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Cultural Complementarity: Reshaping professional and organizational logics in developing frontline medical leadership

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Abstract

With the rise of clinical management, new skills of medical doctors stand out, including leadership skills. Medical doctors organize medical work and improve patient care. The training of frontline leadership skills, however, is weakly developed in residency programmes. Medical professional cultures tend to resist organizational techniques and values. This paper analyses cultural interventions in health-care organizations, aimed at overcoming 'clashes' between professional and organizational logics in frontline domains. These interventions do not work against, but 'use' professional traditions, styles and customs as cultural resources. We use one particular project to illustrate this, a project in which internal medicine residents are invited to join quality improvement sessions, during which they identify critical (organizational) experiences with care provision and realize change. We show how residents feel enabled to establish results and cooperate with other professionals. We also show how this project links organizational responsibilities and medical professionalism – how complementarity (instead of conflict) is established. This is done in practical ways, which commit instead of alienate medical professionals.

Key words

Professionals, frontline leadership, health care, competencies, organizing professionalism

CULTURAL COMPLEMENTARITY

Reshaping professional and organizational logics in developing frontline medical leadership

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INTRODUCTION

With the rise of clinical management, new skills of medical doctors stand out, including leadership skills. Instead of merely producing medical doctors with strong medical and technical skills, as well as communication skills, medical professionals are expected to become medical leaders who render well-organized health-care services. Medical doctors are taught how to organize medical work, lead teams of professionals, establish (multi)disciplinary collaboration, enhance safety and quality and improve patient care, backed by new discourses, for example, on 'frontline leadership' (e.g. Blumenthal et al. 2012), and new competency models. Instead of seeing organizational skills as something separate from medical work, organizing becomes part of medical work; medical and managerial logics are intertwined. Academically this goes beyond the 'hybridization' of professional work (see e.g. Noordegraaf 2007) and is described in terms of *organizing professionalism* (e.g. Noordegraaf 2011a, 2015a, 2015b; Noordegraaf and Steijn 2013).

In addition to learning new methods and techniques for diagnosing and treating patients, physicians become operational leaders or *frontline leaders*. They develop broader perspectives upon health-care delivery, see the provision of services as a more collaborative endeavour and deal with the tensions that are part of organizing health-care work (cf. Block and Manning 2007; also e.g. Ham and Dickinson 2008; Waring and Bishop 2010). This can be set against the background of changing health-care realities (e.g. Plochg, Klazinga, and Starfield 2009). According to Blumenthal et al. (2012, 514):

> Delivering high-quality care requires that physicians work with and oversee large, diverse teams; navigate increasingly complex technological and human systems; and simultaneously manage the care for large numbers of patients, for each of whom there are multiple goals of care.

New competency models in health care (e.g. Frank et al. 2010; Ten Cate, Snell, and Carraccio 2010) add new leadership competencies to traditional medical skills. A well-known model is the so-called CanMEDS model, developed in Canada and used throughout the Western world (e.g. Frank 2005). In addition to classic medical professional and scholarly competencies, that is, acting as 'professional' and 'scholar', the model defines new competencies for doctors; they should also be 'health advocates', 'collaborators' and even 'managers' (see Figure 1).

The training of leadership skills, however, is weakly developed in residency programmes (Blumenthal et al. 2012). Medical leadership aimed at establishing well-organized health care is still seen as residual, at most additional (e.g. Noordegraaf 2011b; Wallenburg 2012). It is 'added' to training other skills, but seen as 'alien' and resisted by groups of professionals. Although medical associations and medical educational programmes have embraced models like CanMEDS, the development of medical leadership is far from guaranteed (e.g. Ten Cate et al. 2010; Noordegraaf 2011b; Blumenthal et al. 2012). Most fundamentally, this is not

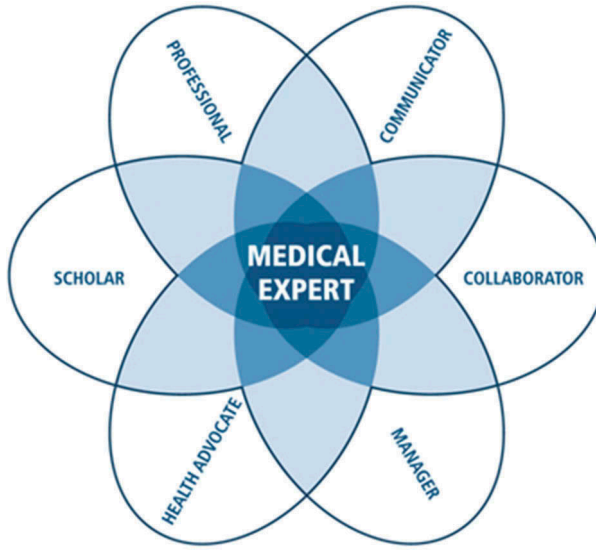

Figure 1: The CanMEDS model

so much a practical of operational obstacles, but of cultural recalcitrance. Organizing is seen as antithetical to medical action, as organizational leadership is generally related to values like control, costs and efficiency which are seen as detrimental for medical professional values such as quality, learning and attention. 'This wariness of managerial work is deeply rooted in the culture of medicine and medical education', Blumenthal et al. (2012, 515) argue. Raelin (1986) stresses the 'clash of cultures'. The rise of medical leadership (or lack thereof) fuels clashes between managerial and professional logics, which are well-documented (e.g. Noordegraaf 2007; also Farrell and Morris 2003; Kurunmäki 2004; Kirkpatrick et al. 2009; Kurunmäki and Miller 2011; Muzio and Kirkpatrick 2011; Noordegraaf 2015c; for oversight, Noordegraaf 2011a).

