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On being a doctor in an acute NHS hospital trust: a classic grounded theory

Mogamat Reederwan Craayenstein

A research report submitted to the Faculty of Commerce, Law and Management, University of the Witwatersrand, in fulfilment of the requirements for the degree of Doctor of Philosophy

Johannesburg, November 2015

ABSTRACT

The aim of this study was to give an account of what it means to be a hospital consultant in a national health service that has been undergoing change for almost three decades. Classic grounded theory was used to identify the main concern of hospital consultants sampled for the study and how they resolved this concern on a routine basis. Data were obtained from three sources: interviews, observation and document analyses. Classic grounded theory procedures of constant comparison and theoretical sampling were used and *Rolling with the Punches* emerged as the pattern of behaviour through which the hospital consultants dealt with their main concern, which was managerialism. *Rolling with the Punches* involves four modes: *Stabilising Temporarily*, *Resisting*, *Limiting the Impact* and *Adjusting to*/*Living with*. The mode of behaviour was contingent on a central and on-going *Weighing-up* process, in which the hospital consultants used their personal narratives, beliefs and commitment structures to make sense of what was happening and what they could possibly do about it. Hence, the mode of behaviour was contingent, historicised and in flux. The *Weighing-up* process can set off triggers that can lead to a change of mode that need not be linear.

Key words: doctors, managers, grounded theory, weighing up, stabilising temporarily, resisting, subverting, quibbling, limiting the impact, lying low, faking it, living with, adjusting to, going with the flow, complying, waiting it out.

DECLARATION

I, Mogamat Reederwan Craayenstein, declare that this research report is my own work except as indicated in the references and acknowledgements. It is submitted in fulfilment of the requirements for the degree of Doctor of Philosophy at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in this or any other university.

(Type your name in full here, and sign in the space above)

Signed at ……Clapham, Bedfordshire, UK……

On the …….. day of …… 2015

DEDICATION

This thesis is dedicated to my wife, Awaatief, and our children Bint al-Huda and Mohammed Al-Sajjad

ACKNOWLEDGEMENTS

I am indebted to many people who have brought me to the point where I could complete this PhD and herewith thank them.

Firstly, I express my gratitude to the hospital consultants who gave up their time to be interviewed, observed and made themselves vulnerable by talking about some of their innermost concerns.

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To every activist whose academic journey and career have been derailed by involvement in struggles for justice, this PhD is a candle that I light for you. To the people in the movement it has indeed been marvellous.

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LIST OF ABBREVIATIONS & ACRONYMS

A & E	Accident and Emergency (Department)
BSP	basic social process
CCG	Clinical Commissioning Group
CD	clinical director
CEO	chief executive officer
CHI	Commission for Health Improvement
DCC	direct clinical care
EWTD	European Working Time Directive
GP	general practitioner
GT	grounded theory
GTM	grounded theory methodology
ICU	intensive care unit
IT	information technology
MD	managing director
MDT	multi-disciplinary team
NGO	non-governmental organisation
NHS	National Health Service
NICE	National Institute of Clinical Excellence
NPM	New Public Management
OECD	Organisation for Economic Cooperation and Development
PFI	Private Finance Initiative
QDA	qualitative data analysis
RCP	Royal College of Physicians
SPA	supporting professional activity
UK	United Kingdom

CHAPTER 1 SETTING THE SCENE

1.1 CAVEAT TO THE WRITING OF THE THESIS

This study was undertaken according the tenets of classic grounded theory (GT). This means that the identification of the main concern, and its routine resolution by the participants of the study was the key organising principle of the study. In terms of how research is traditionally conducted, Chapter 3 (methodology and methods), Chapter 4 (the GT) and Chapter 5 (literature review) and Chapter 6 (integration into the GT) should perhaps be written up first, with the other chapters following thereafter. However, to conform to institutional presentational requirements, a more traditional presentational strategy has been followed, despite the fact that the research did not start with the identification of a gap in the literature, the formulation of a research question and hypotheses to be tested. It started with conversations with participants, observations and the examination of relevant documents pertaining to the research site. This caveat was introduced to avoid impressions of methodological slurring (Suddaby, 2006), remodelling of GT (Glaser & Holton, 2007), forcing and preconception (Glaser, 2012a).

1.2 INTRODUCTION AND NEED FOR THIS STUDY

The initial impetus for this study arose from multiple encounters with hospital consultants in a big English acute National Health Service (NHS) hospital trust. It is just so sad that the principal creative, intellectual and social capital of the hospital (Walshe & Smith, 2011) is fed up and is exhausted by a sense of siege. Hospital consultants can cope with the life and death issues that are routinely part of their work. However, they tend to struggle with managers, targets, and inspections, serious incidents declared by managers or the consequences of the need to balance the books.

Some of the complaints that arose in these multiple encounters were that contracts to be prepared for tender or an existing contract had been lost to a competitor, confidential data had been sent to the wrong person, the water from the borehole tasted like s#!t, for various reasons surgery had been performed on a wrong site, a swab had been left inside a patient, the wrong gas had been administered to a patient, key national performance targets had been missed, the Care Quality Commission had just issued an adverse report about the quality of healthcare being delivered, the hospital had been placed under special measures because the cost improvement programme had been unsuccessful, the auditors of the annual accounts had issued a qualified report, and the Clinical Commissioning Groups (CCGs) had been reorganised and documents had to be prepared again and new relationships built. In this hospital the mandatory Accident and Emergency (A & E) Department targets are almost always missed. The managers wanted to push the patient – who could breach the waiting-time target – under the nose of a clinician so that the target could be met while the clinician wanted to deal with another patient who was about to go into cardiac arrest. There were not enough beds so managers shouted at clinicians

to authorise a discharge so that the patients could be "evicted" from wards to make beds available. The managerial hospital is one where clinical priorities and managerial prerogatives are constantly in a tussle. The hospital, where the research was conducted, has a reputation as a tough place. Some nursing staffs were not willing to take fulltime posts. They came to work as agency or locum staff, which enabled them to pack up and go home at the end of their shift. As a result, doctors ended up having to start with little, incomplete and often no information every time they saw a patient in the wards.

This was when I decided on the research area. I knew that I had to talk to the doctors to find out what was happening and how they were coping. I felt that if it was possible to get access to them, then I could listen to the consultants, perhaps observe what was happening, and consult available online Trust documents. Policy documents on the NHS were also available. However, I realised that I would have to start with frontline staff to see how the tensions played out at the coalface of the NHS.

While the media does appear to treat bashing the NHS as a national sport, throughout my 18 months of fieldwork I met mainly dedicated hospital doctors. When it comes to their patients and their colleagues most of them are wonderful. However, many hospital doctors have difficulty tolerating managers and management. A total of 49 interviews were conducted and observations were made during almost 100 visits to the hospital. Access was made easier because my partner was a consultant at the same hospital at the time that the research was being conducted. About 50 Trust and NHS documents were retrieved.

