# How do elite doctors respond to tensions in hybrid healthcare organizations?

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**Abstract**

*In this paper we explain how and why elite doctors in public service healthcare respond to increasing hybridity through different forms of identity work, accommodation and resistance. We draw on a conceptual framework developed by Besharov and Smith and on research into identity work to explain how senior hospital doctors have become increasingly differentiated in their responses to multiple logics. Our analysis produces three contributions to the study of professions in healthcare. Firstly, based on their responses to hybridity, we identified four distinct groups of elite doctors. Secondly, we found that a new generation of doctors have been more able to assimilate multiple logics into their identities than earlier generations. Although tensions may be reduced as later career doctors leave the labour force, we argue that they are unlikely to disappear because the notion of an 'authentic' identity of medical professionalism is embedded in the social identities of doctors. Thirdly, we problematize the notion of hybrid professional leaders as a form of reprofessionalization. In contrast to earlier literature, our research indicates that doctors resist hybrid medical leadership and subscribe to the notion of elitism defined largely by 'who they are definitely not'.*

**Keywords**: elite professionals, hybrid organizations, doctors' social identities, hybrid leaders, logic multiplicity

**Introduction**

Arising from changes in the institutional environment, many healthcare organizations are characterized by tensions among stakeholders influenced by multiple institutional logics (Battilana & Lee, 2015; Kyratsis, Atun, Phillips, Tracey & George, 2016; Pache & Santos, 2013; Tracey, Phillips & Jarvis, 2011). In some contexts, these tensions create conditions that help organizations become more effective (Goodrick & Reay, 2011; Reay & Hinings, 2009; Waring & Bishop, 2013); in others, they result in deep-seated conflicts and sub-optimal functioning (Kirkpatrick, Jespersen, Dent & Neogy, 2009; McGivern, Currie, Ferlie, Fitzgerald & Waring, 2013). It is widely acknowledged that medical professional groups play a key role in dealing with tensions inside organizations (Ackroyd, 2016; Dent, Bourgeault, Denis et al., 2016; Goodrick & Reay, 2011; Martin, Armstrong, Aveling et al., 2015). Thus we take as our point of departure Freidson's (1970) work, one of the best known researchers on professionalism, who originally saw doctors as a self-serving elite concerned mainly to resist changes to their autonomy and long-held privileges. Yet, in his later defense of professionalism

(Freidson, 2001), he came to see an ideal model of professionals as a necessary antidote to the logics of the market or bureaucratic hierachy - and thus as a force for good. Nevertheless, he contended that this ideal model would only be possible if professionals renewed an ethical commitment to the 'soul of professionalism', comprising 'transcendent values' directed at a 'higher order goal which may reach beyond that of those they are supposed to serve', and the 'right to serve these values independently' (Friedson, 2001). Thus, this commitment embraced a moral obligation to resist the demands of managers or the state when these conflicted with independent professionalism and trancendendent values.

So, drawing on these discussions, we attempt to answer the question: how do elite doctors in public healthcare organizations respond to hybridity? Public healthcare is good context to research professional groups' responses to hybridity because they often embrace multiple logics at different points in time, so testing the will and skill of professional groups to respond to changing hybridity (Reed, 2016). To answer our question we have studied senior hospital consultants in the UK National Health Service (NHS). Consultants are arguably the most elite medical professionals in the NHS because of their required length of training, specialization and dependence on them to provide a 'consultant-led or consultant-delivered service' to hospitals (Academy of Medical Royal Colleges, 2012). In this sense, they are an important intermediary between the state and citizens, enjoying autonomy in defining patient needs and treatment. However, because of increasing demands placed on the state and the rise of new public management (NPM), some argue this traditional bargain between doctors and the state has changed markedly (Ackroyd, 2016; Kirkpatrick et al, 2005). Thus we aim to understand how these senior doctors have interpreted and responded to these changing conditions – and why.

Our analysis produces three contributions to the debate on the future of medical professionals. The first is to theory of elite medical professionals in the public services by identifying four

distinct groups of doctors' in terms of their responses to hybridization: deprofessionalized, incorporated, aligned and insulated. Secondly, we answer a call by Pratt et al. (2006) to study medical professionals at various stages of their careers. We found that a new generation of consultants at an earlier stage in their career have been more able to assimilate multiple logics into their identities than earlier generations. However, we argue that although tensions may reduce as later-career doctors leave the medical labor force, they are unlikely to disappear. This is because an, albeit attenuated, 'authentic' identity (Brown, 2015) of medical professionalism is deeply embedded in the social identities of the majority of consultants. Thirdly, we problematize hybrid professional leadership as a form of reprofessionalization. In contrast to earlier literature on reprofessionalization, our research indicates that doctors contest the notion of hybrid medical leadership as a form of organizational dis-identification, in which a majority of consultants undertake active resistance through identity work to maintain their distinctiveness from medical and non-medical leaders.

**The theoretical framing**

Research on organizational hybridity has provided valuable insights into the problems of organizational change in a range of sectors and settings (Battilana & Lee, 2014; Battilana, Besharov & Mittzenenck, 2016; Denis, Ferlie & Van Gestel, 2015; Pache & Santos, 2013). These insights draw on shifting institutional logics, which provide templates guiding how individuals, groups and organizations socially construct and interpret their material and symbolic 'realities'(Friedland & Alford, 1991; Thornton, Ocasio & Lounsbury, 2012). In this paper, we combine two recent approaches to analysing how changing logics can impact professional identities. The first is by Besharov and Smith (2014) who provide a novel contribution to this literature by theorizing the repercussions of multiple societal-level logics on organizations. The second is the notion of identity threats and identity work (Brown 2015, Brown & Coupland 2015, Petriglieri 2011 and Tracey & Phillips 2016), which have also been

used to analyze hybrid medical professionals (Kyratsis, Atun, Phillips et al., 2016: McGivern et al., 2013).

**Logic compatibility and centrality**. Besharov and Smith (2014) identified two dimensions of logics – logic compatibility and logic centrality – and showed how interlinked field, organizational and individual factors influenced these two dimensions. The first dimension, *compatibility*, referred to the relationship between logics. In some instances, these relationships can result in inconsistencies and conflict over organizational goals and the means of achieving them. In other instances, organizational actors are able to combine multiple logics in a consistent and reciprocal manner so that overarching organizational goals remain unchallenged.

Besharov and Smith's (2014) second dimension was logic *centrality*, referring to the extent to which multiple logics were seen as central to achieving organizational goals. They defined centrality as 'the degree to which multiple logics are each treated as equally valid and relevant to the organizations functioning' (p. 369). By combining these two dimensions, Besharov and Smith (2014) produced four ideal-types of organizations – contested, estranged, aligned and dominant - as a basis for further research into organizational hybridity. While their work certainly has the potential to advance research into the repercussions of hybrid logics in organizations, we believe it can be more usefully applied to the analysis of how professions cope with hybridity (Goodrick & Reay, 2011). As earlier research by Abbott (1988) showed, members of professional groups often enjoy significant agency in how they manifest different logics, especially at particular points in their careers (Gordon et al, 2015; Pratt et al, 2006).

