 1999). However, it could also be seen as something that reconnects the role and purpose of the profession.
with other stakeholders such as the public, patient and taxpayer, as outlined in chapter 5.2.3.

In chapters 5 and 6, participants spoke specifically about moving from a stance of professional defence and protectionism through not engaging with ‘managerial’ agendas to one about working collectively with others. This also meant making known the explicit values, which underpinned the wider purpose – of greater democratization, fairness and transparency in society, as noted by interview participants in chapter 5.3.3. (see pp.150-151). These could also be seen to be valid in this case, in contrast to how too many doctors in the past had ‘stumbled’ into medical management ‘by chance’. If more doctors had been presented with the opportunity to learn about the wider system through development opportunities that were about leadership skills, behaviours and attitudes, the argument goes, it would facilitate doctors’ making a contribution beyond the patient directly in front of them and having a more significant impact on better health for all people, because their skills and behaviours would be developed to see themselves as part of an interconnected system.

Research participants also discussed the need for the project to happen to bring about cultural shifts in the role and purpose of the profession, by introducing it at the outset of medical training and through the curriculum, tapping into an emerging *zeitgeist* and enthusiasm from younger doctors, to offer medical leadership as a viable career option, for some as the main career, but for others alongside a clinical specialty. Driven by changes to the model of care because of increasingly elderly populations and people with long-term chronic conditions, requiring non-acute care closer to home, they held the view that more multi-disciplinary, multi-agency and multiple team-based working was needed. Moreover, bringing about these educational changes in the very first days of doctors’ training would enable them to adapt to the needs of the modern health service, as discussed in chapter 6.2.6 (p.171), rather than leave them to learn from those who had themselves been taught in a different era and under a different model of disease, need and provision. Participants viewed involvement in the ‘dark-side’ of management as no longer caricatured by crossing a threshold to a mysterious and antagonistic world of spreadsheets, bottom-lines and business viability. Rather, there was a recognition that involving yourself in
management was integral to being a good doctor (General Medical Council, 2006b), leading a small team of doctors, or other professionals, or being led by the needs and desires of the patient. Likewise, part of the role of the modern doctor was not just to work collectively for the benefit of those patients needing immediate medical attention, but also for those who live with unseen manageable and stable conditions and those who are yet to need health services at all.

Whilst oppositional attitudes to different professions and their agendas do still exist in the NHS of 2016, as can be seen with the contractual dispute involving training doctors’ contracts (Department of Health, 2015), participants held an increasing appreciation that a ‘we’ attitude rather than a ‘them and us’ attitude was more likely to offer more positive contributions and values. This would be done through embedding changes via the curriculum from the outset of training in an attempt to bring about a shift in the presiding culture or logic of medical education. What analysis of interviewees (in chapter 5.2 and 5.3) and project documents (notably, the project Summary, Overview of Project and Scoping Study Report, appendix 4: documents 1-3) revealed was an interpretation of field-level conditions with an eye to stakeholders wider than the medical and associated professions. Opinion leaders were leading a change that returned us somewhat to earlier definitions of professionalism, based around caring, compassion and a universal humanism towards others (Arnold and Stern, 2005). Whilst my interpretation of the data is not claiming that medicine has returned to be the “most altruistic of professions” (British Medical Journal, 1895), it does demonstrate that embedding leadership behaviours within medicine may result in benefits to those beyond the medical profession. Given the increasing complexity and nature of disease linked to higher life expectancy, Good Medical Practice (General Medical Council, 2006a) outlines the inherent obligation for all doctors to not only make the care of their patients their first concern, but also to protect and promote the health of patients and the public. This aligns to Leadership and management for all doctors (General Medical Council, 2012: 7), for doctors to “…demonstrate effective team working and leadership” and “…use resources efficiently for the benefit of patients and the public.”
7.4.2 System Centrism

This introduces us to the third suggested contribution of this research. System centrism is a disposition that extends beyond orientations towards one own’s professional groups (profession-centrism) or is contingent on thoughts and actions of other professional groups (allo-centrism) (Lockett et al., 2014). A disposition is the result of an organizing action (such as a project) and “…designates a way of being… [or] a predisposition, tendency, propensity or inclination” (Bourdieu, 1977: 214). In line with Lockett et al. (2014), system centrism encompasses profession-centrism and allo-centrism but crucially also extends to awareness and understanding of the interests and perspectives of other non-professional groups (such as taxpayers and service users) as well as concepts such as ‘systems’ with their particular values and ideals (such as a sustainable NHS), capturing a system-wide perspective that is not accounted for within the definitions of profession- and allo-centrism. Battilana (2011) outlined how previous research (Tushman and Anderson, 1986; Leblebici et al., 1991; Kraatz and Zajac, 1996; Haveman and Rao, 1997; D’Aunno et al., 2000) showed that individuals within high-status organizations were more likely to work towards maintaining the status quo. However, the opinion leaders, in particular, who were members of these organizations, were motivated not to protect it, but, responding to prevailing field-level conditions (see figure 5), were able, not exclusively or on their own, to translate those conditions into effecting changes in practice (Zietsma and Lawrence, 2010), leading to change within medical education.

It could be argued that the field-level conditions that we saw in the NHS around 2005 had similarity to conditions that had been experienced throughout its history. As this chapter – and chapter 1 before it – have indicated, there have been many previous attempts to involve doctors in the management of the NHS, for many different reasons, again as outlined previously. However, it was the existence of these particular conditions at this time, together with a collective of individuals accessing system capital that enabled this project to orientate its gaze towards the system. Moving beyond an orientation towards their own professions (profession-centrism; Lockett et al., 2014: 1110), opinion leaders adopted a disposition towards the thoughts and actions of other professions (allo-centrism; Lockett et al., 2014: 1123) but also to a disposition that looked potentially even
beyond particular groups of patients, the public and taxpayers, to the future of health services.

In linking to the prevailing conditions, individuals made sense of these each according to their own capital reserves and social position. This allowed them to deviate from the expected norm through practice towards a particular envisaged outcome. This was demonstrated in the way in which they practised the project, collecting evidence from beyond the NHS, working in reference groups and involving patient perspectives, as exemplified in chapter 6.2. In chapter 3, Feldman and Orlikowski (2011: 11) described such routines “…as generative systems created through the mutually constitutive and recursive interaction between the actions people take and the patterns these actions create and recreate” and it was in the performative aspects of individuals’ practice that they were able to adopt a system-centric disposition. None of the individual exogenous or endogenous events alone were a significant enough ‘shock’ to the system to motivate any particular group of individuals to enact change to the role and training of doctors in management and leadership. However, they constituted general conditions for system change and therefore help to explain why the opinion leaders, in their social positions, took advantage of these conditions to change rather than reinforce existing schemata by adopting a system-centric practice and disposition towards a particular envisaged outcome.

7.5 Alternative explanations

7.5.1 Introduction

Whilst the previous sections have discussed the emerging concepts of system capital and system centrism, it is important to recognize that the data presented in chapters 5 and 6 could be viewed in a different way. This section therefore aims to offer a reflection on how else the research might have been perceived by addressing, in more detail, potential alternative theoretical interpretations of the data outlined in chapters 5 and 6, which relate back to concepts discussed in chapters 2 and 3. These relate to interpretations that put individual power; professional dominance and legitimacy; and government control at the heart of the interpretation of the analysis and consider these at micro-, meso- and macro-perspectives.
7.5.2 Micro-perspective: individual power and ego

From the findings presented in chapters 5 and 6, it can be seen how those at the centre of the project recruited individuals with sufficiently high levels of structural and normative legitimacy (Suchman, 1995) amongst the medical profession as a means of ensuring the project benefited from their influence and support. One of the possible interpretations of this is that, by engaging with the project, these ‘elite’ individuals – our opinion leaders – were able to assure their own positions, employing their knowledge and skills (capital resources) and were motivated by an increase in various forms of capital, be they cultural, social or symbolic. These ‘elites’ emerge because of their specialist role in medical management (Wilson-Kovacs and Hauskeller, 2012), holding the knowledge and capital that allowed them to maintain their privileged positions and enhance their stock of capital. The argument would then be that these multi-professional elites had colluded for their mutual benefit and reinforcement of their power and positions. This perspective would put concepts of individual power and ego right at the heart of such an analysis.

Displaying power?

Bourdieu (1990: 155) argues that “…resistance takes the most unexpected forms, to the point of remaining more or less invisible to the cultivated eye” and this analysis would support an interpretation that this project was about individuals’ engagement with changes such as those envisaged by the project; in order to maintain their privilege, position and power. Those medical opinion leaders who were of but somewhat also above the wider profession supported a government agency’s attempts at controlling the profession through this project, because they would largely be unaffected by changes, either because they were entering the final phases of their careers or because they had sufficient positional power to avoid the consequences of these changes. Therefore, they became complicit with a top-down mission to managerialize medicine and by serving the interests of the Department of Health, they shored up their positions of legitimacy and power. If the self-interested accumulation of capital is the driving factor for engagement in change, that would support arguments that participants in this case – the medical and non-medical opinion leaders – took part predominantly to protect their own interests, maintain multiple professional dominances and play
out the unequal relations of class and power that Bourdieu (2006) discusses with reference to such symbolic and economic capital.

If this line of argument continues, opinion leaders could be perceived to exercise power through exclusion of individuals and groups who had their own agendas regarding the project, which may have included steering it in a different direction or opposing it outright as an infringement on professional values and practice. Claims were made by one participant that the project suffered a little from “not-invented-here” syndrome, that previous ideas, notably those of the former British Association of Medical Managers (BAMM), regarding medical management and leadership development, were disregarded or overtaken by a desire to ‘start over’ with medical engagement in this project. BAMM had long been the standard bearer for medical management in the UK, offering training, development and support to medical managers since 1991.

However, members of the project team and steering group had belonged to BAMM and the purpose behind BAMM was very much the promotion of medical engagement in management, as was the EEML project. In many respects EEML was a continuation of the BAMM ‘project’, which actively engaged and employed some members of BAMM, due to their long-standing involvement in medical management. If individuals were excluded, it would be more a case of internecine professional tension, rather than to displace the project altogether, and would support arguments that jostling for key positions within the project and attraction to its potential allure and success were key to some behaviours. This may help to explain the motivations behind some individuals’ involvement. However, such was the extent of engagement within and towards the medical profession and such was the dispersal of effort and ideas amongst members of the project team and steering group, extending out to reference groups, lay groups and professional organizations, with no a priori guarantee of success, it would be difficult to sustain this argument.

Furthermore, it has been argued that the highly structured nature of bureaucracies like these makes them difficult to change (Webb et al., 2002) and the previous decades of the NHS have shown individuals and organizations unable to collaborate to embed leadership development as a core part of medical training. This is because those at the top of their respective institutions, be it the
medical profession or policy field, have always possessed the ability to enact or prevent change, by the very nature of their structural positions. Moreover, much research reinforces the view that these individuals favour the status quo as a way of protecting their interests (c.f. Battilana, 2011). Indeed, one of Bourdieu’s central premises is that “…habitus always drives practice” (Webb et al., 2002: 58) and in this case, that could be viewed as meaning that the data would show a continuation of incompatible logics (Reay and Hinings, 2005) and relations between the medical profession and managerial actors with an inability to collaborate, based on the inculcation of the different groups since the inception of the NHS (Spurgeon et al., 2011). In that case, these individuals would have chosen not to embark upon this project, as it would have meant ceding some of their control, influence and power to each other across different professional and policy regimes.

However, whilst accrual of personal status and professional standing may be common to both medical and non-medical opinion leaders, what is highly valued as capital or currencies in the fields of health care administration, policy making, management and leadership differ from those which are valued in the medical profession. Moreover, collectively, and beyond ‘elite’ opinion leaders, all of these individuals and organizations did ultimately collaborate to bring about fundamental change, even if we accept the premise that each may have done so according to their own respective agendas.