This study was conceived as a classic GT study; i.e. I intended to find out what the main concern of the hospital consultants was and how they went about resolving this concern on a routine basis. The research proposal indicated that the managerial transformation of the professional bureaucracy with a focus on market-based competition, management-based control systems and metrics-based performance management was a big concern to hospital consultants, with their professional commitments to clinical autonomy, collegiality and peer review. It was necessary to go to the coalface (Barley, 2008), to the inhabitants of the institutions (Hallett & Ventresca, 2006; Scully & Segal, 2002) to hear from them what was going on (Glaser, 2001a) in an area of life that is important socially, economically, politically and morally. The close look at what was happening at the peripheries of the healthcare delivery system enabled me to grapple with some of the big scholarly debates that are outlined in the chapters that follow. However, the foray into the scholarly debates was delimited by the GT that is covered in Chapter 4.

Chapter 1 identifies the motivation for studying the managerial transformation of the English acute NHS hospital and how hospital consultants deal with it on a daily, routine, non-dramatic basis. The background and context of the managerial transformation of the NHS and its institutions are provided. The chapter concludes with an outline of the chapters that follow.

1.3 THE IMPORTANCE OF STUDYING HEALTHCARE

The NHS is a huge player on the United Kingdom (UK) political, economic and moral landscape. It had a 2013/14 budget of over £113bn, which represented about 9% of the UK GDP, and employs over 1.3 million staff. It sees 1 million patients every 36 hours (NHS Confederation, 2015).

In a local economy, a hospital can be a big employer. The hospital that was studied employs almost 5 000 staff (Trust 2013/14 annual report). For the sake of anonymity and confidentiality references o the name of the hospital and its official documents are not provided in the reference list. They can however be made available, upon request, to substantiate any of the claims made in this report. The study of healthcare organisations has been relatively neglected despite their size and importance and the rich intersection of the fields of organisation studies, medical sociology and health policy (Currie, Dingwall, Kitchener, & Waring, 2012a; Davies, 2003). This study shows that the hospital – as an organisation – has undergone significant changes from the 1960s when it was a major area of study (Davies, 2003). A need exists to understand organisations as major social actors in our time (Currie et al., 2012a; Davies, 2003).

1.4 MANAGERIALISM

One of the dominant features of the acute hospital over the past three decades has been its managerial transformation. That involved the introduction of market-based competition, management-based control systems, and metrics-based performance-management systems. Clinical practice has been bureaucratised and standardised (McDonald & Harrison, 2004; Spyridonidis & Calnan, 2011). The question is: what is the sociological impact when these technologies of control are imposed on a professional bureaucracy (Farrell & Morris, 2003; Timmermans & Oh, 2010)? How does the imposition of managerial control over the creative, intellectual and social capital of the hospital (Walshe & Smith, 2011) affect the functioning of clinicians? This study examined what happens when managerialism and medical professionalism "embrace". Is it a generative dance (Currie et al., 2012a) or is it a *danse macabre* (Degeling, Maxwell, Kennedy, & Coyle, 2003)? That is, how do hospital consultants see the process and how do they cope?

1.5 THE NATIONAL HEALTH SERVICE IN ENGLAND

This study was conducted in an English acute NHS hospital trust. Wales and Scotland have devolved authority over the NHS and differ in some important aspects. The NHS is a very complex organisation that offers different healthcare services to different groups of people. Data were obtained from an official source (NHS Confederation, 2015):

- Two hundred and eleven CCGs are responsible for ensuring that national health priorities are translated into local health economy plans. They controlled more than 80% of the NHS 2013/14 budget of £113bn.

- Primary care is provided through walk-in centres in the community, 8 000 general practitioners (GPs) and 853 private and non-governmental organisation (NGO) providers that operate from 7 331 different sites.
- Ten ambulances trusts handle responses to emergency calls and calls for routine transport of patients to and from hospital for emergency or day treatments.
- One hundred and fifty-six acute hospital trusts, including 100 foundation trusts, provide acute and A & E care. The policy of successive governments has been for all NHS hospital trusts to become more independent from central government operational controls as NHS foundation trusts.
- Government policy increasingly blurs the distinction among the publicly owned and operated healthcare sector, the private healthcare sector and the NGO healthcare sector.
- As mentioned above, the 2013/14 budget of the NHS is £113bn in nominal terms. The NHS employed 1.3 million staff, of which more than 80% were frontline staff. These included 150 273 doctors, 377 191 qualified nurses, 155 960 scientists, therapists and technicians and 37 078 managers. This study focuses on the 40 394 hospital consultants in acute hospitals, who in 2011/12 were employed at a cost of £5.6bn (Committee of Public Accounts, 2013; The Comptcontroller and Auditor General, 2013) .
- In the year 2013/14 the NHS saw one million patients every 36 hours; 11.030 million operations were performed; 21.779 million A & E visits; 15.462 million hospital admissions and 80.060 million outpatient appointments took place.

This study focuses on the 40 394 hospital consultants in acute hospitals employed at a cost of £5.6bn (The Comptcontroller and Auditor General, 2013). The NHS is clearly a huge and complex organisation that does require management (The Commission, 2011). Managerialism goes to the heart of medical professionalism. It has implications for the framing of clinical autonomy, control over work, collegiality and duty to the patient (Blomgren & Waks, 2015; Brock, Leblebici, & Muzio, 2014).

1.6 MANAGERIALISM IN THE NATIONAL HEALTH SERVICE

The NHS has been the subject of concerns about effectiveness, efficiency and quality from its birth in 1948 (Klein, 2013; Pollock, 2005). Tension always existed between the political and moral aspirations that underpinned the establishment of the NHS and the affordability of the project. Hospital Activity Analysis, the Resource Management Initiative, the Griffiths general managers and the development of performance indicators (Gray, Jenkins, Flynn, & Rutherford, 1991; Klein, 2013) pre-dated the New Public Management (NPM) wave of the 1980s (Clarke & Newman, 2006; Dunleavy & Hood, 1994; Ferlie, Ashburner, Fitzgerald, & Pettigrew, 1996b). The development of information technology (IT), the rising expectations of the public with respect to public services and the early 1980s fiscal crisis coincided to change the relationship between the state, the professions and the public services sectors. Managers were appointed on contracts that made them responsible for outcomes. Short-term pressures collided with the compassion, patience, and diligence and care associated with dealing with people who are often at the doors

of loss and death. The balance of power had shifted in favour of the managers. Clinicians however, still exercised their reconstituted clinical prerogative on the clinical frontline. Managers controlled costs by outsourcing non-core services such as housekeeping, cleaning, and catering; cutting staff; and closing beds, wards and theatres. Doctors had opposed the appointment of original general managers in the NHS in the 1980s (Griffiths, 1983, 1992; Klein, 2013). The 1990 NHS and Community Care Act further empowered managers by creating a quasi-market and by giving managers greater operational oversight over hospital consultants. The latter were to be directly employed by the hospitals on employment contracts and managers had greater involvement in the drafting of the job descriptions, employment contracts and clinical excellence awards of the consultants. Developments in IT facilitated greater management scrutiny of consultant work content, workloads and productivity (Flynn, 2007).