**Social identity theory in healthcare.** With this last point in mind, researchers have used the literature on social identity to analyse how doctors respond to the changing logics in healthcare (Kyratsis, Atun, Phillips et al., 2016: McGivern et al., 2013). Social identity theory is concerned with association with a particular social group (Ashforth & Mael, 1989; Tajfel &

Turner, 1979), by answering the 'who are we' and 'who we are not' questions. For example, McGivern et al. (2013) and Waring and Bishop (2013) have analyzed later career doctors' responses to hybridization in the UK NHS as enthusiastic, 'willing' hybrids or passive, 'incidental' hybrids. Martin, Beech, MacIntosh & Bushfield (2015) also pointed to fundamental 'disconnects' between doctors and managers, rendering distributed leadership to doctors as problematic. Also, particularly relevant to our theorization is work by Kyratsis et al. (2016) whose research in Eastern European countries has shown how changing logics have challenged the social and role identities of doctors. Employing inductive research, they identified three successful forms of identity work corresponding to three forms of identity threats faced by doctors employed in former communist countries who were challenged with adapting to a new, state-sponsored logic of 'generalism' found in general practice in Western Europe. These identity configurations were: (1) threats to traditional professional values – what it meant to be an expert professional at work and as a member of a professional field – which were addressed by new authentification claims concerning what it meant to be a professional in a changing world; (2) status loss in relation to peers and patients, addressed by reframing a new logic of generalism in a positive light, and (3) social identity conflict, what it meant to be  doctor in the world outside of work and the professional field, addressed by incorporating social or political ideals that gave them a positive sense of self in their new roles. However, in acknowledging their configurations were generated only by physicians capable of managing the transistion between old and new logics successfully, Kyratsis et al., called for further research into situations whereby professionals such as doctors either continued to embrace existing or old logics and rejected new ones, or found themselves unable to deal with multiple logics.

Our work addresses this last call for further research by drawing on theory on deprofessionalization of the medical profession and reactions to it (Freidson, 1970;

Kirkpatrick, Jespersen, Dent & Nagy, 2009). Deprofessionalization is associated with the loss of two, interconnected types of autonomy and control – socio-cultural and task-related autonomy (Numerato et al, 2013) and its implications for doctors' sense of self identity and status. Task autonomy maps onto Kyratsis et al's. (2016) notion of threats to professional values. A decline in socio-cultural autonomy among doctors in public services is often attributed to the developing ideology of (i) public sector managerialism, a set of ideas and a political discourse that emphasizes rationalism and standardization through accountability, transparency and constant evaluation against targets (Ham, 2014; Kirkpatrick, Kuhlmann, Hartley et al., 2016) and (ii) leaderism, a discourse that allows public service professionals to constitute themselves as agents of system reform while still retaining professional values (Reed, 2016) . These discourses of managerialism, bureaucracy and leaderism have pervaded the medical profession by shaping formal systems of control, doctors' sense of professional identity – 'who they are' - and, in the case of elite professionals, 'who are the best' (Brown, 2015). It has also influenced what is considered reasonable and useful in clinical practice, e.g. during the early socialization of trainee doctors into the profession (Gordon, 2015). Finally, certain strands of the deprofessionalization of medicine thesis emphasize how the profession is losing: (a) its traditional status in society, (b) influence over other healthcare professional groups and (c) the respect of patients (Filc, 2006; McDonald et al., 2012). This last point maps onto Kyratsis et al's (2016) social identity conflict and the identity work that 'willing hybrid' doctors have undertaken to 'reprofessionalize' medicine, often by embracing the logic, discourse and practices of medical leaders (Bishop & Waring, 2016; Kirkpatrick et al., 2016; McGivern et al, 2013; Martin, Armstrong, Aveling et al., 2015; Waring & Bishop, 2013).

**Logics, identity threats and identity work.** Following Besharov and Smith (2014), the first stage in developing our theoretical framework is to relate the dimensions of logic compatibility and logic centrality orthogonally. However, to make their approach suitable for analyzing

professionals, requires a transposition of their original notion of multiple logic centrality. Thus, in analyzing consultants' responses to multiple logics, we propose multiple logic centrality would be high when most doctors accept multiple logics and enact these logics in their day-to-day operations without seeing one as necessarily more important than the other. In healthcare the two dominant logics, which are often contrasted, are logic of medical professionalism, frequently used by clinicians as a proxy for patient care, and business-related healthcare (Reay and Hinings, 2009). In socialized systems such as the NHS, a political democratic logic has also had a major influence on healthcare provision So, for example, multiple logic centrality would be high when doctors accept (a) medical professional autonomy, (b) the democratic rights of patients to participate in their own care, often expressed as mutuality (Howieson, 2016), and (c) efficient use of resources, as being equally important. Conversely, logic centrality would be low when consultants see medical professionalism as the dominant legitimate rationale for governing decision making and others such as mutuality and the efficient use of resources as peripheral to their work and the organization's functioning. This transposition allows us to propose four ideal typical responses by consultants to logic multiplicity in their employing organizations in the NHS (see Figure 1), which we have labelled respectively deprofessionalized, insulated, incorporated and aligned consultants.

The second stage in developing the theoretical model is to overlay these ideal types with the notion of identity threats and identity work to provide a more fine-grained explanation of: (1) the causes and nature of resistance through identity work to instantiations of multiple logics in their employing organizations, and (2) the potential for conflict and different forms of resistance (Kärreman & Alvesson, 2009) between senior hospital doctors, non-clinical managers and medical leaders. These four types are set out in Figure 1. We propose identity threats to be a key link between, on the one hand, logic centrality and compatibility and, on the other hand, the extent and nature of resistance/accommodation of multiple logics. We further

propose that different forms of identity work are a useful starting point to explain differentiated forms of tractability of conflict and resistance of consultants to logic hybridity. Finally, we propose that the identity discourses used by different types of consultants to characterize others will have a major impact on so-called 'leader-follower relations' (De Rue & Ashford, 2010) among hospital doctors.

*Insert Figure 1 about here*

In Table 1 below we elaborate our theoretical model, based on the following reasoning. The first is that logic shifts, leading to increased hybridity in healthcare organizations, give rise to three types of identity threats for elite medical professionals. These shifts conflict with traditional medical professional autonomy and values, loss of traditional status in relation to other healthcare professionals and patients, and social identity conflict over what it means to be a senior doctor in the world outside of work, especially in respect of the views of the general public and patients, and among other elite professionals. In turn, identity threats generate different types and intensity of identity work. This work involves the claims of new logics for system reform, how these new logics are framed in relation to medical professionalism and autonomy, and how consultants culturally reposition themselves to deal with managerial and political democratic logics. We argue these differences in identity work fundamentally shape how consultants at different stages in their career and in different positions sense and enact Besharov and Smith's (2014) notion of logic compatibility and centrality at work, so generating accommodation or resistance at different levels of intensity to hybridity.

*Insert Table 1 about here*

However, in setting out a theoretical schema of this nature, we acknowledge its potential for 'misplaced concreteness' (Whitehead, 1929). Typically static 'two by two' maps of this nature do not deal adequately with dynamic changes in how people are aligned with any ideal type over time.

**Methodology**

**Context of the study.** The context of our research is hybridization of the NHS in Scotland. The NHS, one of the world's largest hybrid organizations, is well-known for embodying multiple logics in its decision making and constitution (Harris et al, 2014), despite having a workforce ostensibly bound together by an ideological mission to deliver high quality patient care to all, free at the point of delivery (NHS Constitution, 2011). This hybridization process has involved the cumulative effect of multiple logics available to organizations and professionals, which have been layered, one on top of another, during four time periods in the UK NHS system (Bevan et al, 2014). Thus, medical professionalism was the dominant logic and mode of governance in the UK NHS from 1948 to approximately 1972. This was overlaid by the introduction of New Public Management (NPM) from 1972 onwards, which emphasized efficiency, bureaucratic controls and managerialism. Following changes in government and political philosophy, a market logic – based on choice, competition and financial management as a source of legitimacy –dominanted the institutional order between 1991-1997, but this order was supplanted by a new logic in Scotland, following devolution in 1997 of key areas of decision making and responsibilities to a newly formed Scottish Government, which heralded an increasing divergence of NHS Scotland from the NHS in England. This new logic we label a political-democratic logic concerned to enhance public value through the integration of health and social care and mutuality but sometimes seen as driven by populist politics and opposition to elites. Thus, since 2004, the Scottish government has taken on a much greater role in directing the service through 'targets and terror' and 'naming and shaming'. The government have also been active in promoting a discourse of leaderism by co-opting senior doctors into medical leadership roles. These developments have arguably had the effect (if not the intention) of de-privileging 'rank-and-file' hospital doctors and prioritizing service user (not

only patients) democracy and value for money in an increasingly resource starved service (Brown, 2016).