7.5.3 Meso-perspective: maintaining professional dominance and legitimacy

Related to the micro perspective, the data analysis presented in chapters 5 and 6 could be explained as a project of professional dominance and continued legitimacy, rather than just a project of individual power. In this case, the findings could relate to arguments of institutional maintenance and the work of Lawrence and Suddaby (2006) and Lawrence et al. (2009). The study of institutional work (Lawrence and Suddaby, 2006), as outlined in chapter 3, involves the creating, maintaining and disrupting of institutions. This study could be conceived of as a professional project of institutional maintenance with the actors behind it intent on maintaining the voice and hence legitimacy of the medical profession in the policy making processes of the NHS as well as of those of medical education, development and revalidation.
This project could be viewed as an instance whereby disparate sets of actors, from the medical profession, policy and service improvement worlds, each pursuing their own respective visions, of professional dominance, control and engagement, collaborated and became co-ordinated in a common project, such as the EEML. As such, it could be seen as a classic case of institutional work (Lawrence and Suddaby, 2006). Within the medical education field, these actors could be the individuals and professional organizations and associations of medicine, such as the BMA, GMC and AoMRC.

In their analysis of work that maintains institutions, Lawrence and Suddaby (2006: 230, 233) identify coercive and normative dimensions that promote compliance with existing rules and institutional norms and belief systems. Two of these, ‘enabling’ and ‘embedding and routinizing’, are relevant in this respect. The former describes the creation of rules that “…facilitate, supplement and support institutions”, such as identifying leadership competencies that allow the medical profession to access the managerial and policy world in support of their professional dominance, whilst the latter infuses the “…normative foundations of an institution into the participants’ day-to-day routines and organizational practices”, as the new discourse of doctor-as-leader could be interpreted.

In addition, Currie et al. (2012: 940) provide a critique of health professional behaviours, revealing that they were less about change resistance, but still about professional dominance. Drawing on an institutional work framework, they confirm much of the above interpretation that professionals will shape institutional arrangements to privilege their own jurisdictional claims and retain powerful positions (Battilana, 2011). Their power in doing so derives from two sources; the social legitimacy of their mission and their ability to apply expertise to particular cases, perhaps like the EEML project, even in spite of the wider exogenous changes that have impacted on the NHS, as discussed in chapter 5 as well as by a number of authors (for example, Harrison and Ahmad, 2000; Davies and Harrison, 2003).

In critiquing the institutional work concept, Currie et al. (2012: 956) state that categories such as theorizing and defining are as much a part of institutional maintenance as they are of institutional creation, and in the case of the EEML project, this could be seen to be the case. For example, ‘theorizing’ “…involves
the development and specification of abstract categories, and the elaboration of chains of cause and effect” (Lawrence and Suddaby, 2006: 221), which could apply to the evidence emanating from the Medical Engagement Scale. ‘Defining’ “…is focused on the construction of a rule system around status, identity, membership and hierarchy” (Currie et al., 2012: 956) and could be applicable to the emergence of the Faculty of Medical Leadership and Management in terms of creating a membership body for those who identify as medical managers and leaders.

Moreover, the institutional work concept of ‘constructing normative networks’, labelled as ‘creating’ institutional work by Lawrence and Suddaby (2006), as discussed in chapter 3, involves loose coalitions of somewhat diverse actors from pre-existing institutions bringing about new institutions, which could be demonstrated through the emergence of the Faculty of Medical Leadership and Management as a ‘proto-institution’. In doing so, ‘constructing normative networks’ includes ‘educating’ actors, via the MLCF, which is a necessary step in support of this new institution. However, this argument would pre-suppose that the FMLM came about before the MLCF. Nonetheless, these related concepts of ‘defining’, ‘educating’ and ‘constructing normative networks’ can all be considered ‘maintenance’ institutional work concepts in support of Currie et al.’s (2012) analysis.

In their analysis, Currie et al. (2012: 956-57) argue that “…elite actors are best placed to mediate risk”, thus allowing them to engage in ‘defining’ work and co-opting “…other, more peripheral professionals, who may be relatively powerful within their own professional grouping through ‘constructing normative networks’”, such as the career managers and leaders at the NHS Institute and Department of Health. By combining these different forms of institutional work, the elites – or opinion leaders – are mitigating against attempts to limit their status and position. Citing Freidson (1988) and Battilana (2011), Currie et al. (2012: 958) argue that such “…ongoing stratification, both inter-professionally and intra-professionally, is the end result of institutional work…as inter-professional and intra-professional arrangements are maintained, or even enhanced, in line with the model of ‘medical professionalism”.” This would support the interpretation that the EEML project was a medical education project of maintaining the medical
professional institution (meso-level), thus enhancing the elite actors engaged in its creation (micro-level). By doing so, this case study would equally support the assertion that “…the response of elite actors is more than mere resistance to the external threat or reproducing existing institutional arrangements” and that their positive action serves to enhance their position by regenerating and recreating institutional arrangements, thus shaping “…the change trajectory to ensure continued professional dominance” (Currie et al., 2012: 958).

The project’s approach to ‘mirror’ the language, behaviours and discourses of the medical profession with respect to medical engagement was key to achieving its outcomes. Lawrence and Suddaby (2006) highlight the often language-centred nature of institutional work, which aims to affect the institutional context and associated practices. Perkmann and Spicer (2008: 813) term this ‘cultural work’, establishing or reframing “…belief systems and values, often by linking practices with more widely anchored discourses.” Hence, the argument would go, the profession engaged in the project using acceptable language as a key means of maintaining the profession’s legitimacy of status and hierarchy in the policy field (Suchman, 1995).

In spite of the above interpretation, was this project one of continued professional dominance and legitimization? Zietsma and Lawrence (2010: 217) contest that “…(f)ields and firms that expose their practices to societal influences are likely to experience regular incremental change that maintains their legitimacy, rather than threatens it, and ensures that insiders’ practices are in step with societal norms.” Moreover, Currie et al. (2012: 959) argue that “…elite professionals engage in institutional work to constrain more radical change in healthcare”, yet the outcomes from this project would suggest that opinion leaders engaged in institutional work to promote or achieve substantial, or arguably radical, change. The change could be conceived of as radical by way of its official outcomes in the form of the creation of tangible products such as the MLCF and MLC; as well as other ‘unofficial’ ones such as greater awareness and cultural acceptance of doctors in leadership roles, as supported by Bohmer (2010), Lee (2010) and Mountford (2010); changing practice and improved outcomes; and the emergence of a common language of leadership. Alone, none of these is necessarily radical, but together they form part of a cultural shift that is now being
seen in the growing engagement in medical leadership through the Clinical Fellows’ Scheme and membership (2,200+) of the Faculty of Medical Leadership and Management (Spurgeon et al., 2011).

Moreover, Currie et al.’s (2012: 959) study demonstrated “…how a policy initiative that was intended to develop the workforce enabled elite professionals to delegate routine work to others and, in so doing, …enhanced their position”, thus confirming a view that “…change in healthcare environments is likely to remain inexorably slow or incomplete.” However, by embedding management and leadership competencies into the medical curriculum, the prime means by which doctors are educated and thus their identities, roles and practice are shaped, a significant change was implemented, in that every doctor will undertake leadership development alongside their clinical training. Whilst sustaining that change may be challenged given the short time frame since the project has been completed, given the emerging narrative described above, embedding it through curricula – and thus into the ‘DNA’ of medical professionalism and identity – means there are more structural and institutional factors in place to support its ongoing sustenance than have ever been contemplated or attempted before. The data presented in chapters 5 and 6 would therefore dispute the singular interpretation of an analysis of continued professional dominance and legitimacy.

7.5.4 Macro-perspective: state and managerial control

Moving to another level of interpretation, a case could be made for viewing the project as a means of the state securing increased control over the profession, in contrast to views that the project was one of professional institutional maintenance. Adopting a Bourdieusian field perspective, Webb et al. (2002: 87) argue that “…government is perhaps the most dominant of dominant fields, the field whose institutions, discourses, practices, technologies and general organization provide it with the means to impose particular beliefs and understandings on the whole social field.” This would tie into the belief that the state would wish to engage the medical profession in the project as a means of control. Bourdieu would contend that a case such as this should be analyzed with respect to “…the position of the field vis-à-vis the field of power” (Thomson, 2012: 73), where the latter “…consists of multiple social fields” (Thomson, 2012: 68), such as professional, managerial and education. Likewise, Webb et al. (2002)
state that power is a meta-field or macro-concept, so everything is always about power; it is a metaphor for the ways in which fields conduct themselves and every study of a field would be required to consider it.

Three perspectives can then be explored: who is competing for legitimate forms of specific authority within the field; what constitutes “…the objective structure of relations between the positions occupied by agents or institutions who compete for those legitimate forms”; and finally what is the habitus of agents and the dispositions they have acquired (Bourdieu and Wacquant, 1992: 105). Viewing the project against those three points of view, a complex interplay of individuals and occupations can be established, with opinion leaders from all fields seemingly cooperating and collaborating, yet also trying to secure their position to dominate within their given fields.

Webb et al. (2002: 92) also present an alternative theorization of this, through the work of Foucault (1991), who would argue that the state cannot behave in a dictatorial way because that contradicts its discourses of a commitment to participatory democracy. Instead, through the concept of governmentality (Foucault, 1991), state dominance over subjects is enacted through managing, organizing and regulating individuals, goods and wealth through ownership of the rights of legislative and administrative organization; by way of deciding what tax we pay and thus what income we have left to spend, and how we are educated. In the case presented in this study, government’s prime bureaucratic institution, the Department of Health, is legitimated and recognized by the groups it represents and on whose behalf it speaks, as are the royal colleges and other organizations involved in the project for their respective constituents. What better way to manage professionals than to begin the slow transformation of their gaze from solely clinical to both clinical and managerial matters – or towards ‘new model professionals’, who are self-disciplined and quasi-managerial (Ackroyd, 1996).

Moreover, Freidson (2001: 209-211) argues that, in a growing trend towards reducing the cost and independence of professional services, led by government and private capital and with the dual ideologies of consumerism and managerialism (as discussed in chapter 2) a growing force behind such change, greater control of professional practice could be perceived to be one of the
rationales behind the project. The introduction of competency-based leadership development could be viewed as a means to standardize the way in which the profession practices leadership. Indeed, Currie et al. (2012: 957) cite Lawrence and Suddaby (2006), describing “...the relationship between education practice and control mechanisms [as] a strong one.”

In support of Freidson (2001), Currie et al. (2012: 941) argue that “…the threat or contradiction that elite (and other relatively privileged) professionals seek to repair is one driven by policy aimed at workforce development, which seeks to reconfigure professional roles and relationships, and so enhance the integration of healthcare and reduce costs.” Freidson (2001) would argue, furthermore, that, legitimated by the project through its use of authoritative professional knowledge, one resulting outcome could be a tier-ing of professionalism; on the upper tier, those medical professionals who work with government to introduce the standards, who Freidson (2001: 210) describes as “national cognitive elites”, or in this case our opinion leaders, and those for whom the standardization is created, a lower tier of rank-and-file professionals.

Does this macro-perspective analysis hold true in this case? If the project were considered to be another attempt, in the long line of NHS history, to alter the balance or even break the professional model of monopoly, social closure and disciplinary community (Freidson, 2001), one might expect to see an impact on both credentialism, the device which sustains monopoly and social closure, and elitism, defined as the need to defer to a socially distinct individual, thus making an excluded individual dependent. In light of the data presented in chapters 5 and 6, the effects on them have been limited.