By the 1990s, hospital consultants had taken on clinical-managerial roles as clinical leads, clinical directors and medical directors. Thus, the mood had shifted from hostility towards general managers (Griffiths, 1983, 1992) to ambivalence about clinical-managerial roles (Klein, 2013). Soft bureaucracy (Courpasson, 2000) had replaced the hard edge of general management. The boundaries between management and medical professionalism were blurring. Traditional professionalism was being replaced by professionalism within organisations (Evetts, 2003; Muzio & Kirkpatrick, 2011; Noordegraaf, 2007a). Clinical audits, clinical governance (Scally & Donaldson, 1998) and the introduction of evidence-based practice (Grol & Grimshaw, 2003; Timmermans & Berg, 2003) indicate a shift in clinical autonomy away from the rank-and-file medical professional whilst an administrative and knowledge elite collaborated with policy elites in framing the national service frameworks, clinical guidelines, protocols and pathways that were key outputs of the National Institute of Clinical Excellence (NICE). The public sector Weberian iron cage was being transformed into a Foucauldian glass house (Gabriel, 2008). The delivery of healthcare had become a performance (Exworthy, 2010a).

The managerial hospital empowers managers to cut costs, respond to rising expectations of the public for high quality health services and control the clinical frontline (Bevan & Hood, 2006; Propper, Sutton, Whitnall, & Windmeijer, 2008).

1.7 WHAT THE STUDY CONTRIBUTES

How do hospital consultants respond? The embrace of managerialism and medical professionalism has been described as a *danse macabre* (Degeling et al., 2003). Relations between doctors and managers have been poor to say the least (Davies, Hodges, & Rundall, 2003; Edwards, Marshall, McLellan, & Abbasi, 2003). Sociologically, managerialism is conceptualised to have led to de-professionalisation (McKinlay & Arches, 1985; McKinlay & Marceau, 2002; McKinlay & Stoeckle, 1988), proletarianisation (Haug, 1973, 1988) or restratification (Freidson, 1985). These are big, abstract pictures. I believed that one needed to go to the coalface (Barley, 2008), meet the inhabitants of the institutions (Hallett & Ventresca, 2006; Hughes, 1971; Scully & Segal, 2002) and the carriers of the contradictions, congruencies

and tensions (Delmestri, 2006; DiMaggio, 1988; Jepperson, 1991; Zilber, 2002). It was important to hear from them their concerns (Glaser, 2001a) as they routinely, without drama (March, 1981) or struggle (Smets & Jarzabkowski, 2013a), resolve for themselves the meanings of being a doctor in the managerial hospital. So this study addresses some of the relatively neglected enigmas that are swirling at the micro-foundations of institutional theory, which has become a major lens for studying organisations (Blomgren & Waks, 2015; Zilber, 2013).

Given the focus on identifying a main concern and its resolution, the research explores how individuals – who stand at the crossroads of multiple contradictory logics and demands – frame the intentions and efforts that inform their observed behaviours (Lok, 2010; McPherson & Sauder, 2013; Smets & Jarzabkowski, 2013a). This requires a nuanced account of agency (Battilana & D'Aunno, 2009a; Emirbayer & Mische, 1998; Hwang & Colyvas, 2011; Powell & Colyvas, 2013; Smets & Jarzabkowski, 2013a). Thus, the study contributes understandings of the contingency, fluidity and serendipity of the institutional projects that actors pursue. These fluidities stand in contrast to the fully formulated, strategically pursued institutional visions that are implied by "purposive" actions aimed at creating, disrupting and maintaining institutions (Lawrence & Suddaby, 2006; Smets & Jarzabkowski, 2013a). The study offers an understanding of a complex process by which embedded actors formulate workable balances of the constellations of logics (Goodrick & Reay, 2011; Greenwood, Raynard, Kodeih, Micelotta, & Lounsbury, 2011) that are at play in the hybrid managerial hospital (Battilana & Dorado, 2010; Pache & Santos, 2010).

The study also shows that the implied managerial-professional incompatibility of a *danse macabre* (Degeling et al., 2003) requires a keener examination. The focus has to shift to accounts of how individuals routinely balance, interrogate, negotiate and reconcile competing demands, in the course of meeting the demands of their everyday work. Their actual work instantiates the non-dramatic accomplishment of living with the paradoxes of the managerial hospital. In getting on with their work (Smets & Jarzabkowski, 2013a), they consciously have to navigate the wickedness (Raisio, 2009; Vartiainen, 2005) of the social organisation of healthcare. This is done routinely and non-dramatically (Prasad & Prasad, 1998; Scott, 1985, 1990). That means identifying and using the spaces and constraints of the negotiated order (Strauss, Schatzman, Ehrlich, Bucher, & Sabshin, 1963) of the hospital as a complex adaptive system (Checkland, 1999; McKelvey, 1999; Nelson et al., 2002). In so doing, they are reconciling the constellations of logics (Goodrick & Reay, 2011) and institutional complexity (Greenwood et al., 2011). The apparent contradictions between managerialism and professionalism are being reframed on the clinical frontline. This study shines a light on that frontline. Being a doctor in the managerial hospital requires constant self-surveillance and constitutes an on-going effortful accomplishment (Emirbayer & Mische, 1998; Smets & Jarzabkowski, 2013a). Managerialism and medical professionalism in the acute hospital do not function in splendid isolation from one another. *Rolling with the Punches* is an integrated set of hypotheses about medical professionalism within a managerial context. It is not whether but how and to what extent managerialism and medical professionalism are mutually implicated.

1.8 SUMMARY

In Chapter 1 of this thesis, *Setting the Scene*, an introduction to the study was provided and an indication of continued relevance of applying a sociological lens to organisational phenomena given. This study generates a classic grounded theory. Managerialism had emerged (Chapter 4), as the major concern of the participants and *Rolling with the Punches* is a pattern of behaviours through which they routinely addressed their main concern. An overview of the NHS was provided so that an understanding of the managerial evolution could be gained. The focus on efficiency, effectiveness and transparent quality are not necessarily as trouble-free as some would claim.

1.9 OVERVIEW OF CHAPTER CONTENT

A summary of the content of each of the chapters that follow provides an outline of the structure of the rest of the thesis.

Chapter 2

Chapter 2 provides some background to the day-to-day world in which hospital consultants deliver clinical services to patients. This study focuses on the micro-foundations of the NHS delivery system. The research is a GT of the main concern of, and its routine resolution by, hospital consultants in an increasingly actively managed hospital. The absence of the downing of stethoscopes and white coats or clanging of bedpans on a picket line does not mean that there are no deep problems. However, to get a sense of what is happening, one needs to look at how the managerial hospital is enacted on the frontline (Barley, 2008; Smets & Jarzabkowski, 2013a).