**Research strategy and methods**. Our research approach adopted a mixed-methods design (Bryman, 2006). The first qualitative stage involved in-depth, semi structured interviews with 68 consultants, with questions informed by theory on institutional logics, deprofessionalization, engagement, trust and voice. Access to consultants was facilitated by the Scottish Consultants Committee of the British Medical Association (BMA). These were audio-recorded and subsequently transcribed and analysed using NVivo. The analysis of the interviews condensed the material in the transcripts into the underlying themes emerging from the data. We gained access to consultants in all boards in Scotland, in all types of hospitals, consultant specialties and age ranges to address potential concerns about representativeness, with the number of interviews conducted guided by theoretical saturation. Our analysis of the interviews was iterative, moving between deduction to induction to test and refine our original theoretical framework's capacity to explain our data.

The resulting theoretical framework in Figure 1 and Table 1 and our analysis of the interviews were used to inform the second stage online survey, consisting of 53 questions. The survey was piloted on a group of consultants. The revised survey was distributed online to 3742 consultants in Scotland (estimated total population 4200) using the BMA's database. A reasonably good response rate for online surveys of 28.6% was achieved (Nulty, 2008) with 1058 consultants completing the questionnaire by the due date. Such a response rate is open to non-response bias, so we attempted to assess this by carrying out a wave analysis to determine the extent to which 458 respondents to the follow up email differed in response patterns and demographics from the first wave of 600 respondents. This analysis showed that mean responses across the two waves of response did not vary significantly, apart from views

concerning clinical leadership in the second wave which were significantly more negative (P<0.01). This response rate lends credibility to the survey. In the findings section we make only limited use of numerical data, typically only reporting means for the 5-point scale questions and the variation among mean scores for specific demographic groups where these were significant using standard statistical tests (cross-tabulations tests and one-way analysis of variance (ANOVA).

In addition to the quantitative data from the scale items and demographic question, we also analyzed 430 free text responses in the survey. The majority of these responses provided rich, reflective accounts of respondents' positive and negative experiences of work, in some cases almost a half-to full page of normal typewritten script . These free text comments have contributed substantially to the overall empirical findings and theorization in this paper.

**Findings**

Our overall finding from both the qualitative (and quantitative) data was that consultants in the NHS in Scotland strongly adhered to a dominant medical-professional logic and saw business-related healthcare and political-demographic logics as largely incompatible with medical professionalism and its implications for patient care. For example, only 18% of consultants in our study thought there was an appropriate balance between medical professionalism and business-related logics, with 73% of consultants agreeing that business-related and political logics governed decision-making in their hospitals.

Confirmatory factor analysis showed negative attitudes toward non-clinical managers were highly loaded onto a factor that closely resembled theory on deprofessionalization in medicine. This analysis suggests that there is high correspondence between our definition of deprofessionalization as a decline in socio-cultural and task autonomy, and consultants' views on the growth of non-managerial power and influence, non-clinical managers' lack of understanding of the work of consultants, and consultants' low levels of respect for non-clinical

managers. 63.64% of respondents agreed/strongly agreed that non-clinical managers had too much influence over service delivery, only 15.52% agreed/strongly agreed that non-clinical managers had a good enough understanding of consultants' work to exercise their responsibilities effectively, and only 39.35% agreed/ strongly agreed they had respect for the non-clinical managers and the work that they did.

However, in line with our framework in Figure 1 and Table 1, we also found substantial variation among consultants in how they perceived identity threats and responded to logic multiplicity through identity work. This variation was especially evident among (a) consultants who either were medical leaders or had previous experience of medical leadership, (b) consultants at different stages in their careers, and (c) to a lesser degree, consultants in different specialties. We use the terms early stage, mid-career and later career consultants to refer to those with 1-4 years, 5-10 years and more than 10 years experience as a consultant.

We acknowledge our research has limitations in focusing on one specific region of the UK NHS and its findings may not apply equally to other parts of the UK health system, or other systems of public healthcare elsewhere in the world. However, these limitations are also strengths in allowing us to relate the changing experience of work of these elite professionals to macro and field-level contexts (Kirkpatrick et al, 2016).

**Deprofessionalized consultants**

**Identity work and identity threats associated with business-related logics.** The survey and interview data showed that a dominant perspective of most consultants in our study, especially among those without medical leadership experience or those at later stages in their career, was of profound deprofessionalization. These consultants saw multiple but incompatible logics vying for dominance, but with only one offering a legitimate guide for creating value – the logic of medical professionalism - typically seen as a proxy for high quality patient care. As a consequence, they expressed views of their hospitals and the NHS in Scotland as continuously

contested, with frequent threats to their professional identities and status arising from the new logics of business-related healthcare, managerialism and leaderism. The following quotes by two later career consultants exemplified the interconnected socio-cultural and task dimensions of deprofessionalization, which clearly involved identity threats and conflict over professional values in relation to their expertise and status loss relative to managers (Kyratsis et al., 2016). Thus one later physician expressed his frustration with a challenge to his expertise from non-clinical managers in part of a lengthy free text response:

> *Since I started as a doctor 27 years ago, I have seen an enormous expansion in non-clinical workers in the NHS, many of whom add little or nothing to patient care but count things for political reasons. There seem to be a great number of people who could not do my job but feel qualified to tell me how to do my job. I have also found HR management to be lacking in respect for the roles and responsibilities of consultants (Free text response from later career consultant).*

Another consultant physician explained how business-related healthcare, through increased bureaucracy and funding decisions, had diminished the status of the medical profession:

> *I have been a consultant for 19 years. During that time I have seen management expand through self-perpetuating bureaucracy while the position and role of the consultant has been diminished by underfunding, inappropriate policies and ridiculous diktat. The role of the consultant is clearly viewed by management to provide patient care on a shoestring, to do so unsupported, and to take the blame when patient care goes wrong even if the cause is faulty management (later career physician).*

At the same time, however, these two quotes are evidence of consultants' identity work to disconfirm the claims of new logics by reframing new managerial logics and managerial practice in a negative fashion. In doing so, they attempt to position themselves as experienced and expert professionals serving patients, but constantly having to cope with unqualified (in the medical sense) managers and increasing bureaucracy to provide effective patient care, but without the resources to do so.

**Identity threats and identity work associated with a political-democratic logic.** However, it was not only business related healthcare and managerialism that were seen as the root cause of their deprofessionalization but the direct influence of the Scottish Government's political/ democratic logic, which many consultants felt were guided by populist politics, generating unrealistic expectations among the public, and were an unwarranted intrusion into their professional independence and judgement. As we noted in the methods section, the NHS in Scotland is the most corporatist of the four UK healthcare systems (Bevan et al, 2014). Thus, what was perceived as direct and, at times, pernicious control by the Government, for whom improving access and the quality of heathcare with reduced resources and reducing healthcare inequalities were central planks of their manifesto commitments, was palpable among many consultants. The following interview extract shows how a strong political discourse and alleged government interference was deemed incompatible with medical professionalism, a key theme in interviews with later career consultants:

> *I feel that medical managers are constrained by political targets and meeting these with limited resources in undoubtedly difficult. They tend to isolate themselves, often geographically, from the clinical realities - a fuller appreciation of these would make their decisions more uncomfortable. The clinician is left to get on with working around the ever-increasing obstacles to providing good quality patient care.... My clinical work is profoundly rewarding but the system in which I work, as compared with even 10 years ago, ever impedes me rather than freeing or trusting me to deliver the professional service which I regard as a vocation ( Interview with later career physician).*