Credentialism still remains the prime means to enter the profession, although revalidation and regulation of doctors are more conspicuous topics of issue and contestation in today’s professionalism and mediated increasingly by societal needs, thus reflecting even more so the socially-constructed nature of the curriculum, as explored in chapter 2. Elitism is also largely unaffected in the sense that there are still leaders of the profession and the project has set about increasing the pool from which future leaders will be drawn, by making ‘leaderism’ (O’Reilly and Reed, 2010; Bresnen et al., 2015) as well as ‘managerialism’
discourses more acceptable to practise as well as become more accepted by the profession.

7.5.5 Summary

This section has aimed to explore alternative interpretations of the data presented in the previous two chapters. Considering these at the three levels of micro-, meso- and macro-sociology, with considerable fluidity between all three, these interpretations suggest that individuals acted in their own self-interest, as part of a wider discourse of professional dominance, set against a long held narrative of state control over professionals. In that case, the project could be seen as a multi-layered enactment of a medical professional opinion leader strategy for their continued dominance of the rest of the medical profession (micro-level), thus maintaining their ability to control how jobs and jurisdiction are organized, ensuring that the professional monopoly over medical practice continues (meso-level) under the watchful eye of a chosen few elites. Government control over the larger profession then remains somewhat elusive, yet present through professional elites’ willingness to accede to the government agenda (macro-level).

However, whilst none of these respective interpretations of power games, professional dominance and state control can be discounted fully, it was through the concepts of system capital and system centrism that the data presented in chapters 5 and 6 were able to offer an alternative and equally valid account in relation to how the practices and outcomes of the EEML project were achieved.

7.6 Chapter Summary

This chapter has considered various explanations and interpretations of the data presented in chapters 5 and 6. It began by outlining an empirical contribution of how to enact and effect change in medical education through a four-phase process: Contemplating-Preparing-Mirroring-Revealing. It outlined the process by which individuals engaged in the project undertook their roles, helping us to understand how change was initially considered, pioneered and created. Moreover, it established how a combination of values-based intentions and a vision of the future of leadership development within medical education prepared individuals within the project to ‘mirror’ the behaviours and thinking of the wider
medical profession, enacting agency within an institutionalized context, to reveal products and outputs that contributed to NHS organizational, institutional and system change.

Given the litany of previous, historical attempts at what could be collated under the umbrella of ‘medical engagement’, such as the Hospital Plan of 1962 (Ministry of Health, 1962), the arrival of the clinical directorate structure post-Griffiths (DHSS, 1983) or the Resource Management Initiative of 1986 (Farrar, 1993), as described in chapter 1.3, this project could have become another attempt that failed to contribute to medical engagement in the wider management and policy agenda. Driven on by particular prevailing conditions, momentum had been built that resulted in a hard-wiring of leadership development into the ‘DNA’ of medical training – the curriculum.

In order for that to happen, individuals with a social position that incorporated system capital were able to come together to bring about the EEML project, which was a nationally and professionally recognised, well-funded project that successfully introduced leadership and management knowledge, skills, attitudes and behaviour development into every specialty medical curriculum. For the first time, this ensured that every doctor in undergraduate and postgraduate training would develop the knowledge, skills, attitudes and behaviours regarding leadership and management within the context of the NHS. Using their prominent and significant positions within this institutional field and drawing together their reserves of system capital, these opinion leaders collectively were able to exert profound social change towards and within the medical profession (DiMaggio and Powell, 1983; Dorado, 2005, 2013).

In combining their endowments of capital with non-medical professional opinion leaders, medical professional opinion leaders also had access to and collective dispositions towards others beyond the profession, not only being aware of others’ interests and perspectives, but feeling able to act beyond their own group interests to further system-wide change – that is, they had a disposition towards system centrism.

Hardy (2012: 230) states that positions within social space, meaning the set of all possible positions that are available for occupation at any given time or place
(Bourdieu, 1984, 1985), “…are generated by the forms and amounts of capital…and by the relative values placed on different configurations and volumes of those capitals.” The various opinion leaders from the EEML project, belonging to different professional groupings, had differing amounts and configurations of the forms of capital that constitute system capital, giving them each a range of positions available. Those positions led them to make choices and they employed them in a system-centric fashion throughout the project.

In contrast, the chapter also considered counter-arguments at micro-, meso- and macro-levels that the EEML project was undertaken as an individual project of power, one of professional maintenance or alternatively as a means of state control of the profession. Whilst none of these interpretations could be discounted fully, equally none of them could fully explain the data presented in chapters 5 and 6 to account for how the practices and outcomes of the EEML project were achieved.

In summary, the key contributions that arise from the findings of this case study are how opinion leaders used their prominent social positions, collective reserves of system capital and disposition towards system centrisim to take advantage of a window of opportunity caused by prevailing field level conditions to bring about fundamental change within the institution of medical education. This case, therefore, offers further insight into how actors’ social positions enable them to break with the prevailing institutional position and effect institutional change (Battilana, 2011), through working with others of similar social position and motivated to serve the interests of not only professions but also the wider system. This case has also refined and extended Lockett et al.’s (2014) model on the influence of social position and the nature of dispositions within organizational change through the introduction of two related – yet new – concepts of system capital and system centrisim, by demonstrating how professionals can use their collective capital assets as a stimulus to act collectively towards wider dispositions than their own professions (see figure 6 below).
Figure 6: Adapted Model of Influence of Social Position and the Nature of Dispositions within Organizational Change (Lockett et al., 2014: 1119):

A summary of this contribution to research can be depicted in table 8 below:

Table 8: Summary of research study

<table>
<thead>
<tr>
<th>Background and Context</th>
<th>Research Questions</th>
<th>Theoretical Constructs</th>
<th>Contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest in management and professions</td>
<td>How do opinion leaders enact and effect change within medical education?</td>
<td>Agency (institutional work / entrepreneurship)</td>
<td>4-phase 'mirroring' process</td>
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<td></td>
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<td>System capital</td>
<td></td>
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<tr>
<td>A relevant case in the EEML project</td>
<td>What processes are involved in opinion leaders' actions and practices that are important in effecting change?</td>
<td>Practice Theory</td>
<td>4-phase 'mirroring' process</td>
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<td></td>
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<td>System centricism</td>
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<td></td>
<td>How does this case further our understanding of strongly institutionalized environments?</td>
<td>Capital and social position</td>
<td>System capital</td>
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<td>System centricism</td>
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Chapter 8: Conclusions

8.1 Introduction

This chapter begins by reviewing the aims and objectives of the research and the contributions of each chapter within the study. It then recaps the empirical and theoretical contributions of this thesis, arguing that through using system capital individuals draw on each other's resources to embed leadership and management knowledge and skills into medical curricula. Furthermore, the concept of system centrism accounts for dispositions that include profession- and allo-centric behaviours (Lockett et al., 2014), as well as more intangible future-centric dispositions that allow managerial and professional logics to co-exist. Such an orientation is possible when individuals commit their combined capital resources (system capital) not only for their own professional benefit but for a wider purpose. This helps to establish how change can occur within strongly institutionalized environments, despite the long tradition of opposing institutional logics.

This chapter then continues by reflecting on the research process, identifying potential limitations of the study, as well as my role as the researcher within it. It concludes by offering implications and recommendations for practice and future research.

8.2 Review of aims and objectives, chapter-by-chapter summary and contributions to theory and practice

At the outset, this study aimed to explore and understand how individuals engaged, in practice, with change within medical education, which led to the three research questions contained within this study, namely:

- How do opinion leaders enact and effect change within medical education?
- What processes are involved in opinion leaders' actions and practices that are important in effecting change?
- How does this case further our understanding of strongly institutionalized environments?

The associated objectives were:

- To explore how opinion leaders experience and practise change;
Chapter One outlined the general research setting, which was located in the context of the English NHS of the 2000s and specifically the *Enhancing Engagement in Medical Leadership* (EEML) project from 2005-10. General enquiries were undertaken to understand the potential parameters of the research and literature was reviewed from multiple disciplinary domains, such as organization studies, professionalism, medical professionalism and medical education. In doing so, particular works and texts were accessed as some of the main extant thinking within these domains. Some of these literatures, notably those that would provide the theoretical framing, were outlined along with the expected contributions to the theoretical and empirical field.

Chapter Two critically reviewed debates regarding the professions, professionalism and professionalization, notably with regard to medical professionalism and attempts to engage that profession in governmental and managerial changes. It discussed the impact of that managerialism in the form of New Public Management and considered how medical education had evolved over the past couple of centuries, including the impact of change upon it. This chapter concluded that professional role, status and behaviour had changed over time and that medical professionalism, as with professionalism more generally was an ever-changing project (Abbott, 1988; Freidson, 1986). What was evident is that the professional role is influenced by a number of factors, amongst them the medical curriculum, as well as individual and organizational beliefs about professionalism and the institutional and societal environment. Furthermore, the chapter concluded that medical education remains a key aspect of defining medical professionalism, and at any given time is a mediated result of cultural, social, political and economic forces (Kuper and D'Eon, 2011).

Chapter Three then turned to consider the underpinning theories that helped to explore this case, beginning with a discussion of the various concepts surrounding the institutional context, in light of changes such as EEML. It
considered how institutional theory attempted to deal with change and continued with a focus on agentic processes that helped to explain change within neo-institutional theory, notably through bringing together and considering different bodies of literature such as institutional work (Lawrence and Suddaby, 2006) and institutional entrepreneurship (DiMaggio, 1988; Lockett et al., 2012) as well as practice theory (Feldman and Orlikowski, 2011; Nicolini, 2012). It also examined further theoretical constructs, which helped to shape individuals’ meaning, perspective and sense of actions, practices and change within the working environment and concluded how those constructs of capital (Bourdieu, 1986; Lockett et al., 2014) and social position (Battilana, 2011; Lockett et al., 2014) informed and influenced practice within strongly institutionalized environments.

In Chapter Four, the overarching methodological stance of this study was outlined, combining a relativist ontology and social constructionist epistemology, recognizing and accepting that multiple, constructed realities co-exist amongst the lived experiences of researcher and participants. Moreover, this chapter considered the research strategy of a single case study, with multiple embedded elements and the research instruments that were appropriate to explore this area. The selection and recruitment of research participants to semi-structured interviews and the use of documentary evidence to support and confirm those findings were also discussed, notably how the focus was contained to those actively involved within the project, necessitating the exclusion of potential dissenting voices and alternative views outside of the project regarding its process, practices and work. The chapter also included discussion of the open coding and analytical framework adopted, along with how issues of quality, rigour and ethics were accounted for.

Chapters Five and Six presented a detailed case study of the process and practices through which individuals enacted and effected change within the EEML project. Drawing on interview and documentary data, Chapter Five demonstrated the importance of general conditions for field-level change, such as the legacy of significant events, readiness of the profession to change and available monies in determining the initiation of the EEML project, with a number of key individuals convening at the right time and place, building on mutual interests and motivations and with a loosely defined ‘compass point’ to guide
them towards particular actions and practices. These were developed in Chapter Six, which discussed the role of prior relationships, timing windows and an approach to working in collaboration and practice with the profession to deliver the project aims through the use of routine and recognizable practices. This resulted in embedding leadership and management development into medical education through college specialty curricula, thus ensuring a degree of permanency and commitment for doctors in training to be aware of the broader demands of the professional role towards the wider health care system.

8.2.1 Empirical contribution

Chapter Seven built on the empirical findings outlined in the prior two chapters and offered an empirical contribution to how to practise institutional change with the medical profession through a four-phase process of Contemplating-Preparing-Mirroring-Revealing. By considering the process by which individuals engaged in the project undertook their roles, drawing on interview and documentary evidence in chapter 6.2, it helped to establish how change was initially considered, pioneered and created. As outlined in chapter 5.3, a combination of values-based intentions and a vision of the future of leadership development within medical education were vital in adopting an approach, described in chapter 6.2, which mirrored the behaviours and thinking of the wider medical profession to enact a key moment of NHS organizational, institutional and system change. Key to this effort were the relationships established amongst like-minded people motivated to work on the project, alongside crucial existing relationships to allow a number of the key phases of the project to unfold and occur, which were discussed in detail within chapter 6.