This paper analyses these obstacles from a different angle. Instead of explaining 'competing logics' (e.g. Reay and Hinings 2009), we analyse whether and how organizing becomes embedded within professional logics. Our research question is: *How can cultural interventions in professional practices affect the strengthening of frontline leadership in professional (medical) services?* We focus on cultural interventions, aimed at reconfiguring professional work, so that organizing becomes part of regular professional practices. As far as work is concerned, we more specifically focus on what Boxall and Macky (2009) call professional 'work practices', in which multiple practices are bundled: clinical work, team work and also educational work, which 'shape new patterns of interaction', as Boxall and Macky (2009, 5) stress. Such a focus on work practices seems to enable the rise of both 'high-involvement work systems', including

more effective job design with bundled work practices, as well as 'high-commitment management', aimed at overcoming cultural obstacles. We illustrate this by describing a particular project aimed at developing medical leadership, in one of the largest Dutch academic medical centres. In this project, called 'Wonder and improve' ('Verwonder en verbeter'), medical residents who work *and* are educated in one of the centre's divisions are asked to detect organizational problems, identify causes and solutions and initiate improvements. By seeing it as a part of their normal work and by seeking practical, *on-the-job* training arrangements, medical residents are equipped to deal with organizational challenges in complex health-care delivery. A few exploratory studies have shown the effectiveness of this practice-based work and learning project (Beerthuis 2013; Van de Camp 2013; Voogt 2014). These studies showed that professional and managerial logics were coupled quite naturally and effectively.

Instead of focusing on fundamental conflicts between managerial and professional logics, such a project seems to enact 'reconfigured' forms of professional work that are experienced as workable (cf. Noordegraaf 2015a, 2015b). We first explore the debate on changing (medical) professionalism and the rise of new skills and competencies. We then explain how associations and educations try to introduce new skills and competency models and why this proves to be difficult. Next, we present a cultural perspective on developing medical leadership, which enables us to see leadership development not as opposing medical cultures, but as 'using' them, that is, using certain cultural dimensions of medical action in order to foster leadership skills. We stress the importance of creating 'bundled work practices' in everyday work practices in order to establish cultural complementarity. We describe how we studied one particular case and we present exploratory findings on how medical and managerial logics were linked. Finally, we discuss these findings and draw conclusions.

(MEDICAL) PROFESSIONALISM

Studies of professionalism have a long history, but they have become highly relevant to understand changes in domains like health care. Medical professionalism – but also professionalism in law and accountancy – faces many pressures that have not only generated practical challenges, but also academic puzzles.

Traditionally (e.g. Larson 1977; Freidson 1994; Abbott 1988), professionalism is seen as a regulatory phenomenon whereby a certain occupational group which applies complex knowledge to specific cases manages to institutionalize control mechanisms that enable group members to define, regulate and supervise their own work. Backed by states and linked to universities (cf. Burrage and Torstendahl 1990), this occupational group or 'profession' is able to select its own members, train new members, develop and diffuse new knowledge, watch and judge the behaviour of members and exclude members if necessary. In this sense, the medical profession is one of the classic

professions, next to lawyers, accountants and engineers. Other professional fields – judges, policemen, teachers – are less 'pure' (cf. Noordegraaf 2007); they are less independent (e.g. Larson 1977; Reed 1996) and less sheltered from outside worlds, and more embedded within states, welfare states and organizations (also e.g. Clarke and Newman 1997).

The pure model of professionalism is increasingly hard to maintain, also in case of independent professions. There are many pressures on the regulatory capabilities of professions and as a result it is difficult to 'keep things together'. Professional fields tend to experience fragmentation and they tend to get increasingly dependent on outside worlds (e.g. Noordegraaf 2015b). Often, this is related to the rise of neo-liberal politics and new public management (e.g. Farrell and Morris 2003; Diefenbach 2009; Evetts 2009), but this is too simple (cf. Noordegraaf and Steijn 2013; Noordegraaf 2015a; Kirkpatrick and Noordegraaf 2015). There are many social and societal pressures that affect services, service delivery and service interactions and thus service professionalism. The following pressures are prominent (also Noordegraaf 2011a):

- Professionals such as medical professionals are embedded within *organizational contexts* that set new standards and shape new identities.
- Professionals face new *clienteles and clients* and deal with *cases* that acquire new shapes. Multi-morbidity, for example, means that diseases and illnesses cannot really be isolated from each other. A neurologist, a neurosurgeon and an infectious diseases specialist might treat one and the same patient.
- Professionals work with new *technologies* that are transgressive, that is, they change medical work and the nature of diseases and they change treatment. On the one hand, they fuel (super)specialization; on the other hand, they support self-treatment by patients.
- Professionals operate within *public and political arenas* that not only seek optimal results and better organizations; they also seek safety and security. Incidents and failures – medical errors – symbolize system failure.
- *Professionals themselves* change, both demographically and in terms of work composition and preferences. Instead of fully (i.e. 24/7) dedicated professionals, (female and male) professionals seek work/life balance.

These pressures imply that it is important to be *organized* when it comes to providing health-care services. In order to make services cheaper and faster, as well as more effective (quality and outcomes) and more legitimate (trust and stakeholder support), medical professionalism requires new skills. The classic model of professional control, with a strong emphasis on medical and technical skills, is difficult to maintain in contemporary health care (e.g. Plochg et al. 2009; Blumenthal et al. 2012).

This in itself does not explain the rise of new leadership skills for medical professionals. At the least, it might explain the rise of well-managed health care by well-trained managers and well-organized health-care organizations as professional service firms (e.g. Brock, Powell, and Hinings 1999; Empson et al. 2015). Theoretically, management and leadership might be kept away from medical professionals. Normatively, it might be important to 'shelter' patient treatment from a managerialism logic (e.g. Pollitt 1993), which – at first sight – primarily stresses costs, speed and performances. The aforementioned pressures, however, explain why medical professionals will also need managerial, organizational and leadership skills.

Changes in and around professional work are also caused by changing meanings of health care and changing means and methods for delivering health-care services. Managing and organizing health care cannot be equated with managerialism and the rise of managers. Health-care managers can reduce organizational problems, but if there is complementarity and productive 'interplay' (e.g. De Bruijn 2003; Noordegraaf 2015c), medical professionals themselves will also increasingly organize their work. Not so much in the sense of dealing with costs, speed and measurable performances, but in the sense of working together, taking responsibility, for example, for safety, producing innovations and relating to stakeholders in new and also innovative ways (see also Blumenthal et al. 2012). This is why we and others speak of *leadership* instead of management. Medical leadership is much more substantive than procedural. As Blumenthal et al. (2012, 514) argue:

> Thus, in our view, the term 'clinical leadership' refers to a physician's ability to serve as both a manager and a leader of diverse teams in pursuit of maximally effective patient care.