The next two extracts also illustrate how consultants felt political populism threatened to diminish their expert judgements over which patients to treat and when they should be treated. Moreover, in doing so, it was also interpreted as challenging and debasing their status and broader social identity in society:

> *I think unrealistic targets set by governments in constrained financial circumstances has led to a shift towards employing more non-clinical staff to come up with ways of meeting targets rather than employing more clinical staff to treat patients in order of clinical priority. There is also a culture of raising unrealistic expectations for the public. In that sense although I sound*

*critical of board managers but I am sympathetic to their situation (Interview with later career consultant radiologist).*

*The political agenda based on waiting times is an inappropriate way to assess healthcare. They have taken what is measurable and made it important instead of measuring what is important. Outcomes are all that matter to patients but the media and politicians have 'infantilised' our population by indoctrinating them about what issues are important in healthcare. Consultants have been debased to drones, driven by inappropriate targets, matched with insufficient resources, with the devaluing of time spent on anything other than measurable activity. Time as a clinical tool for patients has be sacrificed on the altar of waiting times (Free text response from later career consulant).*

Whilst highlighting identity threats, these quotes also evidenced identity work aimed at disconfirming the legitimacy of political logics as solely concerned with misguided targets that had little to do with effective patient care and more to do with responding to populist politics. One of the most consistent themes in the interviews with senior consultants was the dysfunctional consequences of waiting time targets that conflicted with medical judgements over which patients to treat and when to treat them. In pursuing this theme, consultants also sought to authenticate their medical professionalism as the only legitimate route to strengthening their relationships with patients and improving patient care.

Evidence of status loss and threats to consultants' social identity in wider society were also attributed to the increasing incursion of a political - democratic logic:

*The public's perception of medicine has changed dramatically. They no longer hold the medical profession in the same respect they did. There's no doubt about that. And I think a lot of it's to do with the media, I think, sets unrealistic expectations of what medicine can offer. ...There's a lot of information out there, and patients are a bit – much better informed, perhaps, than they were. And there's nothing wrong with that. But I think their expectations of care ... before, you might have, you know, said to a patient that, "There's nothing more I can do about it," and they would, sort of, say that, "Thank you, Doctor. You've done your best," sort of thing. But now, they challenge you, as to why they've done so poorly ...it's a lack of recognition for the reality of what medicine is. It's not perfect, and it's never going to be (Senior Surgeon).*

**Adapting to the new political-democratic logic by embracing mutuality.** The above quote also discursively relates changes in the public perception of doctors to the role of the media in

generating unrealistic expectations over the what medicine can offer. 69% of respondents to the survey agreed or strongly agreed that patient expectations outstripped resources available to deliver effective patient care, a percentage that did not vary significant among consulants at any stage in their career. Thus we found 'managing expectations' of patients and managers as a new form form of identity work used by consultants to help them and colleagues deal with this problem. However, as the following quotes illustrate, we also found many consultants employed a narrative strategy of mutuality in avowing patients' rights to challenge doctors as a way of showing how their medical professional logic had changed to reflect a more patient-centred, democratic, less hierarchical narrative consistent with the politics of healthcare in NHS Scotland. As we noted earlier mutuality refers to a wider political discourse that has begun to dominate the healthcare agenda in Scotland, which seeks to rebalance the relationships between those who use services with those who provide them (Brown, 2016; Howieson, 2016).

> *It wasn't a negative thing it was quite a positive thing I felt (referring to mutuality). Generally, I think they had a very high expectation and I don't mind that. I think that the whole point of being a doctor is that you explain what you're able to do and you do it openly and honestly that's what we've got to do and you need to make that very clear. So I didn't mind they had very big demands and they were unrealistic but that's the point of being a doctor is that you can at least educate people as to what's available and what you're able to do and if you can't help them then you would try and find somebody who can and if nobody can help them then that's how it is and you can't change reality (Senior Consultant Surgeon).*

Thus, despite a strong theme running through the interviews concerning the negative effects of a political-democratic logic on consultant identities, we found little evidence of a perceived loss of status among consultants in terms of the nature of esteem and respect they experienced from patients. Indeed, the survey data show the opposite: 88% and 94% of consultants respectively agreed or strongly agreed patients generally showed respect for consultants and that patients generally trusted their judgments and ability to treat them effectively. We argue these data show how even deprofessionized consultants had adopted the mutuality discourse as an identity narrative to talk about a more contemporary and progressive relationship between

doctor and patients, and how they had adapted to, rather than resisted, the democratization and populism of the NHS (Karreman & Alvesson, 2009). They also show how consultants felt patients were on their side, which strengthened their claims to be the legitimate guardians of patient care rather then managers and other professions.

**Identity threats and identity work associated with new medical elites**. One key explanation of deprofessionalization of doctors is the rise of new medical elites, which have arisen to internally regulate the medical profession. In the UK, elite bodies such as the General Medical Council (GMC) and the Medical Royal Colleges have emerged as forces for self-regulating the medical professions, arguably to ward off external government intervention when doctors are implicated in healthcare scandals (Kirkpatrick, 2016). Perhaps an even more significant trend towards internal regulation, the NHS and governments have turned to the creation and incorporation of medical leaders into the running of the NHS (Reed, 2016), in the hope that the leadership of doctors by doctors would help facilitate their responses to hybridization.

Our findings on internal regulation by professional bodies such as the GMC or the prestigious UK Medical Royal Colleges, were typically negative. These bodies were seen as an ineffective substitute for external control, which also threatened their professional identities. For example, only 28% of respondents to the survey agreed/strongly agreed that the GMC had been effective in self-regulation, while around two-thirds agreed that the GMC had introduced unnecessary levels of bureaucracy. Later-stage career consultants in particular were significantly more likely ($p<0.01$) to hold negative attitudes towards the GMC, which was associated with the introduction of appraisal and the regular revalidation of doctors' competence. The following quotes illustrates how many of our later career consultants saw the GMC as a threat to their professional independence:

> *It doesn't really impact on your day-to-day work. However, it's a kind of background endless frustration of the utter waste of time of all the stuff from the GMC and the (Medical Royal) Colleges, you know, revalidation, re-licensing, appraisal, mandatory training - it's just utter nonsense and the*

*amount of money that is spent on it in terms of the time ... you know, the worst doctors sail through appraisal because they know how to play the system (later career Physician).*

*I think medical bodies have actually made it worse, for example, adding on to appraisal and revalidation and things like that on an already busy and committed workforce without any thought for where is this time going to come from... (Later career Psychiatrist)*

The above quotes also illustrate important forms of identity work in disconfirming the authenticity of medical elite bodies and casting the process of internal regulation as either irrelevant or as self-defeating in not sifting out 'the worst doctors'. In interviews, consultants frequently referred to how recurrent scandals involving medical practitioners had failed to be prevented by increasing internal bureaucracy.

**Identity threats and identity work associated with new medical elite leaders.** Perhaps the most surprising and intractable source of tension, however, was reserved for attempts by the employers to adapt to hybridity by appointing a cadre of medically-trained leaders to exercise legitimate authority over consultants (Kirkpatrick et al, 2016; Numerato et al, 2013). The survey results showed that less than a third of survey respondents in total agreed/ strongly agreed that medically-trained managers did an effective job in improving service delivery, with only a fifth agreeing/ strongly agreeing they did an effective job of representing consultants' interests to senior managers. In line with similar studies of doctor-manager relations (Martin et al, 2015), the survey data also provided insights into why consultants, two-thirds of whom had no medical management experience, failed to endorse a system of distributed medical/ clinical leadership designed to legitimate logic multiplicity. Low levels of endorsement of medical leadership in practice was attributed to negative professional and social identity changes doctors in medical leadership positions were seen to undergo: almost 50% of respondents, agreed/ strongly that doctors became 'different people' when going into medical managers, while more than a third agreed / strongly agreed that consultants 'crossed a line in the sand' when becoming medical managers. These perceptions of negative identity changes

among medical managers were significantly more likely among mid-career and senior consultants (p<0.01) and some specialties, including anaesthesia, investigative medicine and surgery.