This process, with ‘mirroring’ at its heart, allowed participants to adopt a genuinely consultative approach to engagement with the medical profession. It also demonstrated the dynamics and tensions inherent in change processes and the micro-level practices of individuals engaged in ongoing actions of institutional change.

8.2.2 Theoretical contributions

Chapter Seven continued by defining and discussing the major theoretical contributions of this thesis, exploring the concepts of system capital and system
centrism and interpreting the findings from Chapters Five and Six in terms of appropriate literatures and relevant theoretical frameworks discussed earlier, notably those linked to capital and social position.

In terms of the theoretical contribution, this chapter identified how individuals came together to build an approach to change through the EEML project that required them to work collectively and share their individual capital resources with each other to gain access to and work across different institutional fields, drawing from a shared pool of system capital. Moreover, it demonstrated how individuals took a disposition that cast itself wider than the profession or other professions and sought to establish the project outcomes for the benefit of the wider system and not only for personal gain and reward, which was defined as the concept of system centrism.

Chapter 7 also considered critiques of the analysis presented in chapters 5 and 6 and of the theoretical contributions of system capital and system centrism by exploring and evaluating alternative explanations to the findings. Firstly, the possibility that individuals effected change for personal benefits and to maintain power as elites within the medical education and management field was considered and rejected as the findings presented demonstrated how individuals also chose to collaborate to widen access to medical leadership and management rather than keep it as the domain of the few. Secondly, at a meso-level perspective, the project could have been cast as one of professional dominance and legitimacy, which would suggest a maintenance of the status quo. However, it was observed that a number of changes were embedded into curricula with the effect of creating significant change, as demonstrated through the findings presented in chapters 5 and 6. Thirdly and finally, at a macro-level, the project could have been perceived as one of increasing state and managerial control of the means of training of the medical profession. The resulting outcome would expect to be depicted as one involving the loss of elitism and credentialism, which appear to be largely unaffected as a result of the project.

Whilst accounting for a number of interpretations of the data presented before it, in light of the interview and documentary data presented in chapters 5 and 6, Chapter Seven concluded that and in concert with others in both the project team and steering group, at all levels of grade and hierarchy, and through using their
individual levels of skill, resource and capital, senior individuals employed their social positions, collective reserves of system capital and dispositions towards system centrism. This was done to take advantage of a window of opportunity caused by prevailing field level conditions to bring about fundamental change within the institution of medical education. This offers the two emerging concepts of system capital and system centrism as theoretical extensions to the work of Lockett et al. (2014) as well as to how actors’ social positions enable them to break with the prevailing institutional position and effect institutional change (Battilana, 2011).

8.2.3 Summary

Therefore, in reviewing its aims and objectives, this study has been able to explore how opinion leaders experienced and practised change. Furthermore, it has been able to understand how these experiences and practices were related to their social position and to explore the processes involved in opinion leaders’ creating meaning, perspective and a sense of their actions, practices and change, by drawing on theoretical concepts from the literatures of capital and social position and by offering up the dual concepts of system capital and system centrism. Moreover, through an in-depth review of relevant literatures, this study has critically reflected on changes within medical education and the medical profession. The final objective of identifying implications for theory and for practice will be considered shortly.

8.3 Limitations of the research process

Tranfield and Starkey (1998) set out the various challenges with research and knowledge management within social and organizational research, notably around the integration of theory, practice, policy and strategy. They argue that management research is theoretically transdisciplinary, quintessentially non-reductionist and engages with both the worlds of theory and practice. In that sense, this research study sits well within those parameters, offering insight into issues of practice as well as extensions to theoretical concepts all within a well-known and established policy and strategy context. Nonetheless, there are inevitably limitations to any research study and this one is no different. Some have been addressed already within chapters 1 and 4 regarding the adoption of
a narrative review and regarding my approach to the research process (and the latter will be considered further in chapter 8.4) but other areas remain for consideration.

8.3.1 Interview sample and approach

The decision to select the research participants that I did has somewhat been dealt with in chapter 4 (notably in 4.3 and 4.6) and also in chapter 5 (5.3.4), where I aimed to acknowledge that other perspectives and voices existed both within and outside of the project teams and groups, albeit recognizing that the scope of this study regarding research participants was limited to those actively engaged within the EEML project. There are undoubtedly other voices beyond the scope of the study and they may have offered different perspectives about the need for, approach to or purpose of the project, notably those engaged with the British Association of Medical Managers (BAMM), which in many ways was a predecessor to EEML. They were discussed in chapter 7, as part of the alternative explanations of the findings, in an attempt to bring in different theoretical perspectives to account for those who fell outside of the scope and constraints of the research process. Given that members of the EEML project were also members of BAMM, some of their feelings towards the project are captured in the narrative in chapter 5.

8.3.2 Categorising ‘opinion leaders’

Through categorising some of the participants within this research study as opinion leaders, I am giving them a certain legitimacy through naming them (Grenfell, 2012), akin to an act of Bourdieusian symbolic violence or power. These individuals, from both medical professional and non-medical professional backgrounds have some form of status or position as representatives of various organizations with a stake in the world of medical education and curriculum oversight and development. In another study, they may have been cast simply as ‘elites’, whose personal influence was the key factor in moving the project forward. There are certainly elements of that within this study as discussed in chapter 7; however, their role, amongst many other actors within the project, was to bring their individual capital assets into the collective pool of capital. Working with others, they negotiated a project course through multiple fields, that embedded leadership and management knowledge into the medical curriculum,
which was done in the interests of not only the medical profession but also others beyond the professional sphere.

As such, when they returned from the project space to their home organizations and associations, their role was to promote and, in many cases, defend the project’s purpose, as well as ease its passage through the various committees and fora of those establishments. Therefore, they held a crucial role as leaders of opinion or thought as to the direction of the project within the medical professional and educational domains. Without them championing its cause, the EEML project may not have found a way to embed itself into college specialty curricula. The nomenclature of opinion leaders thus describes senior individuals from home organizations who carried out a leadership role within the project and extended that back at those home organizations in terms of enacting the project and effecting change.

8.3.3 Single case study – further triangulation

Hartley (2004) described how a case study strategy may begin with one theoretical concept and end in another. This helps to justify the initial framing of this research within neo-institutionalist concepts but which spreads to consider practice theory and the role of capital in the management and development of institutional change.

The case study approach was adopted because it offers an understanding of processes in their context (Hartley, 2004), which was seen to be relevant and important when choosing to focus upon the EEML project, especially given its suitability to research questions which required detailed understanding of those processes in effecting change within a strongly institutionalized and professional environment. Issues of quality and rigour have been addressed in this respect in chapter 4.

However, as a single case study, studied retrospectively, there is a lack of a comparative aspect as to whether opinion leaders would collectively use system capital to effect change in other initiatives. The findings and analysis presented here are a result of an interpretivist stance where I as the researcher have made decisions throughout every phase of the research and another researcher would have made some that differed from those.
In addition to the use of documentary evidence to confirm the findings from the interview data, further methodological triangulation could perhaps have been obtained through use of additional research instruments. Moreover, given the nature of doctoral study the opportunity for multiple analysts to review findings was not possible, but a future research project to assess the value of the contributions made here would benefit from multiple researcher involvement to enhance quality and rigour. In contrast, however, as 22 research participants were interviewed, a case could be made that there has already been the triangulation of 22 different sources of data, in the form of different perspectives, biographies and motivations and the different theoretical frameworks also offer varying assessments of the interpretation of the data (Bryman, 2008).

8.3.4 The study of ‘fields’ – and of power

Bourdieu’s work on fields offers up four semi-autonomous field levels: the field of power or of multiple fields; the broad field under consideration; the specific field; and agents in the field as a field in themselves (Thomson, 2012: 77). A limitation, if it is deemed as such, is that no study can possibly focus on all four levels. Focussing on the potential field-of-power level in this case study was one field too many to analyse, given the study also incorporated exploration of the broad NHS field, then of the more specific field of medical education and the medical profession, and arguably even the field of key actors (opinion leaders) within those fields.

The analysis presented here compared the habitus of a range of individuals (level 3) and examined the interconnections between agents and the field institutions (level 2) rather than focussing on the field in relation to the field of power (level 1) (Grenfell, 2012: 244). Previous studies of professions have considered the role of elite actors (Montgomery, 1990; Freidson, 1994; Currie et al., 2012) and their relationships to power and this could have been an option for this research, perhaps through adopting a different theoretical framing or approach to analysis that was more critical of the motivations of elites and the interplay between power, legitimacy and ego. By keeping the focus on how change is effected through practice, this study adopted an equally valid, yet alternative approach to that.
8.4 Reflections on the research process and my role

8.4.1 Introduction

Bryman (2008: 682) advises that social researchers “…should be reflective about the implications of their methods, values, biases, and decisions for the knowledge of the social world they generate…and [this] entails a sensitivity to the researcher’s cultural, political, and social context.” Coming from the perspective of a social constructionist epistemology, I am implicated in the construction of knowledge, not as an impartial, objective bystander, but as an actively involved and interested researcher, academic and citizen in the development and delivery of health and care services, as discussed in chapter 4.5. Arising from studies in ethnography, the concept of reflexivity is also relevant here, not as an “introspective indulgence” (May, 2011: 180), but as a means of understanding the researcher’s interpretations, role and interactions within the research process, which thus implies an understanding also of their biography and bias. Bourdieu considered reflexivity as more than a pragmatic option, indeed, an epistemological necessity, to ensure the researcher is aware of their own habitus (biographical and academic backgrounds and trajectories) and its impact on research practice to escape any scholastic fallacy (Grenfell, 2012: 224). To that extent, this study is constrained by its very nature because of my worldview, despite the methodological and theoretical attempts for rigour provided by the data collection and analysis process and its conceptual underpinnings.

This is not a case of taking sides in favour of the project’s aims, as Hammersley (2000) suggests such a stance within research is effectively to take a position against it. However, my work and recent career involves me working in the field of leadership development, from a position that leadership can make a positive difference to frontline services; as much as ‘bad’ or ‘uninformed’ leadership practice can also have a negative impact on patient, service user and staff wellbeing in this context.

Nonetheless, a number of questions remain as to my research approach and what I brought to it and these are outlined in the following sections.
8.4.2 What of myself did I give to participants consciously or unconsciously – and what impact did that have on the empirical data collection?

The letter of invitation to participate in the research study (appendix 9) did include using the name of a member of the project whom I had known, as mentioned previously, as an academic supervisor through prior studies. This was to facilitate the process of recruiting participants and the wording was deliberately intended as a means of encouraging project members to take part. However, in the letter, I consciously did not share my background with participants, although if and when asked during the interviews, I did not choose intentionally to hide it either. At one of the interviews, at a location where I had worked early on in my career, I recognize now in retrospect, that I rather naively and certainly unconscious of the potential effects and impact on the interview itself, shared with the participant that I had worked there years previously. This had a very direct impact on the interview and it was related back to me throughout its course.

There is always a judgement to be made as to how much to share of oneself in the research process, but my epistemological stance helps to support the ease with which ‘I/me’ as an active part of the research process was introduced into it. At times, inevitably it helped in building rapport with the participants, some of whom I knew from past professional experiences and using my quasi-insider status was perhaps an encouragement for more disclosure than I might have otherwise got from participants. That was not always the case and there are examples of interviews where I was required to question and prompt more effusively than in others; inevitably these were often the shorter ones where participants chose either consciously not to disclose their recollections of the project or unconsciously had forgotten what it was they did and a number of the interview transcripts attest to that.