It is unclear however how such leadership can be developed, especially in professional fields that do not have much experience in leading and organizing health-care delivery to patients.

DEVELOPING (NEW) PROFESSIONAL SKILLS AND COMPETENCIES

As indicated before, there are initiatives and projects aimed at changing medical professionalism. This includes projects aimed at establishing medical leadership, at various levels, including operational or frontline leadership (e.g. Blumenthal et al. 2012). Many of these projects tend to emphasize new skills and competencies, most specifically organizational and leadership skills. In the medical domain, there is a widespread tendency to define new skills and establish competency-based medical education (CBME). As indicated, new competency models like CanMEDS have been introduced (e.g. Frank 2005), aimed at:

- adding new medical roles (advocate, collaborator, manager) to more classic roles (professional, scholar, communicator);
- devising new policies, as medical associations can adopt the model and turn it into formal rules and guidelines;
- implementing these rules and guidelines, as the model prescribes which (new) skills must be taught by educational institutes.

Despite the fact that medical educations and schools have redesigned medical education according to competency models, such as the CanMEDS model, it is very hard to change professional development and to *actually* develop leadership skills (e.g. Noordegraaf 2011b; Bolton, Muzio, and Boyd-Quinn 2011; Wallenburg 2012; Blumenthal et al. 2012). From academic angles, especially the sociology of medical education (e.g. Becker et al. 1961; Mann 2011), this is understandable. It is not only a practical matter of changing curriculums and adding new skills and competencies. It is a much more principled matter of 'clashes' between professional logics and organizational contexts (e.g. Raelin 1986; for an overview, see Noordegraaf 2011a). Professional fields and professional cultures reproduce themselves. Older generations of professionals train and socialize newer generations and they transfer the already indicated 'wariness of managerial work' that 'is deeply rooted in the culture of medicine and medical education' (Blumenthal et al. 2012, 515) when they train younger doctors. Leadership discourses, as well as organization and management values and vocabularies, have never been part of medical socialization. It is difficult to change medical professionalism (e.g. Bloom 1988, 1989; Thomas and Davies 2005; Tummers, Bekkers, and Steijn 2012), as everyday 'cultural barriers' work against the spread of new principles for medical professionalism (e.g. Hafferty and Franks 1994). It is particularly difficult to develop organizational leadership, including such things as incident reporting (e.g. Waring 2005) and knowledge management (e.g. Waring and Currie 2009). Blumenthal et al. (2012) speak of a '*leadership gap*' in medicine.

Medical professionals are traditionally socialized into certain medical cultural milieus (e.g. Hafferty and Franks 1994) and acquire a medical habitus (e.g. Witman et al. 2011), which make it difficult to turn them into medical leaders that embrace organizational values. Non- medical values are seen as 'alien'. Several explanations can be found for the difficulties that arise when organizational leadership skills are taught (e.g. also Blumenthal et al. 2012).

First, there are practical obstacles as medical education is already time consuming. It takes time to learn anatomical, methodical and technical expertise and there is not much time for other insights and skills. In addition, there are social obstacles as older professionals train younger professionals, which means that existing frames of reference and routines tend to be reproduced. This is also a matter of implicit norms – scholars speak of the 'hidden curriculum' (Hafferty and Franks 1994), the things that are 'really' taught when medical doctors are trained. But more fundamentally, there are deep-

seated cultural barriers, reproduced in day-to-day medical practice. Professionalism represents values and ideological underpinnings that constitute everyday professional acts, set apart from organizational acts that represent a performance-based managerial logic (e.g. Harrison and Pollitt 1994; Farrell and Morris 2003; Noordegraaf 2015b). Whereas *organizational* logic embodies values such as control, risks, efficiency, costs and accountability, *professional* logic embodies quality, time, learning, dialogue, client-centeredness and sensitivity. Although this binary opposition is false in many ways (e.g. Exworthy and Halford 1999; Noordegraaf 2011a; also De Bruijn 2010; Kuhlmann et al. 2013), it is reproduced over and over again.

Obstacles to professional adaptation and innovations in medical professionalism usually lead to one of two possible responses. First, obstacles are acknowledged, that is, seen as valuable and used to protect professional fields from managerial intrusions. One might think of, for example, custodial management (Ackroyd, Hughes, and Soothill 1989) and professional resistance (e.g. Thomas and Davies 2005; Waring and Currie 2009), which might be a matter of (a) explicit conflict, (b) passive resistance or (c) subtle manipulation (e.g. Greenwood et al. 2011; Pache and Santos 2013; Skelcher and Smith 2014; also e.g. Oliver 1991). Second, obstacles are tackled by establishing organizational systems, aimed at controlling (medical) professional acts. Protection of professional spaces has advantages, as it fuels commitment and learning (e.g. De Bruijn 2010). Systems improvement has advantages as well, as is shown by, for example, the introduction of medical checklists within hospitals, aimed at improving medical processes and at reducing medical complications and mortality (e.g. Hales and Pronovost 2006; Bosk et al. 2009).

Both responses have disadvantages as well and – more importantly – in both cases professionals might resist innovation, despite potential advantages of, for example, checklists. This means we must go beyond these two seemingly attractive but superficial responses. Either protecting or controlling professionals is insufficient. There might be everyday mechanisms for linking professional and organizational logics in more productive ways and for embedding a managerial or organizational logic *within* professional action. Organizing might then become part of professional action.