This chapter gives an account of what the acute NHS hospital is like. This section of the thesis shows how the main concern of the participants is constituted. What are the contradictions that the hospital consultants are balancing as situated improvisations (Smets, Morris, & Greenwood, 2012)? How does the managerial context temper their radicalism (Meyerson & Scully, 1995)? In understanding the background, one might get a picture of the feedback loop from observed behaviours as instantiations of their agency which reflect their intentionality (Emirbayer & Mische, 1998). That agency feeds back as a loop that codetermines the make-up of the managerial hospital as a structure (Berger & Luckmann, 1967; Blumer, 1971; Giddens, 1984; Hughes, 1971).

Chapter 3

Chapter 3, *Methodology and Methods*, discusses the rationale for choosing GT as a methodological approach and how the data were obtained through semi-structured interviews, observational field notes and document analysis. It also gives a detailed account of the grounded theory methodology (GTM) and a short description of the acute NHS hospital where the study

was conducted, with the ethical considerations. Text boxes provide accounts of how the methods were applied in the study.

Chapter 4

Chapter 4 presents the GT, *Rolling with the Punches*. Managerialism emerged as the main concern for hospital consultants. A market-based competitive hospital, with control systems led by managers, a metrics-based performance-management system, scientific bureaucratisation and standardisation of their clinical practices meant that hospital consultants were losing control over their relationships with their patients and the content of their work. Participants dealt with managerialism through different modes of behaviour. *Stabilising Temporarily, Resisting, Limiting the Impact* and *Adjusting to/Living with* are the different modes by which hospital consultants are *Rolling with the Punches*. The connecting link between these modes of behaviour is the *Weighing-up* process, in which participants consider what changes in the managerial hospital mean to them and what they can do about them. By *weighing up*, participants are evaluating their current situation against the near future. *Weighing up* does not always result in mode shifts so that participants might choose to stay in a mode, revert to a previous one or skip modes. Moreover, whilst one trigger may result in a mode shift for one person it may not mean the same thing for another person. And even if it means the same thing, it may not result in the same mode of behaviour. It should be emphasised that this study does not make value judgements about the *Weighing-up* processes and modes of behaviours in which participants engage. These processes are meaningful to the individuals concerned and that is as far as the study goes. It is not the only, or a complete, account of all the behaviours in which participants engage but it does account for much of the variation in behaviours that are observed.

Chapter 5

Chapter 5 presents the literature review. It should be possible to read the thesis without necessarily reading Chapter 5 by going straight to Chapter 6. It would shorten the document and avoid repetition. However, Chapter 5 provides signposts in the literature that are relevant to the main concern and its routine resolution. The theoretical framework that is described in Chapter 4 delimited the literature review. Since *Rolling with the Punches* is a theoretical account of a latent pattern of behaviours in which the participants resolve their main concern, this literature review added body to the view – discussed in Chapter 4 – of what it means to be a hospital consultant in a managerial NHS hospital. The review focuses on the sharp end where a constellation of logics (Goodrick & Reay, 2011) creates an institutionally complex (Greenwood et al., 2011) hybrid organisation (Battilana & Dorado, 2010; Pache & Santos, 2010). Managerialism seeks to control the clinical frontline by reframing its professionalism into an organisational professionalism (Brock et al., 2014; Muzio, Brock, & Suddaby, 2013; Muzio & Kirkpatrick, 2011; Noordegraaf, 2007a; Postma, Oldenhof, & Putters, 2015). An organised professionalism would underpin observed professional behaviours that are consistent with managerial performance management (Exworthy, 2010a; Harrison & Ahmad, 2000a). Thus

clinical practice would be standardised (Greenhalgh, Howick, & Maskrey, 2014; Timmermans & Berg, 2003). Moreover, healthcare providers would compete for contracts to deliver services (Le Grand, 2009a; Propper et al., 1998; Timmermans & Oh, 2010). Since this is a grounded study that started with the identification of a main concern of the participants and its routine resolution, it was necessary to take a closer look at the observed behaviours as a routine, non-dramatic (March, 1981; Smets et al., 2012) instantiation of their multi-dimensional and dynamic agency (Emirbayer & Mische, 1998). Then one had to look back further as to how that nuanced agency iteratively constrains and shapes the emerging managerial hospital (Berger & Luckmann, 1967; Blumer, 1971; Giddens, 1984; Hughes, 1971). Rather than starting from abstract theories and their associated hypotheses to the field, the GT approach required that one trace theoretical lines in the opposite direction.

A classic GT approach to the literature review is delimited by the emerging theory but is open to an eclectic mix of bodies of literature that facilitates the making of a novel theoretical contribution. That literature became data that were constantly compared and theoretically sampled to confirm the core category, its subsidiary concepts, their properties and dimensions and the theoretical relationships between the concepts. This understanding generated a better appreciation of how the participants construct and reconstruct the managerial hospital in their routine, everyday work. Out of this process emerged a better understanding of effort, intentionality and agency in shaping the hospital as an institution.

Chapter 6

Chapter 6 discusses the implications of the GT (Chapter 4) and the literature review (Chapter 5). It shows how the concepts that emerged in the GT are used in a wider array of fields than those where one would normally find experts who have dominated the fields of sociology of healthcare, healthcare management and healthcare policy. It shows that one should take an explicit account of history in examining the managerial hospital so that the ebb and flow of the main concern and its resolution can incorporate a maximum amount of variation. It indicates the contingency, historicity and fluidity of understandings and responses. The literature brings to the fore the understandings and agency of the participants which lie at the heart of the classic grounded theory methodology. It also shows the inter-dependencies between structures, agency and observed behaviours. The accounts of the managerial hospital and responses thereto by the participants in the study are not final statements of what is happening in the research context. It is an integrated statement of hypotheses that await affirmation and confirmation with new data. Chapter 6 suggests that Chapter 4 is but a pause. The grounded theory lives.

Chapter 7

Chapter 7 draws the different strands of the thesis together by discussing the technical adequacy; theoretical, empirical and practical contributions (Colquitt & Ireland, 2009); the limitations; and the directions for future research.

This study focuses on the micro-foundations of the NHS delivery system. It is a GT of the main concern of, and its routine resolution by, hospital consultants in an increasingly actively managed hospital. Thus, Chapter 2 provides some background to the day-to-day world in which hospital consultants deliver clinical services to patients.

CHAPTER 2 BACKGROUND

2.1 INTRODUCTION

This chapter was written after the main concern and its resolution had been identified, as detailed in Chapter 4. The chapter provides a background to the precipitation and metamorphosis of the routine anxieties of many of the hospital consultants.