8.4.3 What was the impact of my research on participants?

As Peter Keenan (2012) reminds us, in research like this, we gather rich, intimate data but what effect does this have on the participants, in terms of emotional consequences? This goes beyond the ethical considerations discussed in chapter 4.5. My research asked participants to think back about their practices and involvement in a project that had ended two to three years previously at the time of data collection. For many their involvement may have ended even before
that. Asking them to recall what they did may leave an effect on those individuals; indeed, some spoke about the many positive aspects of working on something they were interested in and the great enjoyment and feeling of working within teams that were committed to seeing the project through. They spoke also of creating what they considered to be necessary and successful outcomes for both the medical profession and wider patient and service user care. Others wondered whether any real change would result from the project in terms of the relationship between doctors and managers in the long term, some in a rather downbeat manner. I captured this after one particular interview in my research journal:

“More sceptical and disheartened perspective on impact but after the tape stopped, spoke of ‘fondness’ of working in the project team.”

Those accounts present a moral responsibility on my part to be conscious of how the interviews may impact on participants, bringing up the past and consequently I ensured that I was not too quick to rush off or leave participants, allowing time for fond memories and recollections to be heard, as indicated above. Despite that, I am still aware that I was leaving individuals to deal with their reflections long after the audio recording has stopped.

8.4.4 What was the impact on me?

My whole career and some of my studies prior to that have been spent in the field of health care, always within the context of the English NHS, a service and system in which I was born and grew up and which I continue to access as a citizen, albeit with a professional interest in how it functions. When I embarked upon this process, my convictions were that individuals working within the system generally wished to make it better and more effective through their actions and practices and that has been strengthened as a result, although that does not necessarily mean that the path towards that is always successful or that there is a lack of tension and dispute along the way. The research has left me still engaged and interested, both professionally and personally, in the type of health service that is emerging and developing within England and what lessons can be learnt about creating a service that works for the many and not just the few.
8.5 Implications and recommendations for theory and practice

There are a number of implications arising from this research. Firstly, this research contributes to perspectives regarding the role of human agency in practices that break with existing institutions (Battilana, 2011) and is therefore of interest to academics and policy makers in furthering their understanding of the capability and capacity of heterogeneous social positions to effect change. Linking the concept of social position to that of system capital, this has the potential to help in understanding how capital resources are collected, shared and employed in future change initiatives. Moreover, this research has demonstrated how agency within institutions can play out the various forms of creative, maintaining and disruptive institutional work concurrently and therefore adds to the empirical evidence regarding Lawrence and Suddaby’s (2006: 249) original taxonomy of institutional work and how “…disparate sets of actors, each pursuing their own vision, can become coordinated in a common project.”

Secondly, the development of the concept of system centrism, drawing on mutual system capital, enables an understanding of how theory may be practised, as well as how practice may itself be theorized (Grenfell, 2012; Feldman and Orlikowski, 2011). Change in strongly institutionalized environments can take place when individuals are willing to look beyond their own world views or logics, which of course may incorporate them, towards something that offers a new, emerging view of all of their constitutive worlds. This study therefore contributes to debates and discussions in social policy, regarding professional and occupational status, across both public and private sector domains. The current case of the junior doctor contract dispute (Department of Health, 2015; Godlee, 2016) demonstrates that when world views or logics are not mutually considered as important and dispositions are not system centric, change is difficult to achieve and all of the available system capital that could be used to bring about change is instead used to present differing views, leaving the purpose of the change fractured. Policy makers, professionals and citizens across all sectors should take note of their particular dispositions and how else they may be able to collectively use their various reserves of capital.

Thirdly, this study has argued that the nature of professionalism is ever evolving and changing. Whilst Freidson (2001) and others might offer an ideal type of
professionalism that is composed of interdependent elements, theoretical constructs and stable standards are not an occupational portrayal of a mutable professionalism. This study offers an interpretation beyond the notion of ideal type professionalism and more in line with understanding of hybrid professionalism. It reports on a project that was about increasing the awareness, understanding of and, eventually, the ability to take action regarding concepts such as effectiveness and efficiency, which are part of the leadership canon. This makes them a mainstream consideration of medical practice, not to be seen as ‘add-ons’, or disdained and forgotten behind more virtuous professional pursuits such as ‘quality’. Both efficiency and quality have a place. Therefore, it is important to recognize that alongside interdependent, ideal-type typologies such as Freidson’s, if we are to continue to make sense of the nature of professional work, we must continue to understand the nature of that work within its specific contexts.

Fourthly, through this process, it has not been lost on me that doctoral research could be conceived of as a form of institutional work, notably in re-creating and maintaining the institution of doctoral research within academia. In terms of ‘creating institutions’, this study has developed new chains of cause and effect – the emerging concepts which contribute to knowledge – and depicts the institutional work element of ‘theorizing’, whilst this thesis is also an attempt in ‘educating’ others to the skills and knowledge necessary to support these new ideas. Moreover, in ‘maintaining institutions’, the PhD process is ‘mythologizing’, creating work that helps to sustain that which is required to demonstrate active scholarship and research ability; and equally my day-to-day academic practice has been subject to ‘embedding and routinizing’ the normative foundations of the PhD institution against other competing priorities. In contrast, there is little within this particular study to suggest a ‘disrupted’ institution; however, the arrival of the ‘alternate form of PhD’ and ‘PhD by publication’ are perhaps general examples of evidence to suggest support for the disruption of the doctoral research process as an institution (Willis and Cowton, 2011). Therefore, academics with an interest in professionalism and institutionalism, as well as those who hold the administrative and managerial roles as gatekeepers to the doctoral process should be encouraged to recognize the need to turn the camera lens back onto
the process itself and consider the institutional dynamics and tensions inherent within this much valued institution.

Finally, this research affords an opportunity to speculate on the future of medical professionals and professionalism. Whilst this research study has demonstrated how leadership and management training and development have become part of mainstream and accepted medical curricula, nonetheless, in the words of Freidson (2001: 212), a danger remains, in that medical professionals may still become “…merely technical experts in the service of the political and cultural economy” and yet will survive because government has not found an alternative way of organizing them. Reduced discretion, a narrowing of the direction of the development of knowledge and a subsequent loss of the idle curiosity that drove the celebrated innovations of Curie, Fleming and others from the past, may result in a profession whose character is being fundamentally altered. The freedom to set their own agenda for the development of their various disciplines will result in problems of a cultural and ideological nature – of the ‘soul’ (Freidson, 2012: 213) – and continually be subject to changing forces.

One of these such forces, as Freidson (2001: 211) argues, is that, as the curriculum continues to adapt, the period of time for training will reduce and “…some of the more humanistic disciplines, which have no clear vocational value may not survive at all, and those that do will be pressed by students to be entertaining.” This could be perceived as a reference to leadership and management which emanate from humanities and social science pedagogies, or to more broad debates around holistic care rather than technical aspects of the science of medicine. At the present time, in some medical schools, training has now been reduced to graduate-entry four-year programmes, away from the traditional undergraduate five-year diet. Might this be further reduced, or might other para-medical professions take on more of the roles of doctors, as we have seen with the increasing professionalism of nursing, leaving doctors more narrowly constrained in their specialist roles? At the same time, might the medical profession be left to adapt to the requirements of being system leaders and resource decision-makers, as the outcomes from the EEML project bed in? There is, thus, the potential for the professional role of doctors to be at once enhanced and reduced through specialization, encroachment and lack of training time. This
is likely to be of relevance to anyone with an interest in the role medical professionals play in delivering our health services, such as policy makers and academics.

### 8.6 Further research

Without revisiting the aforementioned limitations which discussed the necessary constraints of any research study, there are still lessons to be learned for future research practice. The initial scope of this research, that which was edited out of the resulting research protocol (appendix 6), made consideration for seeing how the outcomes of the EEML project were being implemented in practice. Once embedded within curricula and developed in the shape of the MLCF, what is happening *on the ground* with doctors, from the first day of medical school to five years post-CCT, continues to be of interest.

What are the roles of educational supervisors and medical consultants in the workplace; training committees in the locality; local education and training boards at a regional level; and the royal colleges at a national level, in tandem with the Department of Health, GMC and BMA; in ensuring that EEML project documents and ideas become more than outputs that sit within curricula? Whilst participants offered their own views of the outcomes of the project, its resulting impact in terms of changing practice, clinical outcomes and cultures remains of interest. Therefore, both current practice and the lasting outcomes of the EEML project, whilst outside of the scope of this study, persist as areas of interest if we are to take a long term view of medical leadership and professionalism and the roles and identities of doctors.

Furthermore, the concepts of system capital and system centrism require further investigation outside of this study and context to see their relevance and potential within wider professional and institutional domains. This will help in gaining a better understanding of how those concepts may be employed in other strongly institutionalized environments, but may also be of relevance to environments that are less strongly institutionalized.
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## Appendices

### Appendix 1: Literature Search Strategy

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<th>Search terms/alerts</th>
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Appendix 2: Pen portraits of participants

#01 is a physician at a district general hospital and a former chairman of a national membership forum. As with many of the research participants, this individual has a keen interest in medical education and was a member of the steering group.

#02 was a medical director at a district general hospital and had carried out a similar role at a national level for organizations in the NHS. As with many of the research participants, this individual has a keen interest in medical education and leadership and was a member of the steering group.

#03 is a GP by background, is heavily involved in medical education and training at a national level and was a member of the steering group.

#04 has a managerial background and has worked in service and quality improvement roles as well as working at a national level for a medical leadership organization and was a member of the project team.

#05 is a doctor who is heavily involved in medical education and training at a national level and was a member of the steering group.

#06 has a background in regulation, works for a national medical organization and was a member of the steering group.

#07 is a former senior manager in the NHS and worked as a consultant on the project as well as being a member of the project team.

#08 is a senior academic with a long established interested in medical professionalism and leadership and was a member of the project team and steering group.

#09 has a managerial background and has worked in service and quality improvement roles as well as working at a national level for a medical leadership organization and was a member of the project team.

#10 is a doctor working in a teaching hospital, who has also worked at a national level for a medical representative organization and was a member of the project team.

#11 is an academic and independent management consultant with experience of service improvement, leadership development and working with doctors and was a member of the project team.

#12 is a physician in a district general hospital, has previously been a medical director and worked at a national level for a medical representative organization as well as being a member of the steering group.

#13 is a former senior manager in the NHS and worked as a consultant on the project as well as being a member of the project team.

#14 is a former senior manager in the NHS and worked as a consultant on the project as well as being a member of the project team.

#15 is a doctor by background, who worked in district general and teaching hospitals, before taking on a role within those organizations as medical director and at a national level and was a member of the steering group.
#16 is a physician who worked in teaching hospitals and then at a national level across a number of medical representative organizations and who was a member of the steering group.

#17 is a physician who worked in teaching hospitals and then at a national level across a number of medical representative organizations and who was a member of the steering group.

#18 is a physician who works in a teaching hospital and was a member of the project team.

#19 is a GP who was a member of the project team

#20 is a physician who worked in teaching hospitals and then at a national level across a number of medical representative organizations and who was a member of the steering group

#21 is a former senior manager in the NHS and has since worked as an academic and member of various national organizations in leadership roles and who was a member of the steering group and project team.

#22 is a doctor who worked in a number of leadership roles across the NHS and was a member of the steering group.
Appendix 3: Interview Guide

1. What was your role at the time of your engagement with the EEML/MLCF project? i.e. position/job title

2. Please tell me how you got involved in the MLCF project
   - How did others get involved?

3. Why did you get involved?
   - Why were you asked, do you think, to be involved?
   - What was your role in the project? (linked to professional autonomy, sovereignty, practice, obligation)

4. What did you do?
   - Why like that?
   - Did you consider approaching your role differently?
   - What did others do re: the project?