PROFESSIONAL CULTURES AS SETS OF PRACTICAL RESOURCES

Instead of focusing on resistance to change and cultural obstacles, we focus on professional cultures as sources for change, involvement and commitment, instead of obstacles, alienation and resistance. We show how medical professional fields are able to renew practices, skills and competencies *from within* everyday professional work practices. By applying a so-called 'toolkit' perspective on organizational and professional cultures (e.g. Swidler 1986; Noordegraaf and Vermeulen 2010), we emphasize the fact that professional cultures are not static and stubborn. The competing logics described are cultural, as stressed by, for instance, Raelin (1986), in the sense that they

represent different ways of 'programing' (cf. Hofstede 1981) minds and acts. Whereas a professional logic appears to program groups of workers to privilege cases, subjectivities, interventions and accomplishment, a managerial or performance logic seems to program workers to stress order, oversight, trade-offs and performances. When professional skills are changed to enhance professional performances, there seems to be a double cultural problem: skill changes aimed at performances are difficult to align with professional norms and values, *and* turning skills into new skills, including managerial skills, is at odds with case-oriented and interventionist professional action. From a toolkit perspective, all of this is less absolute. Instead of perceiving cultures as fixed and stubborn, it sees cultures as lively and dynamic. The programming of minds and actions is interactive and occurs within contexts, which all imply that there are ambiguities and spaces that provide opportunity instead of rigidity. When medical professionals face medical errors, for example, they will respond and reprogram thought and action, in one way or the other. Moreover, a toolkit perspective does not necessarily see cultural fields as antithetical. Even fields that oppose each other at first sight might have much in common or might be interconnected in one way or the other. This explains the 'action turn' in institutional theory. Instead of seeing institutional logics as distinctive regulative orders, authors increasingly show how they are hybridized, interwoven and 'blended' in day-to-day practices (e.g. Skelcher and Smith 2014). How this is done exactly often remains unclear however. The toolkit perspective enables us to understand these processes better: it portrays cultural dynamics as the implicit but active usage of practical social resources that both program and reprogram minds and acts.

Sets of resources

Cultures offer sets of practical resources that both stabilize and change thoughts and acts – cultures provide shared meanings and norms, but also have innovative potential. We analyse these resources and how they are actually used by (a) identifying various key resources and (b) analysing how they are activated in work practices. By relying on a work activity perspective on organizational/professional action, we highlight the practical sides of cultural changes in work settings (e.g. Boxall and Macky 2009). We describe one intervention – a practical change project in an academic hospital – in order to show, in an exploratory way, how cultural resources can be activated in everyday medical practices and how organizational and medical logics can be interwoven.

We see the development of leadership and management skills as a process of change and assume that people involved can respond to change in different ways. We are interested in counter-intuitive responses, including their effects and the conditions that might hinder or favour effective responses. We have applied the following practical

cultural perspective on change. Noordegraaf & Vermeulen (2010, 513) stated that 'The notion of culture is often invoked to explain why innovations have been unsuccessful'. Instead, they argued that 'this line of argumentation hinges on wrong assumptions about the influence of culture on action. Culture is conceptualized as too static and homogeneous, and too much focused on cognitive aspects' (*ibid.*). They proposed an alternative, 'action-oriented concept of culture', arguing that 'administrative culture can be a source of innovation' (*ibid.*). In line with Swidler's 'toolkit metaphor' (1986), they focus on culture as a set of resources that can be manufactured, used and applied, depending on circumstances and actors involved.

These resources might have varied manifestations and they have various degrees of *depth*, that is, they might be situated at different levels of programming minds and acts. In some cases, they represent firmly programmed, well-established action patterns, historically rooted, widely shared. In other cases, they stand for less-programmed, less-established actions and they might be more equivocal, but they nevertheless enable people to collectively deal with situations, such as patient treatment. At the most established level, *traditions* provide cultural resources that constitute and legitimate action. At a less firmly established level, *styles* enable and direct action. At the least-established level, *customs* signify and *are* everyday action. Noordegraaf and Vermeulen (2010) elaborated these three types of resources as follows:

1. *Traditions*. Widely shared and highly routinized attitudes and actions that provide stability as far as social and professional action is concerned. '*This is how we see and do things around here*'. Traditions, including, for example, a widely shared emphasis on patients and quality, are easily reproduced, not in the least by omnipresent professional discourses, including patient-centred discourses.
2. *Styles*. Expressive dimensions of social interactions that signal certain ambitions and identities and that accentuate affiliations. '*This is how we work around here*'. When professionals like medical doctors are used to interact with patients and colleagues in certain ways and when different groups of professionals interact in different ways, they share certain work styles.
3. *Customs*. Cultural artefacts, that is, clearly visible acts, texts and objects that symbolize social action, but that have multiple meanings in daily practices. '*This is how we behave*'. When professionals tend to work in certain places, such as operating theatres, and tend to dress in specific ways, they develop customs that might be practical but that also signify that they know how to behave well.

These resources are interrelated, especially in long-standing fields or work surroundings, and they can reinforce each other. Organizational or professional surroundings with strong hierarchical traditions can be accompanied by directive leadership styles and by strong daily procedures that regulate talk, meetings and paper flows (who talks to whom, who sits where, who signs which papers). This is not necessarily the case. The

various resources might also be loosely coupled, for instance, when specific groups form their own more open and horizontal meetings within hierarchical surroundings. When medical doctors – or other powerful professionals such as judges – bend or break through well-established procedures for making decisions, for example, by bringing younger doctors or judges in the lead, they rely upon other customs.

Cultural interventions

This action-oriented perspective on culture or *actionality* perspective (cf. Noordegraaf and Vermeulen 2010) is broadly applicable, but is especially suited for understanding cultural dynamics in professional domains. Instead of seeing such culture as categorical and fixed, this perspective enables us to focus on the changeability of cultural patterns and their created – including creative – tendencies. Professional fields might change their ways of working and their everyday acts, not by working against cultural circumstances but by 'using' them. Classic professions such as medical doctors, for example, embody sets of traditions, styles and customs which make these professions special and which at first sight are seen as obstacles in the light of change. Historically, medical professionals dislike interference by others, for example, especially when others intervene on the grounds of 'non-medical' logics, as they focus on 'patients and quality' (*traditions*). In addition, they focus on case treatment and they apply specialized sets of knowledge and expertise to individual cases on the basis of standard operating procedures for diagnosing and treating patients (*styles*). Finally, they see patients and colleagues in designated places (hospital rooms, at bed sides, operating theatres, etc.) and develop habits and day-to-day routines for dealing with cases (*customs*).