The interviews with later career consultants in particular provided insights into professional values conflict presented by the theory and practice of medical leadership. The first set of quotes illustrates a very marked professional values conflict between (a) those consultants who believed that medical professionals should be committed to the day-to-day practice of medicine and developing the professional skills to do so, and (b) thos consultants who embraced the values of professional leadership of doctors by doctors. The proverbial metaphor of doctors having gone over to the 'dark side', often attributed to their needs for personal gain and rewards or a failure to be a 'good doctor', was a widespread identity discourse among the consultants without medical management experience. This discourse was used by them, arguably as the most overt form of resistance, to disconfirm the authenticity of medical managers, and was created and widely sustained to devalue the logic of professional leadership and leaderism as a solution to effective healthcare:

> *There's a suspicion amongst some of us that some of the senior medical hierarchy will go with the flow or with the policy because they will be rewarded later on. At a local level this can be with discretionary points or awards but you see it even at high levels. Many doctors who help a government report will get an OBE, or if you sit on a certain committee and support government policy you'll get a knighthood. As a result I think many younger consultants feel their medical leaders and bosses do not represent them. They get so high up in the system that rewards them that they become part of the management system rather than representing doctors. There are even some joke terms for this; 'Gongitis', 'knight' fever and 'lorditis' (a reference to Lord Darzi). For some people it seems to become very seductive - working for managers, the government or within 'corridors of power'. They seem to enjoy this more than clinical work with colleagues. They are seen as having 'gone native'. ... It's another part of the 'network' that operates with the medical profession. If you're not part of it, you don't get promoted or rewarded. Only those who are prepared to toe the line are appointed and rewarded (Later career Physician).*

Consequently, medical leaders' competence, integrity and benevolence were distrusted (Schoorman, Mayer & Davis, 2007), as these next two quotes illustrate vividly. Distrust was expressed either in terms of the personal motivations and values of those in medical leadership positions or because of having 'sold out' and becoming incorporated into accepting the centrality and compatibility of multiple logics:

> *I'm very sceptical of doctors that choose to become managers because they choose to become managers in order to succeed in management they have to follow the management agenda otherwise they will not succeed in the management circle and to the extent that they succeed in the management then I'm very sceptical about following those people as leaders, I'm not sure that I do trust them to make decisions that I would approve of if I knew the ins and outs of it and that means that they're not really trusted leaders to me (Later career Physician)*

> *And then the management chip gets implanted in them and they forget about being a doctor… associate medical director and up… they then cease to be like doctors and then become part of management (Later career Radiologist)*

Even among consultants in this group who accepted the 'theory' of leadership of doctors by doctors, most saw doctors in such positions as often the 'wrong people for the wrong reasons at the wrong times' in their career:

> *I think certain clinicians should go into leadership but not necessarily those clinicians that apply for the leadership roles. … I worked in places… …both in Europe and in China, the senior consultants are doing less and less clinical work and more and more managerial work because they've got the experience. Some of them actually quite like doing that and at the moment, we've got a culture which tends to allow younger clinicians to be managers because they have an interest in it and maybe twenty years ago, I might have myself… I'm going against myself but I think the trouble is, it does encourage people who see it as a quick way to power and to, shall we say, self um interest, and perhaps because they don't actually like their clinical jobs, you know, for the reason that they can't do it (later career Surgeon).*

**Incorporated consultants**

In marked contrast to deprofessionalized consultants were those who worked in, or had previous experience of, medical leadership roles. This group accounted for almost a third of respondents to the survey and those we interviewed. They were also qualitatively distinctive in being able to incorporate multiple logics into their identities and responses. And, as might

be expected, they were significantly more likely to be positive about the impact of medical managers (p<0.01).  Thus, we label this group 'incorporated consultants' (Bolton, 2005) because the identity work they discursively related frequently attempted to authenticate: (a) the claims of medical elite bodies and non-clinical managers for consultants to be responsive to an increasingly resource-constrained system and (b) the discourse of mutuality, which holds that patients have a legitimate right to be  more challenging of doctors' decisions and holding them to account.  They were more accepting of a need for their employers and modern healthcare systems having to balance the multiple logics underpinning the values, strategies and organization of modern healthcare organizations such as the NHS.  In this sense, they could be seen as giving unproblematized compliance to the new business-related and political democratic logics.  While recognizing multiple logics did create tensions, they did not see such tensions as identity threats to their professional values, status or wider social standing.  Indeed the threat mostly voiced was the intransigence of their colleagues, who they claimed remained strongly attached an 'outdated' version of medical professionalism.   The following free text quotes illustrate how incorporated consultants used the discourse of mutuality as a form of counter-resistance to deprofessionalized consultants' criticisms **(**Kärreman & Alvesson, 2009), articulating the direction doctors needed to travel and framing medical professionalism as a public good rather than privately belonging to the profession:

> *Managers are an easy target for doctors as they have responsibility for implementing difficult financial and political decisions. I have always found working with them more productive than attacking and undermining them as some colleagues seem to prefer. If we wish to be listened to and earn respect from colleagues, clinical and non-clinical, we need to behave the same way towards them... Some of my colleagues expect that I should act as an advocate for doctors exclusively but as a manager it is the public, patient safety and the service that supports patients, which must be the priority (Free text comment).*

Incorporated consultants' experiences of working with multiple logics were often associated with significant social identity changes to help them make legitimate claims to be  leaders

(Besharov, 2014). These changes, evidenced through the survey data and the quote below, was, in effect, was a form of cultural repositioning. Accordingly, consultants with experience of medical management were significantly more likely ($p<0.01$) to hold more positive views of non-clinical management, to see the GMC in a positive light ($p<0.01$) and to agree that medical managers performed an effective role in service delivery and representing consultants interest. The following quote illustrates how one medical director distanced himself from his non-managerial colleagues:

> *I'm not in the least bit anti-manager. I mean a lot of doctors they're anti-manager I mean I've worked as a manager as I said earlier on in my career…. I think some of them do but you thought that nobody has it as hard as doctors and that managers have it easy. Yet, when you go into medical management you realise well actually it's just the stresses are different but they are just there in just exactly the same way. The idea that an organization as big and as complex as the NHS shouldn't be managed is just ludicrous really so we need to have them...(Psychiatrist Medical Director).*

Two further free text comments provide stark illustrations of cultural repositioning by medical leaders, and pleas for their colleagues to undertake reframing identity work to redefine what it means to be a professional consultant:

> *My eyes have been opened by what I've seen in medical management: huge efforts to engage with consultants and appalling behaviour by doctors (Free text comment, medical manager).*

> *Clinicians need to be given control over financial decisions for their team, but also the responsibility for delivery. Only then will clinicians face up to tough decisions and make them in patients' interests (Free text comment, medical manager).*

**Insulated consultants**

We also found another group of consultants we label as insulated. These consultants were either at an early career stage or operating at a level at which they were rarely required to make decisions requiring them to confront the financial implications of their actions (e.g early or mid career consultants in well-funded areas of medicine where resource constraints were less of an issue). In this sense they were already socialized into the hybrid healthcare system or were less exposed to the direct effects of financial and political logics. These consultants tended to

discursively relate their organizations as strongly influenced by a medical professional logic which dominated patient care decisions. Although they saw evidence of business-related and political democratic logics shaping decisions in the overall running of their hospitals, they did not regard them as central to the organization's functioning and thus a threat to their medical professional values. Instead they engaged in a form of authentication as identity work (Kyratsis, et al., 2016) by relating financial and government constraints as a necessary burden associated with requirements of operating in a resource-constrained, public health service. This identity work was given quantitative expression in the survey: for example, early career consultants were significantly more likely to agree/strongly than mid and later career consultants with the statement that "I see bureaucracy as an essential, if not always welcome, element of my job" ($p<0.01$) than mid or late career consultants. The following quote illustrates the lack of an identity threat from bureaucracy and identity work in authenticating the need for a certain level of bureaucracy:

> *I must say it – it [bureaucracy] doesn't impact very badly. Most of the… form-filling, and paperwork… that I end up having to do does seem to be fairly, fairly appropriate. In my day-to-day working, I don't feel it's affecting me badly – or at least not, in terms of unnecessary stuff (Early Career Physician).*

Further evidence of business-related healthcare logic being less impactful on the day to day experience of this group is that early career consultants ($p<0.05$), alongside consultants with medical management experience ($p<0.01$), were significantly less likely to agree/ strongly agree with negative items related to non-clinical management interventions. Nevertheless, despite their partial authentication of multiple logics, when directly confronted with situations such as dysfunctional waiting times targets, which reflected political rather than clinical judgements, they reported what might be decribed as moderate and temporal opposition to logic multiplicity. The following quote shows how a surgeon has learned to incorporate the effects of a business-related logic into his identity and everyday working:

*There is more bureaucracy, more admin, paperwork and meetings and these can take over, but I am getting better at managing these and keeping meetings to time ... In terms of the clinical aspects, it gets easier to do the operations but I wouldn't say it gets routinized. I am still getting better at my specialism and I get real satisfaction from doing it well. Every day/week brings something new which keeps it interesting (early career surgeon)*

In summary, insulated consultants discursively related and positioned their work and employers as being dominated by medical judgements and the values, strategies and practices of the medical professionalism. Thus conflict was temporary, only moderately threatening to their identities and likely to be resolved in their favour.

**Aligned consultants**

Finally, we identified a group of aligned consultants. These doctors were at earlier or mid-career stages, working in part-time clinical leader posts and/ or consultants working in smaller hospitals, in which they were co-located with non-clinical managers with whom they enjoyed close relationships. These two groups could be characterized by multiple logics being incorporated into their identities and functioning, but where, from time to time, multiple logics could provide contradictory prescriptions for action and internal conflicts. Typically, identity threats were minimal and consultants in this group engaged in identity work that tended to authenticate new logics, and reframed themselves in such as way that there was no real gap in theory between their values and practices and those of management. However, in practice, especially among part time clinical leaders, internal conflicts would surface in their discursive reasoning.

One example of alignment between logics involved a physicians explaining how his work had been improved by the introduction of electronic patient records, a new form of bureaucracy that was not always seen in a positive light:

*Oh absolutely yes, yes but at the same time that that's happening from the point of view of me having to fill in spread sheets for cancelling clinics or whatever there's also been a massive improvement in the access to electronic data from a patient point of view so in clinic we've now, well there's a few problems with it but on the face of it if you compare my access*

*to patient data when I became a consultant to now it's unbelievable I mean I could have never dreamt that I would be working in an environment where I could just log in and get all the radiology pictures up on screen and you know get all the blood results, (Physician)*

Another illustration of how the small size and rural location of a hospital may have shaped acceptance of multiple logics that had a potential to conflict was provided by a general surgeon and a general physician working in a remote hospital:

*(Name of manager) is our own hospital manager. We work very closely with her, she's been a tremendous, a lot of the changes are from her. Because we're small we do see a fair bit of our other managers…. Now (name), our chief executive, If, you know, if I was in (major urban hospital in region), I wouldn't know who it was. (CEO name) you know comes down here, visits, has a coffee and has a chat and things. (CEO name) has been massively supportive (mid-career Surgeon).*

It is worth noting how this surgeon equates positive changes with the proximity advantages of working in a small hospital close by non-clinical managers, which was a marked theme among general consultants in remote locations. Similarly, a co-located physician tentatively explained how proximity demands closer working relationships and acceptance of new logics for him to achieve his aims. In this sense, he is doing a form of identity work in aligning his values and needs with those of managers, albeit in a calculative fashion.

*This is quite a small place so you don't really have that pure sort of, you know, command that rarely works. We've had one chief executive who probably did offer instruction and was difficult to challenge but, by and large, managers - I think you know like self-interest - would get on with people so it would be quite unusual for you to be told to do something you didn't want to do that's you know there's plenty of negotiation…I kind of do trust the managers here because I think they are, they're pretty much all, they're all good people I don't think anyone's on any kind of hidden agenda power trip really I don't feel anyone's got any ill will at management level so I kind of, I do trust I've got a very good relationship with our general manager though you could argue that I probably cultivate that because it's a useful thing to have you don't really want to fall out with somebody or you know if you're seen as difficult you're not going to get you know what you want without a real struggle (mid career Physician).*

Nevertheless, alignment between professional values in this group was not always evident, and this was most evident among some part time clinical leaders, as the next quote illustrates:

> *My experience (of clinical leadership) … personally, I find it a distraction. I found it very hard to do the… what I would call the day job as well as I would like because of all the harassment of trying to do the other things, um, and… and that's too conflicting, I think, for me. I think, you're either dumping work on your colleagues who are also busy or you're not doing the work properly…and that's… that's not good (part-time physician clinical leader).*

This clinical leaders' experience highlights the inherent conflict over professional values experienced by consultants who take up part time leadership posts, a common practice in the NHS. Here, however, the identity work undertaken is blaming herself for not being able to cope with the demands of the job, which contrasts with the discursive strategy evident in the next quote from a part time clinical leader. Here, the clinical leader incorporated multiple logics into his planning and resign project but blames senior managers' failure to implement these: .

> *I have found the experience working as a leader in my specialty at NHS (name of board) most challenging. I have effectively done everything I can to act on the values inherent at all levels of society in accordance with the zeitgeist, the GMC, Social Policy, NHS and Health Board Policy in relation to good patient care and redesign of services with the utmost integrity. Key areas include service user and carer involvement in redesign and service delivery, values led approach to service delivery, shifting the balance of care and integrated working, In turn, senior management at Board level having paid lip service to these values during a redesign of services, with wide representation at my insistence. I feel I have been 'betrayed' (extract from free text comment by a part time clinical leader).*

**Discussion**

To answer our research question – how do elite doctors in public healthcare organizations respond to hybridity - we developed a new framework that brought together the literatures on hybrid organizations, institutional logics and social identity theory in healthcare. This framework combined Besharov and Smith's (2014) theoretical work on logical centrality and compatability in organizations with the notion of identity threats and identity work among elite professionals (Brown, 2015; Brown and Coupland, 2015; Gill, 2015; Kyratsis et al, 2016) as responses to changing logics in medicine. In doing so, we have created four ideal types of

responses to increasing logic multiplicity among these elite healthcare professionals. We proposed that increased hybridization in our research setting would lead to consultants expressing different types of identity threats. These would be met by corresponding types of identity work, contingent on how consultants interpreted the centrality and compatability of logics. Consequently, consultants would display different forms of engagement in identity work - to understand themselves and convince their colleagues of their understanding of their situations - would result in different degrees of tensions, conflict and resistance. Broadly speaking, this framework helped explain our qualitative and quantitative data on hospital consultants' interpretation of logic shifts, identity threats and identity work, and levels of accommodation or resistance to hybridization of the NHS and their organizations. Based on the analysis of our data, we identified four types of responses to hybridization, which we now discuss.