5. Was anything you did about legitimising your role / your organisation’s role or position? Other agendas?
   - Do you think actions of others were?

6. Who else was involved in the organisation you represented at the time?
   - So who was that? What did they do?
   - Who wasn’t involved? Who should have been?

7. Were there any key relationships for you on the project?
   - Other people or organisations?
   - Was the steering group typical of groups you’d been involved in?

8. Were there any particular incidents of note along the way?
   - Things you remember about the project / process (tensions, agreements, tipping points)
   - What did you do when these occurred?

9. What is your view on the MLCF?
   - Has that changed since your initial involvement?
   - How would you describe the MLCF?

10. What were the outcomes of the project?
    - Probe unofficial outcomes, i.e. benefits, legacies etc.

11. What might the project have looked like without your / your organisation’s involvement?

12. Are there any other areas regarding the MLCF that you wanted to talk about that we may not have covered?
    - Probe current developments / latest thoughts
Notes on Interview Guide

After the first interview I decided to ask interviewees their thoughts not just on what they did, but how they saw others’ actions (i.e. what did others do? How did they get involved?) and what they did at any ‘critical’ / important moments in the project – how did they respond to anything noteworthy. I also started asking rather than about ‘legitimising’ behaviours, about ‘agendas’. Finally, I asked them what the project might have looked like (i.e. in terms of outcomes), if they hadn’t been involved. After the first 5 interviews I rewrote my interview guide into this current version.
## Appendix 4: Documentary Data

<table>
<thead>
<tr>
<th>n = 90</th>
<th>Document Number and Title as listed in 'War and Peace'</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documents listed under Project Initiation and Background / Project Plan (11)</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Project Summary v5.doc</td>
</tr>
<tr>
<td>2.</td>
<td>Overview of Project 310107.doc</td>
</tr>
<tr>
<td>3.</td>
<td>Scoping Study Report 110507.doc</td>
</tr>
<tr>
<td>4.</td>
<td>Project Plan 08-09 as at 150808.doc</td>
</tr>
<tr>
<td>5.</td>
<td>Enhancing Engagement in Medical Leadership - Project Plan v10 091006.doc</td>
</tr>
<tr>
<td>6.</td>
<td>Project Plan 09-10 v2.doc</td>
</tr>
<tr>
<td>7.</td>
<td>Steering Group – Terms of Reference 090806.doc</td>
</tr>
<tr>
<td>8.</td>
<td>Terms of Reference.doc</td>
</tr>
<tr>
<td>9.</td>
<td>Steering Group – Communications Strategy 090806.doc</td>
</tr>
<tr>
<td>10.</td>
<td>Communications Plan August 08.doc</td>
</tr>
<tr>
<td>11.</td>
<td>Conferences Publications and Websites 9 Feb 09.xls</td>
</tr>
<tr>
<td>Documents listed under Project Plan - Team Minutes and Notes of Actions (49)</td>
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<tr>
<td>12.</td>
<td>Actions 051206.doc</td>
</tr>
<tr>
<td>13.</td>
<td>Actions 191206.doc</td>
</tr>
<tr>
<td>14.</td>
<td>Project Team Meeting Notes &amp; Actions 24.10.06.doc</td>
</tr>
<tr>
<td>15.</td>
<td>Actions 090107.doc</td>
</tr>
<tr>
<td>16.</td>
<td>Actions 230107.doc</td>
</tr>
<tr>
<td>17.</td>
<td>Actions 270307.doc</td>
</tr>
<tr>
<td>18.</td>
<td>Notes &amp; actions 010507.doc</td>
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<tr>
<td>19.</td>
<td>Actions 210507.doc</td>
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<td>20.</td>
<td>Actions 010607.doc</td>
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<tr>
<td>21.</td>
<td>Actions 190607.doc</td>
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<td>22.</td>
<td>Actions 040707.doc</td>
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<tr>
<td>23.</td>
<td>Actions 120707.doc</td>
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<td>24.</td>
<td>Actions 070807.doc</td>
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<tr>
<td>25.</td>
<td>Actions 210807.doc</td>
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<tr>
<td>26.</td>
<td>Actions 110907.doc</td>
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<tr>
<td>27.</td>
<td>Actions 091007.doc</td>
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<tr>
<td>28.</td>
<td>Actions 061107.doc</td>
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<tr>
<td>29.</td>
<td>Minutes 201107.doc</td>
</tr>
<tr>
<td>30.</td>
<td>Actions 041207.doc</td>
</tr>
<tr>
<td>31.</td>
<td>Actions 181207.doc</td>
</tr>
<tr>
<td>32.</td>
<td>090108 Project Team Meeting Notes &amp; Actions.doc</td>
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<tr>
<td>33.</td>
<td>160108 Project Team Notes and Actions.doc</td>
</tr>
<tr>
<td>34.</td>
<td>160108 Project Team Site Leads Notes and Actions.doc</td>
</tr>
<tr>
<td>35.</td>
<td>300108 Meeting Notes.doc</td>
</tr>
<tr>
<td>36.</td>
<td>Project team meeting notes and actions 050308.doc</td>
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<tr>
<td>37.</td>
<td>080408 Project team meeting notes and actions.doc</td>
</tr>
<tr>
<td>38.</td>
<td>Project Team Meeting Notes and Actions 130508.doc</td>
</tr>
<tr>
<td>39.</td>
<td>Project Team meeting notes and actions 100608.doc</td>
</tr>
<tr>
<td>40.</td>
<td>Project Team meeting - notes and actions 010708.doc</td>
</tr>
<tr>
<td>41.</td>
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</tr>
<tr>
<td>42.</td>
<td>Project team meeting - notes and actions 160908.doc</td>
</tr>
<tr>
<td>43.</td>
<td>Project Team meeting - notes and actions 141008.doc</td>
</tr>
<tr>
<td>44.</td>
<td>Project Team meeting - notes and actions 111108.doc</td>
</tr>
<tr>
<td>45.</td>
<td>Project Team meeting - notes and actions 161208.doc</td>
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<tr>
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<td>Document Name</td>
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<td>---</td>
<td>-------------------------------------------------------------------------------</td>
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<tr>
<td>46.</td>
<td>Project Team meeting - notes and actions 20.01.09.doc</td>
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<tr>
<td>47.</td>
<td>Project Team Meeting - notes and actions 17.02.09.doc</td>
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<td>48.</td>
<td>Project Team meeting - notes and actions 17.03.09.doc</td>
</tr>
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<td>49.</td>
<td>Project Team meeting 28.04.09 - notes and actions.doc</td>
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<tr>
<td>50.</td>
<td>Project Team meeting - notes and actions 02.06.09.doc</td>
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<td>54.</td>
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<td>55.</td>
<td>Project Team meeting - notes and actions 08.12.09.doc</td>
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<td>56.</td>
<td>Project Team meeting - notes and actions 12.01.10.doc</td>
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<td>57.</td>
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<td>59.</td>
<td>Project Team meeting - notes and actions 25.05.10.doc</td>
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<td>60.</td>
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**Documents listed under Project Plan – Steering Group Minutes (10)**

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<tr>
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<tr>
<td>81.</td>
<td>Steering Group Minutes 220806.pdf</td>
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<td>82.</td>
<td>Steering Group Minutes 181206.pdf</td>
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<td>83.</td>
<td>Steering Group Minutes 240407.pdf</td>
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<td>84.</td>
<td>Steering Group Minutes 030907.pdf</td>
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<td>Steering Group Minutes 200208.pdf</td>
</tr>
<tr>
<td>86.</td>
<td>Steering Group Minutes 230708.pdf</td>
</tr>
<tr>
<td>87.</td>
<td>Steering Group Minutes 241108.pdf</td>
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<tr>
<td>88.</td>
<td>Steering Group Minutes 270209.pdf</td>
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<td>89.</td>
<td>Steering Group Minutes 080509.pdf</td>
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**Documents listed under Project Plan – Progress Reports (15)**

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<td>91.</td>
<td>Progress Report for AoMRC July 06.doc</td>
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<td>92.</td>
<td>Steering Group – Project Progress Report 311006.doc</td>
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<td>93.</td>
<td>Progress Report for AoMRC December 06.doc</td>
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<td>94.</td>
<td>Progress Report for AoMRC January 07.doc</td>
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<td>95.</td>
<td>Steering Group – Project Progress Report 120107.doc</td>
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<td>Progress Report for AoMRC February 07 v2.doc</td>
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<td>97.</td>
<td>Progress Report for AoMRC April 07 v2.doc</td>
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<td>98.</td>
<td>Progress Report for AoMRC May 07 v2.doc</td>
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<td>99.</td>
<td>Brief Cover Note for MLCF for AoMRC September 07 v2.doc</td>
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<td>100.</td>
<td>Progress Report – Steering Group and AoMRC – November 07.doc</td>
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<td>104.</td>
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**Documents listed under Project Plan – Print Media (5)**

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<td>Enhancing Engagement in Medical Leadership Project Update Feb09.pdf</td>
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<td>109.</td>
<td>Enhancing Engagement in Medical Leadership Project June 09 Update.pdf</td>
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<tr>
<td>110.</td>
<td>Enhancing Engagement in Medical Leadership Project October 09 Update.pdf</td>
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<tr>
<td>111.</td>
<td>Enhancing Engagement in Medical Leadership Project March 2010.pdf</td>
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### Appendix 5: EEML Project Coding Frame

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<tr>
<th>Grandparent Node</th>
<th>Parent Node</th>
<th>Child Node</th>
<th>Grandchild Node</th>
<th>Definition</th>
<th>Linked to... (code / concept)</th>
<th>Source of Code</th>
<th>Created</th>
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<tr>
<td>Credibility</td>
<td></td>
<td></td>
<td></td>
<td>Any mention of the word OR similar</td>
<td>Legitimacy</td>
<td></td>
<td>4.6.13</td>
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<tr>
<td>Culture</td>
<td></td>
<td></td>
<td></td>
<td>Working culture “getting on with others” (#16)</td>
<td>Teams Organization</td>
<td>Org/Inst. Theory literatures</td>
<td>5.6.13</td>
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<tr>
<td>Enthusiasm</td>
<td></td>
<td></td>
<td></td>
<td>passionate, keen etc. LINKED TO motivation of individuals, towards the work of the project task</td>
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<td></td>
<td>22.7.13</td>
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<tr>
<td>Glory</td>
<td></td>
<td></td>
<td></td>
<td>In vivo code (#01) regarding the perception that people would or did get involved for personal reward, e.g. knighthood AND/OR talking themselves / their actions up as really important/significant // grandstanding (#14)</td>
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<td>10.6.13</td>
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<tr>
<td>Influence</td>
<td>(influencing)</td>
<td></td>
<td></td>
<td>also Power [#17 peer pressure of other orgs to get</td>
<td>Legitimacy Behaviour</td>
<td>Concepts of power (RQ); social position</td>
<td>4.6.13</td>
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<td></td>
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<tr>
<td>----------------</td>
<td>-----------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td></td>
<td></td>
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<tr>
<td>Legitimacy</td>
<td>in terms of behaviours, of being of value, useful, the right thing to, particular agendas, (“mood music” / &quot;tick box&quot;) - rationale? enhancing/protecting reputation, for the project team it was more about purpose, mission, value, benefit and actual legitimacy of the project itself - for others it might have been protective behaviours or other agendas/opinions/concerns on what should happen regarding medical leadership</td>
<td>Behaviours Credibility</td>
<td>Suchman (1995) (capital; social position)</td>
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<td></td>
<td>Reluctance Apathy, not understanding or recognising the need for something, similar to resistance but more passive, apathetic, uninvolved rather than active, e.g. reservations about something</td>
<td>Resistance Knowledge (capital)</td>
<td>In vivo (#16)</td>
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<tr>
<td>Resistance</td>
<td>Threat, opposition to, criticism of, scepticism or cynicism towards or problems with something, lack of trust towards individuals involved or not involved with or relating</td>
<td>Legitimacy</td>
<td>A priori / gut feeling about the political context of medical</td>
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</tr>
<tr>
<td>(Resisting)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Collectively</td>
<td>Decisions (Deciding)</td>
<td>Discussions (Discussing)</td>
<td>Implementation (Implementing)</td>
<td>Process (Processing?)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>to The Project / also conflict/tension</td>
<td>Any mention of the word or the act of a decision being taken or made</td>
<td>Any mention of the word OR similar, e.g. arguments, debates, conversations, things that get talked about; events like meetings</td>
<td>Launch, reveal, delivery, embedding or sale (not buy-in) of the Product/The Project - towards use in practice rather than a document sitting on a dusty shelf. Or implementation of leadership development and buy-in for the &quot;need&quot; to develop doctors as leaders</td>
<td>How things happened, i.e. The Project, includes structures put in place and how events etc. were organized - events (told as recollections, stories) LINKED to STORIES and ANECDOTES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>22.7.13</td>
<td>Practice</td>
<td>Decisions Process Practice</td>
<td></td>
<td>&quot;War &amp; Peace&quot; (internal) project) document detailed steps of project</td>
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</table>