These resources embody cultural sources of identification, support and socialization. Professional resistance is generated when change projects ignore instead of use the cultural sources of certain professional groups of fields. The dislike of interference, the focus on cases, the time-consuming change of routines and the localized nature of case treatment generally work against organizational ambitions as managers bring in other considerations (costs, efficiency, measurable quality), stress the importance of dealing with multiple cases (planning, prioritization, capacity) and drag professionals away from localized action (transparency, monitoring). When organizational strategies and projects accept these features and 'use' them, changes might happen more naturally. When work practices and their resources are 'used' in such a way that traditions, styles and customs are activated instead of alienated, change can happen *due to* instead of *despite* cultural circumstances.

In order to explain how the usage of cultural resources contributes to changing work practices, we stress the practical side of using cultural resources. We rely upon (professional) work perspectives that highlight the importance of 'work systems' and

'work design' for enhancing involvement and commitment (e.g. Boxall and Macky 2009). These authors especially show (p. 7) how both *work practices* ('the way the work itself is organized') and *employment practices* ('practices used to recruit, deploy, motivate, consult, negotiate with, develop and retain employees') affect performance outcomes. When work practices are '*bundled*', that is, when practices are combined and when their *complementarity* is enhanced, there will be more 'systemic or synergistic' effects (p. 5). Although this is traditionally emphasized outside professional service settings, as 'the management of professionals has always involved high levels of involvement' (Boxall and Macky 2009, 9), it is increasingly relevant to study everyday work design in professional services. High levels of involvement seem to be increasingly weakened due to the pressures identified above. Using cultural resources and influencing 'social and organizational climates', as it is called, becomes important (also Boxall 2012, 178). How professionals *experience* work becomes crucial (*ibid.*) and traditions, styles and customs are important dimensions of everyday work experiences.

As indicated, we focus on one particular project for showing how cultural resources can be used. The project is called 'Wonder and Improve' or WaI ('Verwonder & verbeter'). In one of the biggest academic medical centres in the Netherlands, internal medicine residents are invited to join quality improvement sessions, during which they list critical (organizational) experiences with patient treatment and care provision, prioritize and identify a few improvement projects and make change plans. Sessions end with a clear description of the most important improvements, responsibilities, action plans and support. After we have described our exploratory research set-up, we explore the project in the light of the aforementioned three questions: its features (what happens?), workings and effects (how does it happen?), and conditions that make it effective (why does it happen?).

EXPLORATORY RESEARCH SET-UP

The 'Wonder and Improve' (WaI) project runs since 2011, in the Department of Internal Medicine of one of the biggest academic medical centres in the Netherlands. The WaI project was studied as a case study by three different researchers. The empirical data are based upon document analysis, observations and interviews. The data were collected by two researchers who primarily studied WaI (Beerthuis 2013; Van de Camp 2013) and by one researcher who studied WaI from a comparative perspective. She also studied comparable projects in two other academic centres and a teaching hospital (Voogt 2014).

For the document analysis, relevant documents of the organization were collected and analysed. These documents include a project description of 'Wonder and Improve', work sheets used during the sessions, lists of critical items and specifications of each

improvement project and presentation of the project. Moreover, Dutch websites concerning specialty training were analysed.

The most important observations took place during the sessions. Several of these sessions were observed. In addition, the researchers were present during one work day of a resident and one of the researchers is a resident herself. Finally, observations were made during several conferences and expert meetings where the project was presented to professionals coming from other medical centres and hospitals. During one of the workshops, the audience was invited to participate in a simulated 'Wonder and Improve' session.

In total, 29 residents were interviewed, as well as 9 programme coordinators, in the various academic centres and hospitals, including two key persons related to the project in the UMC Utrecht (the head of the department and a staff member). Based upon the practical and theoretical perspectives developed above, the following items were explored during the semi- structured interviews: (1) description of the project, (2) type of change, (3) effects on work (conflict or complementarity?), (4) using cultural resources (work practices) and (5) conditions (context).

During interviews, these items were used as topics. They were operationalized by relying upon the theoretical framework described before and they were used to analyse the data. Most importantly, traditions/styles/customs were used as analytical categories to code empirical data. On the basis of the cultural framework elaborated earlier, we identified several indicators of these cultural dimensions and we used them to analyse professional (re)action. These dimensions and indicators are summarized in Table 1. In addition, we analysed the usage of cultural resources and its effects by focusing on the conditions within which cultural resources were used. In terms of the theoretical framework, this relates to our emphasis on work practices and the

Table 1: Cultural dimensions and indicators

Dimension	*Features*	*Indicators*
1. *Traditions*	Shared resources that constitute and legitimate action	Symbols
		Referrals to the past
		Stories
		Reliance on experience
2. *Styles*	Shared resources that enable and direct action	Interaction patterns
		Communication
		Movement
		Expressions
3. *Customs*	Shared resources that are and signify action	Encounters
		Usage of objects
		Clothing
		Everyday talk

bundling of work. We hypothesize that cultural resources are used appropriately – that is, they lower conflicts and increase complementarity – when multiple work practices are *bundled* and when organizational responsibilities are 'woven into' professional actions. We operationalized this by defining bundling as connecting (a) different work practices, including educational practices (cf. Boxall and Macky 2009) and (b) different work streams, of different organizational/professional participants. We focused on mechanisms for enhancing *complementarity*, which we see – negatively – as the absence of conflict, as well as the absence of passive resistance and manipulation, and more positively as the productive alignment of different work logics, especially professional and organizational logics.

EXPLORATORY FINDINGS

An important question concerning our illustration is, how does the usage of cultural resources enable organizational actors to generate change and complementarity instead of conflicts? A second question is, why does the usage of cultural resources generates the effects it generates? We tentatively focus on the usage of cultural resources as well as the mechanisms that enable the rise of complementarity. But first we discuss the features of the project, how it worked and which effects were generated.