An ageing population, rising demands for quality healthcare and tight national budgets mean that governments have been searching for efficient ways of delivering healthcare (Ferlie & Shortell, 2001; Joumard, André, & Nicq, 2010). Hospitals have been the focus of attention because of the central role that they play in the delivery of healthcare. In the English NHS, the acute hospital represents 47% of the costs of the budget (Roberts, Marshall, & Charlesworth, 2012). Hence, any attempt to control costs, meet rising public expectations for quality healthcare and control the clinical frontline (Bevan & Hood, 2006; Propper et al., 2008) would have to pay significant attention to the acute hospital sector. Within this sector by September 2012 there were 40 492 hospital consultants at a cost of £5.6bn (Committee of Public Accounts, 2013; The Comptcontroller and Auditor General, 2013).

The perspectives and behaviours of hospital consultants are significant issues because the following figures (NHS Confederation, 2015) show how important the provision of healthcare by acute hospitals is:

- The NHS has one million patient contacts every 36 hours;
- In 2013/14, the acute hospitals:
    - Performed 16.516 million operations;
    - Admitted 15.462 million patients; and
    - Had 82.060 million outpatient attendances.

From the same source, we learn that compared to its peers – Austria, Canada, France, Germany, Italy, the Netherlands, New Zealand, Norway, Sweden, Switzerland and the USA - the UK had the lowest number of doctors and hospital beds per 1 000 population. Its average length of stay in hospital was lower and its percentage of national income spent on healthcare was also lower.

Despite these figures, the NHS is under pressure to be even more efficient. The NHS could face a funding gap of £30bn between 2013/14 and 2020/21 (Appleby, Galea, & Murray, 2014; Hawkes, 2012). A few factors drive hospital productivity. These fall into three areas: the external environment, hospital management and hospital operational processes (Hurst & Williams, 2012). The external environment includes national policies that link hospital income to clinical activity and the performance-management system. Hospital management has a significant impact on hospital productivity. It includes good general management, clinical engagement and clinical pathway designs. Hospital operational processes involve reducing length of stay in

hospitals and moving patients and staff into community settings, improving staff productivity through meeting demands with fewer staff and reviewing the skills-mix used to deliver services. In the midst of an increase in demand and a funding squeeze, the scrutiny of NHS organisations has intensified from the regulator, the Care Quality Commission, and other official inquiries such as the Francis Report (Francis, 2013) and the Keogh Report (Keogh, 2013). So the NHS has to do more with less while being closely watched.

I undertook this study because I know a number of the doctors at the hospital. They have been complaining for some time about what is happening. For them, every day seems to be a bad day. A "bad day" does not refer to patients because acute hospitals are places for dramatic interventions. The anguish of the hospital doctors involves the management of the hospital. Management declares some or other crisis virtually every week. This means that time for supporting professional activities (SPAs) is cancelled and direct clinical care (DCC) is delivered instead. SPAs include teaching, research, audits, reading, attending conferences, formal discussions with colleagues and visits to other hospitals. DCC sessions involve clinics, patient contacts and operations. Normally, when SPAs are "taken", the consultant receives time in lieu at a later stage. However, when crises become chronic problems then SPA time is lost because the hospital is unable to replace it.

What is happening on the ground? The details are to be found in the Trust documents available online from 2008. References have been made to documents but the actual documents have not been cited – or recorded in the references – to protect confidentiality. If needed, the actual statements could be verified.

2.2 THE RESEARCH SITE

The hospital is located in a large city in England. It serves about 750 000 people, making it one of the largest English acute NHS trusts. The population is diverse, with about one-third having low socio-economic deprivation, another third having average deprivation and another third having high socio-economic deprivation. The hospital operates from multiple sites but the main hospital is located in the area with low deprivation, with the other hospital closer to the areas with average and high deprivation. Services are fragmented and duplicated between sites because the organisation was formed from the merging of a number of organisations. Names and faces may have changed but the rationalisation of services is another wicked problem (Raisio, 2009; Rittel & Webber, 1973). A wicked problem is difficult to formulate and solve because it is essentially a social problem. One does not solve it but manages as one goes along.

This hospital has a cumulative financial deficit of £277m (by 2013). It had a deficit in 2013/14 of about £38m and the projected deficit for 2014/15 is about £40m. The audited financial statements have had adverse comments for every year that the Trust documents are available online. The hospital has been under special supervision for much of the time reported in these documents. Its income is not guaranteed but the hospital has contractual relationships with four CCGs in the geographical area in which its patients reside. Moreover, it has a contractual

relationship with NHS England to provide breast and dental services. Sexual health services are provided on contract with the local authority. So the hospital has to prepare documents, monitor its competitors and its own performance against contract, and make necessary operational interventions to keep to the terms of the contracts because failure to do so could result in penalty clauses being invoked by the CCGs. Competitive tendering for contracts requires that a hospital has to manage the relationship with commissioners.

Just about everything that could go wrong in a hospital appears to go wrong in this hospital. There are severe shortages in the A & E Department. Consultants do not want to work there because it has a poor reputation. Registrars are unhappy to go there because of the poor consultant cover and a lack of time to study because it is just "work, work and work". Registrars measure time from one professional examination to the next. Nurses are uninterested in becoming fulltime staff, preferring agency or locum positions because staff shortages make caring for increasingly frail and clinically dependent patients very hard. Mandatory national A & E targets are missed routinely and the hospital has to put in place corrective targets that it invariably cannot meet. Moreover, with capacity constraints associated with a Private Finance Initiative (PFI) hospital, this hospital does not have enough resources to receive patients at its main hospital and also not enough wards to admit them.

The hospital was built with a targeted number of A & E visits of 90 000 and it currently processes over 145 000 attendances. So, patients end up in the wrong ward and being moved multiple times during one hospital stay. That is a nightmare for the patient and the family. But it is also a problem for the staff having to deal with "bed-blockers" and their associated administrative burdens. Staff shortages and the use of agency and locum nursing staff mean that continuity of care is lacking. Hospital consultants, who intermittently contact their patients, often know more about the patient than the nursing staff and healthcare assistants. In fact, as part of cost-cutting exercises, cheaper, unqualified and under-trained healthcare assistants replace qualified nursing staff.

Difficulties in primary and social care result in normally avoidable arrivals and admissions. They also complicate discharge planning. A patient may be well enough to be discharged but has to remain in hospital until the out-of-hospital arrangements are considered safe. The management of the outpatients is a problem as patients are often booked into the wrong clinic and see the wrong clinician. Patients are often not properly informed about the date, time and venue of their outpatient appointment. Clinics are also frequently rescheduled or they run late because of missing notes or the late arrival of staff. In operating theatres, staffs do not consistently follow infection-control procedures. Nursing documentation and record keeping do not meet conventional standards. This is worrying because in a hospital the spatio-temporal rhythm (Zerubavel, 1979) time is recorded in documents. When those documents are incomplete, the management of patients is compromised.