Decisions (Deciding):
- Any mention of the word or the act of a decision being taken or made

Discussions (Discussing):
- Any mention of the word OR similar, e.g. arguments, debates, conversations, things that get talked about; events like meetings

Implementation (Implementing):
- Launch, reveal, delivery, embedding or sale (not buy-in) of the Product/The Project - towards use in practice rather than a document sitting on a dusty shelf. Or implementation of leadership development and buy-in for the "need" to develop doctors as leaders

Process (Processing?):
- How things happened, i.e. The Project, includes structures put in place and how events etc. were organized - events (told as recollections, stories) LINKED to STORIES and ANECDOTES
<table>
<thead>
<tr>
<th>Area</th>
<th>Description</th>
<th>Interview Guide / a priori</th>
</tr>
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<tbody>
<tr>
<td>Incident</td>
<td>Anything said in response to question about incidents that may have occurred during the project; something significant or important that happened - positive, neutral or negative</td>
<td>The Project Process Resistance</td>
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<tr>
<td>Profession</td>
<td>Of the professions; expert/expertise; professionalism/professional behaviours USUALLY medical BUT sometime other professions; grandees / opinion formers / position holders</td>
<td>Doctors</td>
</tr>
<tr>
<td>The Project</td>
<td>Any mention of the word OR similar, e.g. stages like the creation of the framework, interactions, efforts to engage etc.</td>
<td>Team</td>
</tr>
<tr>
<td>Individually</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contribution (Contributing)</td>
<td>Anything said in response to what the project would have looked like without their involvement</td>
<td>Interview Guide / a priori</td>
</tr>
<tr>
<td>Practice (Practising)</td>
<td>A specific action or practice by the research participant; strategy; mechanism, approach, style - whether</td>
<td>Agency Intentionality</td>
</tr>
<tr>
<td>Representation (Representing)</td>
<td>Required to act for/by others for a purpose; membership of/on the Steering Group, a voice /perspective for a particular stakeholder, e.g. patients</td>
<td>Social position</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Role</td>
<td>what the individual's (their organization's) purpose was in getting involved in the project, perceived or actual - related to but distinct from “practice” ALSO job, title, position</td>
<td>Practices Buy-in Behaviours Legitimacy Representation Motivation</td>
</tr>
<tr>
<td>Buggin's Turn</td>
<td>The idea that positions of leadership had to be passed around because it wasn't a role anyone really wanted, so everyone had to take a turn</td>
<td>In vivo</td>
</tr>
<tr>
<td>Bodies</td>
<td>Decline, no longer functioning, disbanded</td>
<td>Organization Practice</td>
</tr>
<tr>
<td>Management (Managing)</td>
<td>Any mention of the word OR similar, often referring to managers as opposed to clinicians</td>
<td>Leadership</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Med Ed Organisations</td>
<td>Deaneries/LETBs/Health Education England, CoPMED, University Medical Schools, GMC, PMETB not AoMRC</td>
<td>Other research participants</td>
</tr>
<tr>
<td>Non-Med Ed Organisations</td>
<td>any organization named, e.g. AoMRC, DH/The Department, the NHS, Trusts, NHS Institute, FMLM, BAMM, HEE, University departments (not medical) etc.</td>
<td>Other research participants</td>
</tr>
<tr>
<td>Other Groups</td>
<td>group, working party, NOT team, could include committees of the BMA etc.</td>
<td></td>
</tr>
<tr>
<td>Project Team</td>
<td>Any mention of the word or people who were part of it</td>
<td>Steering Group</td>
</tr>
<tr>
<td>Reference Groups/ Workstreams</td>
<td>Engagement &amp; interaction with either UG, PG or CPD and focus group checking &amp; testing ideas</td>
<td></td>
</tr>
<tr>
<td>Steering Group</td>
<td>Any mention of the word or people who were part of it</td>
<td>Project Team</td>
</tr>
<tr>
<td>----------------</td>
<td>------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Drivers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change (Changing)</td>
<td>Any mention of the word OR similar, e.g. “moving things on”, spread; but includes societal change/demographics, i.e. more BME &amp; female docs</td>
<td>A priori</td>
</tr>
<tr>
<td>Policy</td>
<td>Any mention of policy initiatives from government etc., incl. Legislation; environment for change, e.g. new govt etc.; new initiative / reform or actual policy or politics</td>
<td>Institution theory context / a priori; Sabatier (1999); Taylor and Gibbs (2010)</td>
</tr>
<tr>
<td>Rationale</td>
<td>driver for change, i.e. The Project - or bigger picture looking after the patient in front of me AND caring about the next in line, the wider community etc.</td>
<td></td>
</tr>
<tr>
<td>Right time, right place</td>
<td>In vivo code, any mention of this as a means to explain why them, this Project etc. when it took place (see #02, #21)</td>
<td>In vivo</td>
</tr>
<tr>
<td>Wider education</td>
<td>policy etc. like Tomorrow's Doctors</td>
<td></td>
</tr>
<tr>
<td>Finance</td>
<td>Resources, Money etc. to drive the Project, engage doctors/profession and how they view it in decision making for patient care</td>
<td>Strauss (1987) talked about constraints or conditions</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Motivation (Motivating)</td>
<td>Desire, need, want for something, interest in, keen/ness</td>
<td>A priori (discussions with stakeholders 2011)</td>
</tr>
<tr>
<td>Of individuals</td>
<td>also incorporates values &amp; beliefs that drive that</td>
<td>(capital)</td>
</tr>
<tr>
<td>Individual biography</td>
<td>Background / education / roles / experiences / career prior to and after The Project; Talk about themselves or people of similar profession/background, e.g. upbringing, career</td>
<td>Lawrence et al. (2011: 55) (capital; social position)</td>
</tr>
<tr>
<td>Of organizations</td>
<td>LINKED to agendas, legitimising behaviours/actions</td>
<td>(capital)</td>
</tr>
<tr>
<td>In the past</td>
<td>Memory (Remembering)</td>
<td>trying to remember, difficulty recalling what happened, choosing not to remember, or not knowing something = &quot;i</td>
</tr>
<tr>
<td>Reaction (Reacting)</td>
<td>Feedback the participant received during The Project or in the course of recalling their actions and practices from the past in the context of medical leadership/education; actual concrete reaction from a specific experience/event/interaction etc., feedback on something</td>
<td>In vivo</td>
</tr>
<tr>
<td>Reflection (Reflecting)</td>
<td>more abstract reflection on concepts, questions, statements etc. from researcher</td>
<td>Interpretation</td>
</tr>
<tr>
<td>Insight</td>
<td>Implicit norms, values, rules, mores, how participant made sense of phenomena or perceived how others did OR beliefs, views on things not mere reflections but linked to them // offers an interpretation or opinion on something, such as what they learned from the experience/process - may link to opinions on things that will be positive/negative or benefits/failures</td>
<td>Mason (2002); Taylor and Gibbs (2010)</td>
</tr>
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<td>Outcomes</td>
<td>Interview Guide / a priori</td>
<td>4.6.13</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>also Interventions, not just of The Project but if you were to look more broadly around leadership training and development, also Legacy; anything said in response to question about what the outcomes of the project were in their mind // Consequences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doctors</td>
<td>Professionalism</td>
<td>A priori</td>
</tr>
<tr>
<td>Medics, Medical Professionals etc., definitely UG/PG/CPD and distinct from the wider profession in a cultural sense, more grounded/jobbing docs and more focussed on the younger generation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leadership (leading)</td>
<td>Management</td>
<td>A priori, this was a project about education and management &amp; leadership knowledge</td>
</tr>
<tr>
<td>Of leaders, leading, esp. Leadership involving doctors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negatives / Failure</td>
<td>Introduced in #14 (Mindmap 010813b), weaknesses, things that didn't work or went wrong</td>
<td>1.8.13</td>
</tr>
<tr>
<td>Patient Care and Safety</td>
<td>Any mention of the word OR similar, e.g. service users, patient voice, patient concerns AND safety, quality, improving care/service</td>
<td>A priori, this is research into health care!</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Positives / Benefits</td>
<td>Of use/value; for the greater good (#10) - making a difference etc., successful not just in the NHS/health care, but wider applicability of competence [changed to include positives in #14, Mindmap 010813b - hence meaning it was easier to capture positive behaviours for managing the process etc.], advantages, strengths</td>
<td></td>
</tr>
<tr>
<td>Product (Producing)</td>
<td>...as an intended (or otherwise) result of The Project; Artefact, Document/Report/Book/Publication, Competency Framework, Course/Training/Conferences, Tools - these could be existing CFs, e.g. Volkswagen, LQF or existing documents that have been built on and tweaked (sedimentation), CLCF/LF</td>
<td>Institutional theory: Role of the 'end product' as mediating artefact and focus for the actions/practices of individuals</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td>Date</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Education</td>
<td>The package of doctor education from UG to CPD, also incorporates trainers/teachers etc.</td>
<td>22.7.13</td>
</tr>
<tr>
<td>Assessment</td>
<td>Any mention of the word OR similar, e.g. curricula, training process/package</td>
<td>17.6.13</td>
</tr>
<tr>
<td>Curriculum</td>
<td>knowledge, knowing, understanding, aware/ness, &amp; skills, training (#3 educational prescription), learning, evidenced</td>
<td>A priori</td>
</tr>
<tr>
<td>Knowledge (Knowing)</td>
<td>A priori, this was a project about education and management &amp; leadership knowledge (capital)</td>
<td>4.6.13</td>
</tr>
<tr>
<td>Measurement incl. MES</td>
<td>Medical Engagement Scale - tool for measuring clinical engagement ALSO a proxy here for measuring of practice, performance, outcomes, curriculum, doctors, standards etc. - technology adoption</td>
<td>22.7.13</td>
</tr>
<tr>
<td>MLCF</td>
<td>The final competency framework</td>
<td>22.7.13</td>
</tr>
<tr>
<td>Training &amp; development</td>
<td></td>
<td>22.7.13</td>
</tr>
<tr>
<td>Researcher</td>
<td>Bias</td>
<td>Biography</td>
</tr>
<tr>
<td>-----------</td>
<td>------</td>
<td>-----------</td>
</tr>
<tr>
<td>anything said by the researcher - reflexive, particular questions from the researcher, their role in the social construction of the interview NOT reflexivity caused by researcher questions (see Reflection)</td>
<td>when i potentially led the interview, put words in interviewees mouths, suggested or finished their sentences!</td>
<td>My role, background, career, e.g. as an NHS manager, academic at university</td>
</tr>
<tr>
<td>Words, Meanings &amp; Form</td>
<td>Language</td>
<td>Stories &amp; Anecdotes [1]</td>
</tr>
<tr>
<td>design of the MLCF, alongside level of language and detail used</td>
<td>Any mention of the word OR similar, e.g. Jargon – words, dialogue used</td>
<td>Metaphors, analogies, example</td>
</tr>
<tr>
<td>Language</td>
<td></td>
<td></td>
</tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reflection Interpretation</td>
<td>Mason (2002); Taylor and Gibbs (2010)</td>
<td></td>
</tr>
<tr>
<td>5.6.13</td>
<td>22.7.13</td>
<td>22.7.13</td>
</tr>
<tr>
<td>4.6.13</td>
<td>10.6.13</td>
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<td>22.7.13</td>
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<td>22.7.13</td>
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<td>22.7.13</td>
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</tr>
</tbody>
</table>
ownership, concept of a 'swept channel' (#16), people having been persuaded/negotiated with (the act of persuasion/negotiation is PRACTICE), "won round" to a way of thinking