Features of the project

Three-times-a-year sessions are organized for residents who are receiving specialty training within Internal Medicine. The residents are invited by the department head to participate voluntarily in the sessions. The sessions are characterized by an informal atmosphere and last for 1 hour. They mostly take place at the end of the day. Each session follows a specific format. First, an update and progress of the improvement projects from previous sessions are presented. Then, the list of projects which have not yet started is discussed. In small groups, the residents come up with new critical items, that is, issues that surprise or frustrate residents. These issues come from daily practice and have many practical organizational aspects. It is important that the improvement of these issues is within reach and circle of influence of the residents. Next, all critical items are prioritized by the residents. Three or four most important items are selected and one or two dedicated residents volunteer to be appointed to each item. Furthermore, a contact person is assigned (mostly being the head of the department). The session ends with a smart articulation of subsequent steps. In a few sentences, the outcomes of the various projects are described as well as which other professionals (nurses, secretary, 'chef de clinique') should be involved for each new improvement project. A

committed staff member is responsible for organizing the sessions. This person also monitors progress of the improvement projects between the sessions. A small budget is available if needed to implement an improvement. The head of the department takes the role of chairman during the sessions and stimulates staff and other workers to cooperate constructively.

Type of change

In the selected academic medical centre, four improvement sessions took place during the period studied, involving 20 of in total 45 residents. Fifteen improvement projects are completed; 17 projects are running. In all of the 4 centres and 1 hospital studied, 13 sessions were held, identifying 114 improvement points. Most of these points relate to organizational and technical factors, most specifically efficiency and safety (Voogt 2014). The WaI project generates visible results; we found various examples of perceived improvements that occurred as a result of the project. Without the project, the following changes would not have been realized:

1. New residents start with fewer patients during their consulting hours.
2. Policy developed and implemented for these specific patients.
3. Read back procedure has been implemented; this is actively requested by residents.
4. A two-day ATLS training is compulsory for all first year residents.
5. Attending supervisor is required to be present at transfer of patients during duty.
6. Uniform dress code conform norms implemented.
7. Redesign of clinical rounds.

Effects on work(ers)

These tangible effects are accompanied by much less tangible effects – experiences, opinions, feelings – of WaI participants. First and foremost, there is much enthusiasm. When respondents were asked to state whether they liked the project or not, they were positive, sometimes very positive (Beerthuis 2013, 93), One even said, 'I like it a lot. Really cool.'

This indicates that conflicts (and resistance or manipulation) were largely absent. In addition, there is 'productive alignment' as we described it when we defined complementarity. Many participants see the value of a project like WaI and they feel 'empowered' by it. They feel as if they become part of change processes, instead of

subjected to changes initiated elsewhere. The young medical professionals studied do not feel threatened or alienated by the project.

One of the respondents of Beerthuis (2013, 79) argued: 'Skills in micro-management and leadership concerning your patients can be very handy, in order not to get the idea "this is organized terribly because it is organized terribly", so that people realize they have leeway and possibilities to organize things better themselves'.

Such empowerment occurs during WaI sessions, but also after these sessions and their consequences. Residents feel they are better equipped to do their work and to undergo further medical training as they gain more insight in organizational issues. They acknowledge the fact that such insight is lacking in their formal training. Again, one of Beerthuis' (2013, 79) respondents said: 'We are mainly busy with being trained. We are turned into better doctors, most specifically in terms of content – medical content. Everybody wonders about things I guess'.

But really dealing with things is often lacking, first because we have little time and secondly because we do not know how to deal with it. This is accompanied by more emphasis on working with others, including (senior) doctors and nurses, which – they feel – does not come naturally (*ibid.*: 82). 'Where are the obstacles, how far can I get as resident and where are my limits? And how do I overcome them? And when I overcome them, who do I need for that?'

All in all, tackling organizational issues seems to become a more natural part of medical repertoires. This might work in two ways. Some residents discover that they have affinity with leading and managing health-care services and they are likely to develop skills; they like 'to improve the work process', as one respondent stated (*ibid.*: 94). Others experience the opposite; they would like to stay away from leadership and management, but they acknowledge the fact that leading and managing medical services is relevant and demanding. They get much more insight in the complexity of running a big hospital. They acknowledge the fact that (*ibid.*: 96): '[It is] nice to see what your colleagues run into. And also to see that other colleagues mention things of which you think, yes, indeed, I was surprised about that, but I didn't do anything with it'. Generally, residents think, one of them argued (*ibid.*): 'the layer above us will tackle it'. This changes when residents participate in the project.

Using cultural resources

The various types of cultural resources identified above – *traditions, styles, customs* – might be 'used' in the project, in such a way that professional resistance to change is reduced instead of increased. In and around the project, we hardly witnessed conflicts or (passive) resistance – we traced much complementarity. Educational and work practices of medical professionals were aligned; work flows of multiple organizational

participants were aligned as well. We can explain this by focusing on the cultural resources that make up professional action and the ways in which these resources are managed.

First and foremost, the WaI project relies upon professional *traditions* in order to shape change and connect organizational and professional logics. The project does not primarily emphasize organizational and managerial ambitions. It emphasizes medical work, including well-known elements such as togetherness and teamwork within the medical domain. This is done both symbolically, in terms of stressing groups and teamwork, as well as narratively, in terms of stressing medical discourse, aimed at dealing with patients. As one of the young residents argued (Voogt 2014): 'I would attend a session just to help out my colleagues and to see what kind of problems they face during the day. We probably encounter the same issues, but when you don't talk about it you'll think it only happens to you. . .'

Instead of bringing management into medical teamwork, it uses medical groups and group dynamics to start managing. One of the respondents of Beerthuis (2013, 84), responsible for running WaI, argues: 'Medical doctors often say, "I am losing my autonomy. Everything is taken out of our hands." I say: individual autonomy is not disappearing; it is replaced by something else, namely collective autonomy.' In addition, the project is and remains case-oriented, that is, patient-oriented, and seeks new standards for dealing with organizational aspects of patient treatment. It also concerns medical professionals themselves. Tackling these organizational aspects might alleviate their work – collectively they regain (some) control. According to one of the respondents (*ibid.*: 84), 'many things on health care are decided whilst no one ever visits a hospital'. The fact that medical doctors start making some of these decisions legitimates the project and secures confidence. At the same time, the project uses the traditional emphasis on hierarchy; the project is led and chaired by a senior doctor who is highest in rank and also formally responsible for the training of residents in the division we studied. This means participating in the project is not innocent. It might have career implications as the head of divisions is able to judge residents and decide about further career steps.