The 2014/15-improvement plan of the hospital addresses issues such as the financial shortfall, the management of the workforce, problems in A & E, outpatient and inpatient process

management and clinical governance. It aims to rationalise the business processes that underlie these problems. A hospital functions as a complex adaptive system. It is made up of subsystems that function independently and have loops and feedback loops that facilitate communication between subsystems. Whatever happens in one area could potentially affect other areas of the hospital delivery system. As mentioned above, the hospital claims that problems in the community and primary care systems result in a deluge of avoidable arrivals at A & E. The combination of a poor reputation and financial cuts to meet a statutory financial obligation results in staff shortages in A & E and a shortage of wards, beds and theatres. The result is a hospital where the clinical staffs on the ground have fewer resources with which to attend to highly clinically dependent patients. As an example, patients end up in the wrong ward among patients who are acutely ill. These patients end up getting inadequate attention because they are in place until a more appropriate bed in a more appropriate ward becomes available. Given staff shortages, nursing staff have to attend to bigger patient loads; hence, they prioritise providing patient care and hope that they will remember to fill in details in the records later. From the 2013/14 annual report, this hospital has 244,720 A & E visits at its two main sites i.e. 40 per hour. At the same time, given 7 730 births per year, this means 21 births per day.

Table 2.1: Summary highlights from the 2013/14 annual report

Category	Per Day (253 working days/year)	Per Hour or Per Day * Where appropriate
Outpatients	2 338	292 per 8 hour regular office hours
Births* 365 days	21	0.88 per hour (24-hr days)
Inpatients	725	30 (24-hr day)
A & E	670	27 (24 hr day)

So, we see a hospital that handles 292 outpatients per hour and almost one birth per hour, admits 30 patients and has 27 A & E arrivals that have to be seen by a clinician within 4 hours. Factor into the way these numbers play out the fact that the management of outpatient clinics does not meet conventional standards, there are shortages of midwives and obstetricians, there is a shortage of qualified nurses and available hospital beds and in A & E there is a shortage of consultants and middle-level doctors. At the same time, notice the row of ambulances in the A & E drop-off zone. The hospital receives about 150 ambulances per day. The target is a 20-minute hand-over procedure. The large number of regular ambulances has turned the driveway into a virtual ward.

The hospital management has a statutory duty to balance the books. This often means cutting clinical staff numbers – especially qualified nurses - closing wards and theatres. However, the hospital also has to meet other mandatory national performance targets. Many of the key

performance targets that relate to the four-hour A & E waiting time, the cancer pathway and GP referrals have been systematically missed (CQC Quality Report, 2013). This document is not referenced for the sake of confidentiality. According to the CQC Quality Report for 2013, for the workload in A & E, the hospital had 50% of the consultants needed. Nursing staff shortages meant that the nurses met the immediate clinical needs of patients but record keeping was accorded a lower priority. This was exacerbated when patients – with incomplete records – were transferred between hospital sites that are a few miles apart. The same report records that the hospital had three "never" incidents; i.e. serious incidents that posed severe risks to patients but could have been prevented had the necessary precautions been taken. These incidents were swabs left inside a patient during an operation; wrong site surgery and the wrong gas administered during an operation. In the annual report for the year that ended on 31 March 2014, the Trust stated that the Coroner had issued a report that a doctor had administered penicillin to a patient with a known allergy to penicillin. Although it did not contribute to the death of the patient, this should not have happened. The same report also noted that the information governance procedures of the Trust were below required levels. Personal sensitive information about a patient was sent to the wrong fax number. The Information Commissioner did not issue a sanction under Section 1 of the Data Protection Act 1998 but the Chief Executive Officer (CEO) of the hospital had to provide the commitment that it would not be repeated and that the data-management activities in the hospital would comply with the relevant data-protection principles. The same report stated that the water supply of the Trust – at one of its main sites – was decommissioned because of high levels of *Escherichia coli*. The matter was rectified but it appears to be a metaphor for the overall state of the Trust. Yet, the wards, corridors and offices of the PFI-funded building were bright and airy. In many cases, patients – other than those who were directly affected by particular incidents – did not even know about the drama below the surface.

The management tries to do what is necessary to cut costs and balance the books. This means reorganising the delivery of the services and cutting staff costs. Efficient delivery means that the duplication of services at the two main sites has to be rationalised. The hospital management has had plans for this rationalisation for a long time. The aim is to centralise all unplanned emergency and complex care at the new hospital site, which is located in the area with low socio-economic deprivation. All planned elective and diagnostic services – for adults and children – and rehabilitation services are to be located at the other main site, which is about three miles away in the area with a combination of average and high socio-economic deprivation. Maternity services, which are highly visible, would be centralised at the newer site.

These structural changes can only be effected once the situation at the newer site has stabilised. However, the new site cannot stabilise because the hospital does not own the site and all alterations have to be made by the private consortium that owns the PFI. It can cost £300 to change a light bulb in a PFI hospital. Moreover, stability might be a mirage because of a lack of staff to carry this out as the PFI hospital was built on erroneous assumptions about patient throughput, efficiencies and therefore staffing levels. Even if the staff were to agree to the

rationalisation of services, the consultation required at a local level with communities, patients and representatives of the public, including CCGs (purchasing healthcare services on behalf of patients), the local authority (which is responsible for community health services) and local councillors and Members of Parliament (NHS England, 2013), present significant stumbling blocks.

Stabilisation can make "business sense" but it must be clinically led and have public support. If clinicians believe that the changes do not have much to do with the quality of care to patients but are more about financial considerations, it is often hard for them to accept. When local councillors and Members of Parliament agree about the financial issues but the political costs may be just a bit too high for them, it is a case of turkeys not voting for Christmas. Hospital managers and clinicians also would like to treat people at home to prevent avoidable arrivals and admissions. How can people, with chronic conditions be treated at home when the local authority budgets for these services have been cut over a ten-year period? How does an acute hospital step into the breach when the hospital itself is in a financially desperate state and has a poor clinical reputation? Who will relocate a family to work at a place like this despite the fact that it is a regional referral centre for neurosciences medical conditions, a regional centre for hyper acute strokes and a major cancer treatment centre? These medical specialities suggest that despite the underlying drama and the hospital's poor reputation and on-going need for long-term financial life-support, it still has pockets of excellence.

Some of the few things that the management can do are to cut the numbers of qualified staff and increase the numbers of unqualified and untrained staff, double-book their lists so that clinicians do more in a day, take away SPAs and require more DCC work, and close wards and theatres. In an environment like this when one adds an ever-increasing demand, with increasing numbers of avoidable clinically dependent ageing patients, the mandatory 4-hour A & E waiting time target, the 62-day cancer pathway target and the 18-week referral to treatment target, managers do anything to meet the target and lose sight of the purpose of the hospital. Clinicians take pride in their work and there is no widespread culture of deliberate poor work. On the contrary, people seem to want to do their best but work stress and structural problems can result in the serious incidents mentioned in the CQC Quality Report for 2013. Each of these incidents has huge impacts on everyone in the hospital. They are professionally damaging and emotionally exhausting and associated with huge drama and trauma. The hospital is turned upside down as people try to find out what happened and why it happened and some may even do a bit of blame shifting. When sensitive, personal data are sent to the wrong address it is a nightmare. Then when your water is undrinkable it may just be the end of the line.