**Deprofessionalized consultants**. Consultants who interpreted their situations in terms of *deprofessionalization* were by far the largest group numerically in both stages of the study. These were mainly later career consultants, many of whom expressed high status anxiety (Gill, 2015). Such deprofessionalization manifested itself in their interpretations of, and threats to, their identity from increased bureucracratic and political-democratic control. They also interpreted attempts by new medical elite bodies and the appointment of a cadre medical managers as an unwelcome and, in some cases, pernicious threat to their identities as expert medical professionals. The identity work undertaken by these deprofessionalized consultants was largely aimed at: (a) disconfiming the authenticity claims of these new logics, (b) reframing these business-related healthcare and political-democratic logics in a negative light, especially when compared to 'superior ethos' and values of medical professionalism. This work, we argue, is a good example of the power of elites to resist bureaucratic power (Kärreman & Alvesson, 2009; Martin et al, 2015).

However, even among this group we found evidence of identity work being sufficiently flexible to make themselves situationally relevant (Ashforth, 2001) by culturally positioning themselves as the legitimate guardians and/or champion of patient care. They did so by assimilating a new narrative of mutuality, an important political discourse emphasizing patient rights and a more equal relationship between patients and providers. Arguably, to strengthen their version of what they saw as an elite professional, they contrasted themselves with hybridized medical managers, whom they regarded as having 'sold out' their medical professional values and as having gone over to the 'dark-side' in adopting the logic of business-related healthcare (Surgeon et al, 2011). Consistent with this strategy of positioning themselves as the true guardians of patient care, they appeared to draw on the extant respect and trust of patients as a means of sustaining their elite identities. This finding contrasts with the deprofessionalization thesis, which sees doctors as losing their status in society (Filc, 2006; McDonald et al., 2012).

**Incorporated consultants.** Deprofessionalized consultants contrasted most markedly with *incorporated consultants*, who we estimate compromised about a third of survey and interview respondents. Incorporated consultants had current or previous experience of medical management, and identified much more closely with authenticity claims of medical management and the tenets of leaderism to enhance patient care. We argue that their experience of working with multiple logics led them to regard multiple logics as much less threatening to their core identities as working in the interests of patients. By authenticating the claims of the new logics and reframing what it meant to be an elite consultant in a 'modern' world they managed to incorporate and accommodate these logics into their daily functioning, thus laying claim to being leaders of the profession. This authentication and reframing work was further reinforced by challenging consultants who were unable to embrace these new logics as being out of touch, downright hostile and, in some cases, near 'neanderthal'.

**Insulated consultants**. The third group of consultants in our study were what we have labelled 'insulated consultants'. They were mainly early career consultants who had become relatively insulated from the negative effects of hybridization because they had entered into medical training at a period of greater logic multiplicity. Otherwise, the group comprised consultants who were operating at a level at which they were rarely required to make decisions that required them to confront the financial implications of their actions, for example, as early or mid career consultants in well-funded areas of medicine where resource constraints were less of an issue. This group, somewhat similar to the deprofessionalized consultants, interpreted their identities as an elite professional by paying homage to the authentic past ethos and practice of medical professionalism. However, because of their socialization and/or insulation from the demands of business-related healthcare, were able to rationalise and incorporate multiple logics into their positive identity of a medical professional. In this sense they exhibited a 'working self-concept' that allowed for a changing accommodation of new logics (Brown, 2015). Nevertheless, they could not be described as having bought into hybridization, and when brought into close contact with resource decisions and external regulation, they exhibited similar levels of criticism and opposition to business-related and political-democratic logics as deprofessionalised consultants.

**Aligned consultants**. Finally, we identified a smaller group of aligned consultants, who, like insulated consultants, tended to be at earlier or mid-career stages, and thus had been socialized into a hybrid healthcare system. Some worked in part-time clinical leader posts which suggests they had been flexible enough to incorporate a business related logic into their self-concept of elite professionals, although when confronted with the demands of medical judgements coming into conflict with external regulation such as waiting times or appraisal, they found difficulty in doing identity work that was able to successfully reconcile them. Another sub-group worked in smaller hospitals, in which they were co-located with non-clinical managers with whom they

enjoyed close relationships. So we found proximity to non-clinical managers to be an important influence on their understanding and relationships to business-related decisions, which was evidenced by their typical attribution of blame for negative outcomes of business-related decisions to 'Board Headquarters', typically distant from their hospitals in material and symbolic senses (Martin et al, 2015).

**Differentiation at various stages of doctors' careers**

In our study we also answer a call by Pratt et al. (2006) to study medical professionals at various stages of their careers. We find that a new generation of consultants at an earlier stage in their career have been more able to assimilate multiple logics into their identities and day to day functioning than earlier generations. However, we argue that although tensions and conflicts may be reduced as later career doctors leave the medical labor force, they are unlikely to dissappear. This is bec ause an, a attenuated 'authentic' identity (Brown, 2015) of medical professionalism, embracing the need for clinical autonomy, transcendent moral values and expertise, is deeply embedded in the social identities of the majority of consultants and used by them to challenge the legitimacy of market, bureaucratic and state logics.

Hence, our findings suggest the following: the greater the extent of hybrization in healthcare systems, the greater the extent of differentiation among consultants in their perception of identity threats, identity work and how they resist or accommodate new logics. Such an argument mirrors Abbott's (1988) proposition that it is the nature of work control which brings professionals into conflict with one another. Our analysis of differentiation among senior doctors, we argue, contributes to the literature on identity construction among elite professionals, which is concerned with status narratives about 'being among the best' rather than just 'who we are' (Alvesson & Robertson, 2006; Gill, 2015), and how identities are regulated by structural forces (Brown, 2015). We find, in this case, that there are significant differences in consultants' responses to hybrid logics dependant on: (1) when doctors in

training became early career consultants, which will have influenced their socialization into logic multiplicity, (2) their choice of 'authentic' career trajectories, namely whether they seek and obtain clinical leadership roles, (3) the location in which they choose to work (urban, large hospital v rural/ small hospital, both of which are likely to shape their sense of 'being the best' and 'who we are', and (4) the extent to which they are insulated from the effects of hybridization because the specialty in which they work and/or because their day to day work does not require them to directly confront the effects of multiple logics. What was most marked about intra-professional differentiation in our study was the contrast between medical managers' ability to be able 'flex' their cross-cutting identities of medical professionalism and leaders (Ashforth & Johnson, 2001) and those consultants for whom a salient, central identity was defined by remaining solely loyal to the heritage and ethos of medical professionalism (Brown, 2015; Martin et al, 2015; Reay & Hinings, 2009). We argue this latter group came close to expressing sentiments close to Freidson's (2001) notion of soul of professionalism, combining transcendent values with a desire to define their identities by who they were not (Ashforth & Mael, 1989; Elsbach & Bhattacharya, 2001).

**Hybrid medical leadership**

Our framework and data also contribute to the debate on the future of professionalism (Dent et al., 2016; Freidson, 2001). Freidson's earlier works (1985, 1994) pointed to all professions undergoing restratification to mitigate the effects of external threats to their autonomy. Such restratification, he argued, created an administrative elite within professions, which have come to be known as hybrid professional managers (Kirkpatrick, 2016). Orginally these elites were perceived by fellow professionals as a shield to guard against threats to their professional interests – in effect, as advocates for professional colleagues. Simultaneously, however, they were also tasked with exercising managerial authority over, and leadership of, professional colleagues. In fulfilling this latter role, many hybrid professional managers came to blend or

assimilate bureaucratic-managerial logics into their identities, values and practices (Goodrick & Reay, 2011; Spyridonidis et al, 2015). They also undertook identity work that sought to provide a form of counter-resistance to the claims by colleagues that they believed had 'sold out' (Kärreman & Alvesson, 2009). This two-pronged thesis, as Kirkpatrick (2016) proposes, produces both continuity with the past and the potential for change in professions.