Secondly, the WaI project mirrors professionals' *styles*. Instead of emphasizing management styles, including management speak, it activates medical work styles, including interactions, communication and expressions (in terms of Table 1). In fact, medical work and dealing with work conditions is central when WaI meetings are studied. Paradoxically, the emphasis on 'this is how work around here' is used to reflect upon 'how we work around here'. One of the residents argued (Beerthuis 2013, 87): 'We as doctors have very strong routines that are difficult to break through'.

The WaI focuses on such routines by sticking to routines. The project meetings, for example, are to the point. When sessions are held, time is used very efficiently and sessions are meetings but meetings in medical style. Medical doctors are very busy and many of their encounters are brief and efficient, and the WaI project has the same atmosphere. Although it takes some time, the

meetings are organized at the end of the day, in-between busy activities. The meetings are decisional, that is, they focus on solving problems instead of, for example, speaking about how to solve problems. This fits the clinical gaze (e.g. Witman et al. 2011) of medical professionals. Identifying (organizational) problems is really about identifying problems and solving them. Participants feel comfortable instead of uncomfortable.

Finally, the WaI project relies upon the artefacts and *customs* used in and around professional action. To start with, the project uses the right terminology, participants argue. 'Yes', one of the respondents states (Beerthuis 2013, 99), 'be amazed is the right, nice term'. Interestingly, it is not only management speak that is avoided, also terms like 'competencies' are hardly used to describe what is going on. And when participants try to reflect upon what WaI means for them, they mainly emphasize practical skills (Beerthuis 2013, 101): 'We learn a bit of management, because what is nice about it, we learn to deal with specific problems, like arranging beds at the emergency unit. We also learn how to deal with people responsible for the emergency unit; how do you communicate with them? As we deal with people from coordination. In this way we develop ourselves in terms of management'.

Furthermore, the meetings are not only efficient in terms of meeting style, they are supported by facts and figures, schemes and tables. One of the attendants keeps systematic lists with all of the improvement projects identified in order to trace progress over time. These lists are used to structure the meetings. During the meetings, other objects are important as well, including food and drink, which also strengthens the aforementioned sense of togetherness. The meetings themselves are led well. The senior doctor who also heads the divisions makes sure that results are realized. One of the participants states (Beerthuis 2013, 106): 'A good chair does not steer in terms of content but in terms of time, in the sense of, indicating how we approach things, we have three times twenty minutes, this is the set-up'. As a chair, the senior doctor sets the example, participants state. In fact, some indicate the chairing itself sets the example on how medical work can be organized effectively. Although the things participants speak about (organizational and technical issues) differ from the rest of their work which is more directly related to patient care, they have the feeling they act normally.

Conditions

The usage of cultural resources in change processes which – at first sight – go against professional preferences is important but does not secure effects. Favouring conditions are important to embed the projects within the workings of a professional domain, something which became particularly visible when the selected WaI project was compared with comparable projects elsewhere (esp. Voogt 2014). The following

conditions appear to be important for enhancing complementarity. Whether this is really the case, also elsewhere, requires further research. We return to this point in the 'Discussion'.

Leadership by example

Peers appear to be very important to implement change, that is, new competencies and skills. Participation to the project seems innocent, but participants get the feeling that they are in it together and that they can jointly tackle issues. This is symbolized by leadership from one of the more senior peers. As one of the respondents argued, 'The simple fact that there is attention from supervisors for my problems, gives me the courage to keep going, and keep improving. . .'Instead of being pessimistic about 'the organization', residents can develop the ability to get to know the organization and take a share in improving it. Instead of an individual endeavour, becoming and being a medical doctor becomes a joint endeavour. This is enacted in such a way that it reinforces instead of alienates professional cultural reflexes.

Practical emphasis

The project is linked to everyday work in terms of project efficiency and emphasis. Meetings are not only efficient and the project does not only emphasize everyday practice – the project is organized as if it is normal work. Instead of organizing the project *outside* regular work flows, it is organized *as* a regular work flow; it is directly related to elements of normal work flows. As one respondent argued (Beerthuis 2013, 85), this affects reactions: 'We are invited for many things and some of these things are obligatory, but one often thinks, this is a waste of time as I have so many other things to do and one tries to escape it'. Others complained about the fact that residents are 'tired of meetings' and stressed the heavy schedule of residents, with 60–70 hours per week spent on operational clinical activity. Although residents sometimes had to skip WaI meetings due to work obligations, they saw WaI meetings not as regular meetings. They also like the terminology with which it was surrounded: 'yes, "wondering" is the appropriate, nice term' (Beerthuis 2013, 99).

Organizational weight

The project is not only well-organized, that is, prepared and monitored, the follow-up is secured by good support staff and there is a clear emphasis on deliverables and delivery. The organization invests in the project as a vehicle of change and underscores the importance of its processes and effects. 'One of the staff members is present and she does a lot. Also in order to prepare the next meeting – she lets you know, what were your action points and she asks you to prepare feedback information. I think this goes

all right' (Beerthuis 2013, 109). Respondents agree (*ibid.*) they need 'someone to stimulate things', also because they are all busy.

In sum, because (a) the WaI project is organized from within a professional field, at least, it is felt like it is coming 'from within', because (b) it is not organized outside everyday work but *as* everyday work and because (c) it is organized well, a professional logic is linked to an organizational logic in a rather natural way. Instead of much reported responses on the side of professionals (especially conflict, but also passive resistance or avoidance), medical professionals accept organizational challenges and seek ways to tackle them. They might even value the organizational skills they develop, or value the fact that others use such organizational skills.

DISCUSSION

The research question we posed was: *How can cultural interventions in professional practices affect the strengthening of frontline leadership in professional (medical) services?* The project we described, as exploratory case study, shows that it is possible to link and interweave organizational and medical-professional logics in frontline domains, which are generally seen as separate and conflictual. The project showed that medical doctors might be involved in managing and leading health-care delivery, and might be turned into frontline leaders. Becoming a frontline leader implies that (young) medical doctors develop a sense of organizing as well as organizational skills. They frame practical medical issues and problems as organizational problems that must not be ignored or reasoned away ('people above or around me will take care of it'), but coped with. This works in two ways. Some residents might discover that they are able to lead and manage health-care delivery. Other doctors might discover they have little affinity with leadership and management, but they might acknowledge the importance and difficulties of leading and managing service delivery.