All of the above interventions by the management are achieved with expensive assistance from big brand management consultants with PowerPoint presentations and Excel sheets, which do not appear to take account of the wickedness of the social organisation of healthcare delivery and the spatiotemporal rhythm of the hospital as a complex adaptive system.

CHAPTER 3 METHODOLOGY AND METHODS

3.1 INTRODUCTION

The previous chapter set out the background to the study. It provided the context within which the main concern of the participants was formulated and in which they routinely sought to resolve that main concern. Chapter 3 advances an argument for the use of the classic GT as the appropriate research methodology for the conducting of the research and its suitability for my temperament and level of experience as the researcher. The chapter also explains how this methodology was used during the research project.

3.1.1 Methodological Approach

In the research proposal for this study, the purpose of the thesis was specified as being to identify the main concern of the participants and how they routinely resolve that concern. It was clear that there would be a need to understand how the hospital consultants made sense of their workplace and how that understanding informed their observed behaviours. Quantitative questionnaires or surveys would have created avoidable problems in these matters, especially with respect to how and why things are as they are (Miller, Dingwall, & Murphy, 2004). Having considered the alternatives, I decided to use a qualitative research methodology.

An ethnographic approach (Hammersley & Atkinson, 2007) to making observations was an option but, owing to practical difficulties in the research environment (Pope, 2005), the complete observer role (Gold, 1958) would not be the most appropriate option.

A decision to use classic GT is a full commitment to the totality of the classic GT process. This is the approach of Barney Glaser. Other "versions of grounded theory" exist; for example, constructivist GT (Bryant & Charmaz, 2010; Charmaz, 2006) and Straussian GT (Strauss & Corbin, 1990). There still are huge debates around adjusting the GT methodology (Bryant & Charmaz, 2010; Glaser, 2003; Glaser & Holton, 2004, 2007; Locke, 2001). I decided to follow the classic GT methodology rigorously, even though this was likely to take time as the process of abstracting concepts from fractured data through constant comparison is time consuming (Glaser, 1998). The development of concepts requires an openness and theoretical sensitivity to go where the data may lead. This suggests the maintenance of a degree of distance from the data, allowing for it to process subconsciously and tolerating the confusion and frustration along the way (Holton, 2007a, 2007b). Given my own temperament and academic training in sociology and philosophy, I am comfortable with the slow percolating processes of classic GT.

3.1.2 Methodological Approach

Classical grounded theory is a general research methodology that can work with any theoretical perspective and any type of data. The research methodology is neutral but the researcher is not. Hence, my chosen theoretical perspective is a version of pragmatism called Innocent Realism

(Haack, 2008). The epistemological framework i.e. the theory of knowledge that is consistent with *innocent realism* is foundherentism (Haack, 2007). Innocent realism argues that the world is a reality that is largely, but not completely, independent of what you, I or anyone else believes about it. However, it is not independent of what the community of researchers would believe it to be at the end of the inquiry. The opposite of real is fictional and imaginary. There is one real world that consists of natural things (rocks and tsunamis) and human artefacts (social institutions, theories and imaginary constructs). Innocent realism argues that human beings indeed claim, sometimes fallibly, to know some things about the world. Those claims about the world can either be true or false. Innocent realism suggests that truth and falsity depends on what is claimed (which is a function of human convention) and how things in the one real world actually happen to be. That opens a huge philosophical can of worms, with those who believe that truth is that which can be agreed or that with which one can get away with conversationally (Rorty, 1979). I do believe that there are things like hospitals, and that we are able to make claims about hospitals in the same ways that a police officer would try to establish facts from a crime scene or a plumber trying to find the cause of a water leakage. Academic inquiry is but a continuation of everyday enquiry with a number of "helps" (Haack, 2000). There is no doubt that the NHS exists and that it is not a figment of our imagination. We are also able to make truth claims about the hospital. That is not "truth" with a capital "T". So, we can argue about whether clinicians or managers hold the balance of power in hospitals. If one researcher were to argue that the balance of power lies with managers and another argues that it lies with clinicians then both cannot be equally valid and true whilst being mutually exclusive. The NHS acute hospital and the balance of power therein, at any given time, exists separately from what individuals believe it to be.

The epistemological position that I adopt is that of foundherentism (Haack, 2000, 2007). It strikes a path between foundationalism and coherentism whilst avoiding their shortcomings. It suggests that the plumber does not start looking for the cause of the leak with the idea that finding the cause of the leak is a hopeless exercise or that one only has interpretations of where the leak might originate and that all such truths are equally valid. The purpose of scientific enquiry is but an enhanced form of investigation that aims to discover truth. The opposite of an enquiry for the establishment of truth is a sham. In this case, the enquirer investigates to collect evidence in support of a position that is immune to evidence. With an enquiry one observes a phenomenon of concern, makes informed conjectures about possible causes, works out the consequences should these conjectures be true, checks the conjectures against all the evidence, chooses a conjecture that best fits the evidence and prepares to adjust the conjecture against further evidence. Scientific enquiry is continuous with everyday enquiry with a bit of help from theoretical models, sophisticated controls, technology and institutions. Foundherentism suggests that the degree to which one is justified in making certain claims about the world depends on the evidence that one can obtain as well as the coherence with other claims that one accepts. Haack presents the ways in which one solves a crossword puzzle as an illustration of foundherentism. One has confidence in a particular entry depending on the clue at hand (partly

foundational) and the ways in which the proposed entry fits in with other completed entries (partly coherent).

I accounted for my theoretical and epistemological perspectives in a bit of detail because it orientates the research (Creswell, 2013).

3.2 THE GROUNDED THEORY METHODOLOGY AND METHODS

3.2.1 Introduction

This section gives an account of key classic GT processes. Text boxes are used to provide indications of how these processes were applied in this study.

Theoretical sampling and constant comparative analysis were the methods through which data were collected and analysed. The study took place within the context of a single acute health care trust – with multiple constituent sites - because gaining ethical approval from and access to multiple healthcare trusts can be complex and difficult (Exworthy et al., 2010b; Pope, 2005).

ACCESS IN THIS STUDY

The Human Research Ethics Committee (Non-Medical) of the University of the Witwatersrand granted ethics clearance on 16 September 2011, Protocol Number H110911. The hospital granted ethics clearance on 6 March 2012, as R & D 941. The insider had convinced a divisional director of the relevance of the study to the concerns of the hospital. This divisional director supported the application for ethics clearance from the hospital's Research and Development Department. The department required that the insider, a member of staff, be named as a co-researcher on all the application forms to the Trust, that a formal questionnaire be included in the application pack and that the early results be presented as an audit to the hospital consultants in a named clinical department. The University also required that a questionnaire be included as part of the research proposal. The questionnaire is a departure from classic GT (Glaser, 1998). Research into Glaser's approach to GT solved the problem for me. Glaser writes that one should meet the institutional requirements and conduct the study by following the full package of GT steps and the methodology will correct the earlier compromises (Glaser, 2001a). However, I intended to "instil the spill" (Glaser, 1998) by asking general questions about the main concerns that participants faced on a daily basis and how they went about resolving those concerns.