Thus, a number of studies on professional leadership and distributed leadership have suggested how the emergence of a new elite of hybrid medical leaders is likely to disrupt institutionalized medical professionalism, so resulting in a reform of healthcare systems worldwide (Gilmartin & D'Aunno, 2007; McGivern et al, 2013; Martin et al, 2015; Spyridonidis, Hendy & Barlow, 2015; Waring & Bishop, 2013). In contrast to these studies, however, our research highlights how the claims of these new hybrid medical elites to a leadership identity (DeRue & Ashford, 2010) are resisted by most consultants, whose notion of elitism is defined largely by 'who they are definitely not' (Ashforth & Mael, 1989), i.e. managers. So our data provides little support for advocates of the incorporation of doctors into leadership roles and distributed leadership theory (Martin et al, 2015; Spurgeon et al, 2011).

The majority of consultants in our study saw non-clinical leadership in a negative light and as a field and organizational phenomenon with which to dis-identify (Besharov, 2014). What was more surprising and interesting was the strength of feelings towards medical professionals who had 'crossed a line in the sand'. Identity co-construction theories of leadership point to a reciprocal need for leaders to undertake identity work to construct themselves as leaders and make legitimate claims for a leadership identity to potential followers (DeRue & Ashford, 2010). In turn, followers have to see themselves as followers and grant the claims of potential leaders. Our data show this co-construction process has been largely unsuccessful, with neither leaders nor followers being successful in making such claims, or granting those claims of the other party. Instead our study comes down hard on lines in the sand remaining tightly drawn

among this group of elite professionals, whose allegiance to a pure version of professionalism is so deeply embedded in the past to make it a relatively stable working self concept (Petriglieri, 2011). Thus our research highlights how the claims of these new  hybrid medical elites to a leadership identity (DeRue & Ashford, 2010)  were resisted by most consultants, whose notion of elitism is defined largely by 'who they are definitely not'  (Ashforth & Mael, 1989), i.e. managers.  This contestation can also be seen  as a form of organizational dis-identification (Besharov, 2014; Elsbach & Bhattacharya, 2001), in which a majority of consultants undertake active resistance through identity work to maintain their distinctiveness and to separate themselves from clinical and non-clinical leaders' acceptance of hybridity (Kärreman, &Alvesson, 2009).  They do so by  challenging the rights of hybrid professional leaders to control their work, often by questioning their expertise and moral claims for elite status.

**Implications for the study of elite doctors in public healthcare**

Our analysis has two key implications for the study of how elite professionals in public service organizations (Brown & Coupland, 2015; Gill, 2015; Reed, 2016) have interpreted and responded to increasing organizational hybridity.  First, it sheds new light on process of hybridization and the future of the professions in public services organizations (Light, 2000; 2010; Martin, Armstrong, Aveling et al., 2015).  In most studies of hybridity and professionals, typically only two logics have been discussed – professional and a business related logic (Reay & Hinings, 2009).  However, in situations where professionals are employed in public services, a third logic – a state logic – has become increasingly important (Ackroyd, 2016; Barbour & Lammers, 2015; Dent et al, 2016).  Accordingly, we show how populist, political-democratic issues influence consultants' identities, autonomy and values - in our study expressed in a new discourse of 'mutuality' between patient and doctor.  This logic is experienced by a majority of consultants as both dominating, in setting unrealistic expectations through direct performance controls, but also liberating, in facilitating their claims to have disguarded their

self-serving but outmoded neglect of patient rights and to have adapted to a democratic, rather than consumerist, call to 'partner with patients'. In doing so, consultants have been able to advance a simultaneously more credible and moral stance to be the 'true' guardians of transcendent values in healthcare (Freidson, 2001). The majority of consultants in our study, somewhat contrary to the picture typically painted of a reprofessionalized group responding positively to logic multiplicity (e.g. Kyratsis et al, 2016; Waring & Bishop, 2013), are deeply embedded in identities that resemble Freidson's call for professionals to demonstrate 'soul' and resist hybridization.

The second implication is that this majority in our study exercised their power and resistance through identity worked aimed at discrediting medical leaders and thus the discourse of leaderism, which allows public service professionals such as doctors to constitute themselves as agents of system reform while still retaining professional values (Reed, 2016). Leaderism has been promulgated in the public services as a distinctive discourse from NPM's emphasis on bureaucracy and control, particularly to appeal to elite professionals such as doctors, academics and school teachers and incorporate them leadership roles to bring about reform of public services. Our analysis, however, suggests that elite professionals in public services are more likely to interpret the discourse of leaderism as a failed attempt to replace the managerial bureaucrat with the professional bureaucrat, thus revealing the inherent limitations of bureaucracy and political-democracy as alternative logics to professional values, autonomy and judgements in such contexts.

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**Figure 1. Four ideal types of consultants' responses to hybridization in healthcare organizations**

| | **Low compatibility**<br>Logics provide contradictory prescriptions for identities and action | **High compatibility**<br>Logics provide compatible prescriptions for identities and action |
|---|---|---|
| **High centrality**<br>Multiple logics successfully incorporated into consultants' identities and functioning | **Aligned consultants**<br>*Minimal identity threats and resistance* | **Incorporated consultants**<br>*No identity threats and accommodation* |
| **Low centrality**<br>One logic dominates consultants' identities and functioning; other logics are seen as peripheral or are rejected | **Deprofessionalized consultants**<br>*Extensive and profound identity threats and resistance* | **Insulated consultants**<br>*Moderate identity threats and resistance* |

**Table 1 Ideal-typical responses of consultants to logic multiplicity and associated identity threats**

| Ideal Type | Identity Threats | Logic manifestation through identity work and resistance |
|---|---|---|
| Deprofessionalized consultants | High professional values conflict, high status loss and high social identity conflict brought about by logic multiplicity | Identity work involves defining their social identities in opposition to managers; disconfirming the claims of the new logics and the leadership claims of non-clinical and medical managers; reframing the new logics in a negative light compared to the old logics, and culturally positioning themselves as the legitimate guardians of patient care by incorporating the logic of mutuality into their notion of medical professionalism, <br><br> Leading to: <br><br> Extensive and profound resistance to logic multiplicity, resulting from the high centrality of medical professionalism to consultants' everyday functioning, and the incompatibility of medical professionalism with business related managerialism and political control. |
| Insulated consultants | High professional values conflict, minimal status loss and minimal social identity conflict brought about by logic multiplicity | Identity work involves disconfirming the claims of the new logics as dominating their jobs, reframing compliance with new logics as necessary but seeing them as peripheral compared to the medical professionalism, and culturally positioning themselves as maintaining their wider social identity as the legitimate guardians of patient care, <br><br> Leading to: <br><br> Moderate resistance, resulting from the high centrality of medical professionalism to consultants' everyday functioning but where multiple logics are seen as necessary for the running of hospitals and as offering consistent implications for action |
| Aligned consultants | Minimal professional values conflict, minimal status loss and minimal social identity conflict brought about by logic multiplicity | Identity work involves unproblematized compliance and confirmation of the claims of the new logics, reframing the new logics in a relatively positive light compared to the old logics, and culturally positioning themselves as the legitimate arbiters of patient care, <br><br> Leading to: <br><br> Minimal resistance to multiple logics, which are see as central to their everyday functioning but where multiple logics could be seen to have incompatible implications for action in certain circumstances. |
| Incorporated consultants | No professional values conflict, no status loss, and no social identity conflict brought about by logic multiplicity | Identity work involves authenticating the claims of the new logics and exercising claims to leadership of the profession, reframing their identities and new hybrid logics in a positive light compared to the traditional hierarchical view of medical professionalism and out of |

| | | date and/or disruptive colleagues, defining their identities in opposition to , and culturally repositioning themselves by adopting new and more 'modern' perspectives on healthcare management,<br><br>Leading to:<br><br>Accommodation of multiple logics because consultants readily accept and draw on multiple logics for their everyday functioning, and see these multiple logics as compatible. |
|---|---|---|