The strengthening of frontline leadership happens when certain interventions take place and when certain conditions are met. In terms of *interventions*, residents must develop the ability to *interpret* medical professional action, including organizational aspects, and to *intervene* in professional/organizational processes. Instead of waiting or hoping for solutions, coming from others (such as managers), residents must become aware that they themselves are part of the solution. They must feel empowered to deal with organizational challenges. This is done by consciously relying upon *and* adapting cultural dynamics at the same time. The cultural interventions we studied, that is, the usage of professional traditions, styles and customs, were aimed at strengthening medical professional action and organizational action at the same time. Instead of decoupling these logics, several cultural resources are used to rework work practices, so that educational and work practices are bundled and professional and organizational work flows are *bundled* as well. In other words, coping with

organizational aspects is taught by relating it to regular work processes, and by using 'normal' ways of working: efficient meetings, diagnosis, joint decision-making and allocating responsibilities.

In terms of a 'managing competing logics' perspective (e.g. Reay and Hinings 2009), this goes further than the combination, hybridization or 'selective coupling' of sets of principles. When work flows change, due to the bundling of practices, medical professionals develop professional abilities to cope with complicated work circumstances in which professional and organizational challenges occur at the same time. On the one hand, this has implications for reflections upon institutional logics, which tend to ignore everyday work practices, or dive too strongly into the manufacturing of (hybrid) professional identities. On the other hand, this relates to alternative research perspectives on coping, especially 'proactive' or 'positive coping' (e.g. Greenglass and Fiksenbaum 2009). They stress that coping is not only a matter of protecting oneself against burdens and obstacles, such as organizational 'intrusions', but also of learning to do things in different ways and/or doing things in different ways. A more proactive bundling of professional and organizational challenges *inside* work processes gives (younger) doctors the opportunity to get to know the hospital organization better – which, in the case of the medical centre studied, is a huge organization – and to strengthen some sense of ownership, and it enables (young) doctors to do things differently without radically changing professional identities. When they feel they co-own service delivery and its (organizational) improvement, they will be inclined not to resist changes but to show commitment to various kinds of changes that are introduced in order to create better care.

As far as *conditions* are concerned, the project suggests that it must be organized well, that senior doctors must be willing to act as change agents and that peer pressure is important. The project was led by a senior medical doctor, and although participation was not mandatory, the sense of peer group involvement proves to be important for strengthening commitment dynamics. In addition, participants did not get the feeling that the change project demands too much of them. On the contrary, the project succeeded in linking change to regular work flows. The efficiency with which improvement sessions are organized and the direct links to everyday practice gave the feeling that leading and organizing health-care delivery occurs inside instead of outside 'normal work'. Developing frontline organizational leadership happens because it enables doctors to deal with practical medical experiences. All of this needs to be studied more systematically. The current empirical focus is limited, both in terms of research period and breadth of project(s) studied. Our exploratory result generates multiple research questions for further research, which will widen the empirical reach, generate more comparative research and provide more data:

- Which effects can be traced when cultural interventions strengthen professional/organizational alignment: do professionals become more aware? Are they more empowered? Do they perform better? Are services improved?
- Are effects improved when additional or other cultural interventions invoked? Which additional interventions are effective outside explicit projects?
- How do interventions and effects differ in different medical contexts? What happens when medical professionals work across contexts?
- Which conditions explain the improvement (or lack) or results? To what extent are peer pressures, practical methods and organizational qualities important?

In addition to generating new data, this would also imply the strengthening of cross-disciplinary outlooks. As indicated, the combination of institutional, cultural and psychological insights is important to interrelate professional and performance in organized contexts.

CONCLUSION

By relying upon cultural dimensions of medical professional domains, as *resources* instead of *restrictions*, a project like WaI could be developed and embedded and could result in organizational effects as well as renewed professional socialization. By using residents' work and patient focus, by making it decisional and by holding efficient meetings, residents have the feeling they are jointly responsible not only for delivering services to patients but for organizing health-care provision. This type of operational or frontline leadership will be increasingly important and medical faculty and organizations will have to find ways to realize its potential.

As argued, whether and how this works in other medical contexts, whether and how it leads to improved medical effects and outcomes, should be part of subsequent research studies. In health-care contexts, other groups of medical professionals will have to be studied, which vary in terms of age and career phase, as well as discipline. In this paper, we focused on young residents, working within the field of internal medicine; other studies will have to focus on older doctors, in other fields. This is not only a matter of mapping variety; we might hypothesize that institutional features count, that is, that the manifestation and manipulation of cultural resources will differ. When medical doctors are older, they are less likely to be shaped by educational practices and it will be more difficult to connect their work streams to other work streams. When medical doctors work across fields, cultural dynamics will differ, for example, as far as status and stratification are concerned, and it might be more difficult to align professional/organizational action.

Outside health care, additional research will be valuable as well. In other public and non-profit domains, professional action is reshaped as well and educational and work

practices are shifting. How and whether the principles we traced in the WaI project can be used elsewhere remains to be seen. The ways in which professional logics are interwoven differs, as the organizational circumstances differ; educational routes differ; cultural resources differ. We can hypothesize commonalities between strong medical professionalism and, for example, judicial professionalism (think of judges) and differences between these strong forms of professionalism and weaker forms of, for example, educational and welfare professionalism. At the same time, we can expect differences between medical and judicial professionals, as external forces and pressures differ. The strong emphasis of medical domains on cost control as well as medical errors will differ from circumstances in legal fields.

Despite these varieties, the WaI project might primarily show the importance of developing organizational leadership and leadership skills, but also that this is not a mere matter of developing leadership as a separate discourse and isolated grand project. Instead of focusing on the cult and ideology of *leaderism* (cf. O'Reilly and Reed 2012), leadership can be interwoven into the daily fabric of service delivery, including patient care and rendering health services. Medical doctors learn how to lead and manage health-care delivery in a very practical way. The interweaving of organizational and professional logics happens in a rather invisible and innocent way when it is led by one of their peers, fits work flows and is organized well. Professional cultures are activated instead of alienated.

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