<p>| Effort | Any mention of the word OR similar, e.g. Try things, do something, talk to someone, go out of your way to do, work really hard at, energy...challenge, frustration, | Practice Intentionality | Mair &amp; Mair | 4.6.13 |
| Getting (People) On Board | Effort Interaction | Interview Guide / a priori / RQ | 22.7.13 |
| Engagement (Engaging) | Involvement, participation | Process Effort | Strauss (1987); Lofland et al. (2006); Taylor and Gibbs (2010) | 4.6.13 |
| Interaction (Interacting) | Relating to others, working with others NOT relationships; with others not directly attached to The Project? | Engagement Relationships | 4.6.13 |</p>
<table>
<thead>
<tr>
<th>Relationships</th>
<th>such as prior rapport / long standing working relationship / friendship OR new relationship / getting on well with someone / networking</th>
<th>Interactions</th>
<th>Interview Guide / a priori / Strauss (1987); Lofland et al. (2006); Taylor and Gibbs (2010)</th>
<th>4.6.13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support (Supporting)</td>
<td>Any mention of the word OR similar, e.g. agreement, consistency, uniformity, consensus reached or support offered</td>
<td>Relationships Interaction Resistance</td>
<td>In vivo</td>
<td>4.6.13</td>
</tr>
</tbody>
</table>
Appendix 6: Research Protocol

PhD Organisational Change Management (Health Care), De Montfort University, 2012: Individual engagement with change in medical education

Simon Moralee BA (Hons) MSc
Doctoral Student P00245147
Senior Lecturer, Health Care Management
Programme Leader, Medical Education
De Montfort University
Hawthorn 0.22a
Leicester
LE1 9BH

Supervisor(s) / External adviser

Professor Allan Macpherson, De Montfort University and University of Wisconsin-La Crosse (1st)

Dr. Deborah Price, De Montfort University (2nd)

Summary of research:

My research question is “How do individuals within organisations engage, in practice, with change?” The aim of this research is to gain a better understanding of the creation of changes to training in the context of the medical profession in the English health care system. This research will explore the actions and practices of individuals within organisations in the changing context of reform and modernisation; investigate medical professional perceptions of government objectives, policy and strategy; examine how change may be introduced into healthcare organisations; and ascertain factors that help explain the relationship between doctors and managers/government in the context of legitimacy and power. The specific focus will be on the introduction of management and leadership training to medical curricula, via the Medical Leadership Competency Framework (MLCF, NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges, 2010). It is timely and relevant in the context of the changes to the current health care system in England, notably the role for doctors in both the primary and secondary care sectors.

Population to be studied:

This research intends to involve those implicated in the implementation process of the MLCF, in particular the actions and practices of those who engaged in the creation of the MLCF. The aim is to interview 'higher-level' stakeholders – staff at Healthcare Workforce Deaneries, the General Medical Council (GMC), Academy of Medical Royal Colleges, specific medical Royal Colleges and others closely involved in the formulation of the MLCF, such as staff at the NHS Institute for Innovation and Improvement, most of whom were part of the steering group for the MLCF project. The research also involves studying documentation regarding the creation of the MLCF, which I have been given access to by my external adviser, who was the national lead for the MLCF project.
Recruitment/Inclusion/Exclusion criteria:

The inclusion criteria are that the individuals must have been involved in the MLCF steering group at some point during its lifespan, have been suggested as key individuals in the MLCF by members of the steering group or have taken a role at Deanery level with its implementation. It therefore adopts a purposive and potentially snowball sampling approach. There are no exclusion criteria based on age, gender, race, age, social condition, sexual preference.

I have discussed with my supervisors which individuals I think would provide me with a relevant sample of views and opinions so as to meet the aims and objectives of the research. I will then write via email to the potential participants explaining the purpose of the research and what I would want to achieve in the interview and seek their agreement and permission to continue. I intend to interview these participants for no more than 60 minutes, during which the interview will be audio-recorded.

Information and consent process:

I will set out in the participant information sheet and covering letter the aims of the research. If individuals are willing to participate, I will ask them to sign a statement agreeing to the research and thus obtaining their informed consent. This will take place after they have received the information sheet and before the commencement of the interviews.

Details of the research to be performed

The chosen design and methodology of this study is qualitative in nature and will involve semi-structured interviews. I will prompt the interviewees to think about and comment on their actions and practices with regards to the MLCF and their motivations for becoming involved. I acknowledge that this process will involve particular biases I may hold regarding the topic area, but the predominant principle is to listen more and ask less and allow time and space for interviewees to respond in their own words.

My aim is to interview 25 individuals about their views on the research topic, all of which will then be transcribed. They will then be subject to a form of analysis, which may involve thematic, narrative, process or discourse techniques. Interviews will take place at the office/work environment of participants, or somewhere of equal convenience for them. There are no plans for interim analysis / reports. Feedback will be offered to research recipients if they want to receive it.

The documents will also be subject to investigation and analysis, again using thematic, narrative, process or discourse techniques.

Assessment of possible adverse effects:

The most evident risk of this research is not obtaining the permission of individuals who are willing to be interviewed. Access to them is via my external adviser who worked with them as national lead for the MLCF project and I will write to the individuals mentioning his name as a way of obtaining access to them. I recognise that there will be an imposition on individuals in terms of their time, but I have aimed to keep this to a very minimal amount and only "inconvenience" willing participants.
Appendix 7: Participant information sheet

Participant information sheet

You are being invited to take part in this research study. Before you decide to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact me if there is anything that is not clear or you would like more information.

What is the study about? The study is designed to explore how individuals within organisations engage, in practice, with change. The study is part of my doctoral research within the Faculty of Business and Law at De Montfort University and your involvement is part of the empirical phase which is scheduled to last three months from October until December 2012.

Why have I been approached? Professor Peter Spurgeon, who is acting as a supervisor to my PhD, suggested that you may be interested in taking part due to your involvement with the Enhancing Engagement in Medical Leadership Steering Group.

Who is involved in the study? The research will be carried out by myself as part of my PhD research.

Do I have to take part? It is up to you to decide whether or not to take part in this study. If you do decide to take part, please keep this information sheet and indicate by return email that you wish to be involved, suggesting some convenient dates and times for me to interview you, preferably before 21st December 2012. I will then send you a consent form to complete. If you decide to take part, you are still free to withdraw at any time and without giving a reason. Your involvement in this study will be kept confidential to me as the principal investigator and will not be released to any other party.

What is involved? I would like to come and interview you in person for approximately one hour. The interview will, with your permission, be audio-recorded and subsequently transcribed. I will also take notes during the interview.

What happens to the information? The information will be used for the purposes of research. All the information is confidential. No one will be able to identify you from the study. The audio-recordings from the interviews will be transcribed (listened to and typed out in full) and along with the audio-recordings will be saved on a computer to be analysed. The notes taken by myself, the digital audio-recordings and the transcripts will be password protected and only the research team (my supervisors and I) can see them. Notes, audio-recordings and transcripts will only have codes and not names in order to safeguard confidentiality. At the end of the research the audio-recordings will be erased. All data will be treated in accordance with the current Data Protection Act.

What if I wish to complain? Please raise any concerns or questions initially with myself, Simon Moralee, on (07940) 536774; email p00245147@myemail.dmu.ac.uk. If I am unable to give you a satisfactory answer, please contact one of my supervisors: Professor Allan Macpherson via email at amacpherson@dmu.ac.uk; Dr. Deborah Price on +44 (0)116 257 7214, email dprice@dmu.ac.uk; Professor Peter Spurgeon, p.c.spurgeon@warwick.ac.uk. You can also contact the Faculty’s Head of Research, Professor Anthony Ferner on +44 (0)116 250 6441 or via email at afhum@dmu.ac.uk.
What will happen to the results of the study? The results will be made available following the completion of the PhD in or before 2016. I will provide a summary and you will be able to receive a copy of this if you wish.

Version: 1.2

Date: 15 October 2012
Appendix 8: Participant consent form

CONSENT FORM

Title of Project: Individual engagement with change in medical education

Name of Researcher: Simon Moralee

1. I confirm I have read and understood the information sheet dated 8 October 2012, version 1.1 for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.

3. I agree to take part in the above study

………………………
Name of Participant

………………………
Date

………………………
Signature

To be completed on return:

………………………
Researcher

………………………
Date

………………………
Signature

The data will be used for research purposes.
Appendix 9: Invitation to interview letter

[Date]

Dear

RE: Doctoral research regarding the Medical Leadership Competency Framework (MLCF)

I am carrying out a research study as part of my Doctor of Philosophy in Organisational Change Management (Health Care) at De Montfort University, Leicester.

Professor Peter Spurgeon, who was the Project Director for the Enhanci

ng Engagement in Medical Leadership project which encompassed the MLCF and suggested that you may be interested in taking part.

Your involvement would encompass an audio-recorded face-to-face interview of approximately one hour at a convenience time and place, preferably before 21st December 2012, as my employers have granted me research leave until January 2013 and I am hoping to be able to carry out the research before that date. If you are interested in being interviewed, please email me at p00245147@myemail.dmu.ac.uk to indicate as such. However, I would still be interested in interviewing you after that date if a convenient time before the New Year cannot be found, so if you could indicate a date in Spring/Summer of 2013 when you would be willing to take part I would be grateful. If I have not heard from you after two weeks, I will send a follow up email to see if you would be willing to take part, so please also indicate if you do not wish to be involved.

The research question I am investigating is “How do individuals within organisations engage, in practice, with change?” The aim of this research is to gain a better understanding of the implementation of changes to training in the context of the medical profession in the English health care system. Its focus is the introduction of management and leadership training to medical curricula, with specific reference to the MLCF.

In the course of my study, I aim to:

• Explore the actions and practices of individuals within organisations in the changing context of reform and modernisation;
• Explore perceptions of government objectives, policy and strategy regarding the medical profession;
• Explore how change is introduced into healthcare organisations;
• Explore factors that help explain the relationship between doctors and managers/government in the context of legitimacy and power.

I have enclosed an information sheet further detailing the research. I would like to thank you for taking time to read this email and hope to hear from you soon. If you have any queries, please feel free to contact me via email or on the telephone number below.

Yours sincerely,

Simon Moralee
Senior Lecturer, Health Care Management and Programme Leader, Medical Education
De Montfort University, Hawthorn 0.22a, Leicester, LE1 9BH
p00245147@myemail.dmu.ac.uk
Appendix 10: Prior Relationships Map

Key

- **Org**: Organization relevant to medical professionalism, education or leadership
- **Medical professional opinion leader**
- **Medical professional project team/steering group member**
- **Non-medical professional opinion leader**
- **Non-medical professional project team/steering group member**