Ethics approval and access were sought in one trust and a case study was made part of the design considerations. Here a point must be emphasised that GT is a general research methodology that generates an integrated set of hypotheses that transcend person, time and place (Glaser, 1998). I took account of case study considerations as noted herein but advise against reading the research as if it had followed a case study methodology. I am merely having a dialogue with some elements of qualitative research methodology without necessarily straying into the theoretical debates between classic grounded theory and qualitative research methodologies. By engaging with non-GT thoughts and practices, I believe that I keep my own

commitments to classic grounded theory honest. I spent the next few lines writing about case study methodology and its potential relevance to this study to show that classic grounded theory has its own criteria and advantages and therefore classic grounded theory methodology was chosen.

This study concerns a current problem that had been unfolding in a real-world context, with the boundaries between the issue being studied and the context not being clear-cut and multiple sources of evidence being used. The literature review presented in Chapter 5 clarifies the lack of specificity and boundedness, with references to "wickedness" and "complex adaptive systems". A case study approach is recommended for exploratory, descriptive and explanatory studies where either existing theory has proved to be inadequate or new insights are sought (Eisenhardt, 1989). An instrumental case study approach is useful when one is seeking insight into an issue or to refine a theory (Stake, 1994). This study aimed at providing new understandings of what has been described as a *danse macabre* (Degeling et al., 2003), an unhappy relationship between doctors and managers (Davies et al., 2003) and as a problem without a solution (Edwards et al., 2003). Thus, the criteria for a case study (Eisenhardt, 1989; Stake, 1994; Yin, 2014) have been met, with the hospital being the case. However, although case studies are good at providing in-depth descriptions of the practice and context (Murphy & Dingwall, 2003), concerns exist about the generalisability of their findings (Hammersley & Atkinson, 2007). This study did not aim to generalise its findings because the principal goal was to establish the main concern of the participants and how they went about routinely resolving this concern. Hence, a deep understanding across a range of contexts would suffice (Charmaz, 2006). Yin offers criteria to judge the quality of a case study; i.e. construct validity, internal validity, external validity and reliability (Yin, 2014).

However, as noted earlier this is a classic grounded theory study. It has its own criteria: fit, relevance, workability and modifiability that are different from those for a case study (see Section 3.9 of this chapter). Moreover, because of the process of abstraction, a GT transcends time, place and person (Glaser, 1998). This meant that generalisability would not be a problem in this study because, as the researcher, I had committed the study to a rigorous adherence to the GT methodology and methods.

3.2.2 Data Collection

GT is a general research methodology that aims to generate conceptual theory from data. There are at least six sources of data for use in case studies (Stake, 1994; Yin, 2014). These sources include documents, archival records, interviews, direct observation, participant observation and physical artefacts. Classic GT can use any data be they quantitative or qualitative. A fundamental GT principle is that "all is data" (Glaser, 1978, 1998, 2001a), which meant that I was not restricted to specific types of data. The case study sources of data just provided categories of potential data. Classic grounded theory allowed me to go beyond that. I could use any data, be it qualitative or quantitative. Moreover, the data are never inappropriate or wrong. What is

needed is to figure out the data for what they are (Glaser, 2001a) and work with them to determine what is happening. Hence, Glaser argues that the data might be:

- Base-line (the best description that the participant can provide);
- Proper-line data (what the participant thinks is appropriate to tell the researcher, irrespective of what the reality might be);
- Interpreted data (data provided and processed by experts who treat their data as objective but in reality the data are altered); and, lastly,
- Vague data (where the participant has no vested interest in telling the researcher anything so the participant is unclear).

The researcher should follow GT inductive procedures to generate abstract concepts systematically, irrespective of the type of data (Glaser, 1998).

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The doctors appear very guarded. It is important to put them at ease by getting them to talk freely and, as Barney says, "instil the spill" (Glaser, 1998). In that way, the data about their main concern and their ways of dealing with that concern should later emerge. Many are afraid because they almost have nowhere else to go. They have to work in the NHS or leave the service, which can mean emigration. So, one has to reassure them so that they talk freely. Leaving no trace seems important to them. The presence of the insider contact does help.

3.2.3 Getting Started

The aim of classic GT is to find out the main concern from the perspective of participants and how they go about resolving that concern. The role of the researcher is to let the natural organisation of social life in the research context emerge by listening to participants and observing them rather than by approaching them with preconceived topics and hypotheses, which may be of little or no relevance to them (Glaser, 2003; Glaser & Holton, 2004). Staying open to whatever the participants say and doing what matters to them (Glaser, 1998) are vital. The orientation for the researcher is to be open to what is actually happening and not to attempt to apply preconceived notions from professional interests or extant theories and frameworks (Glaser, 2003). The general problem, the problem as perceived by specific participants, the codes that may explain the general problem, the codes that may integrate the theory and the theoretical perspective are all potential candidates for preconception that should be avoided (Glaser, 2012a).

3.3 RESEARCH POPULATION

Researchers in healthcare settings who seek ethical approval need to have a clear idea of their research population.

RESEARCH POPULATION IN THIS STUDY

There are 156 acute NHS trusts, which include 100 foundation trusts (NHS Confederation, 2015). By September 2012, the NHS as a whole was employing about 40 394 hospital consultants at a cost of £5.6bn (Audit Commission, 2013).

The aim of the study, however, was to seek data that would contribute to the development of categories of an emerging theory (Breckenridge & Jones, 2009; Glaser, 1998). I used theoretical, rather than statistical considerations (e.g. representativeness and randomness). Decisions about data are determined by theoretical considerations not volume (Glaser, 2012b). In grounded theory studies, the researcher should stay in the field until the point of theoretical saturation has been reached while taking account of resource and time constraints. I was unable to say how many participants would be chosen from the population but aimed at holding interviews with between 30 and 60 doctors who had varying experiences of being permanently employed by an acute NHS trust. That would allow the perspective of the participants to emerge (Glaser, 1992) and avoid the saturation of researcher preconceptions (Artinian, Giske, & Cone, 2009), thus increasing the likelihood of the emergence of a dense conceptual GT (Glaser, 1998). It is worth repeating that the substantive GT, although it is generated within a given data set, is transcendent of time, person and place, as mentioned in Section 3.2.1 above. However, it will not be a sole, comprehensive or complete account of what is happening in the substantive area. The substantive GT that emerges at the end of the study just has to account for much of the variation in the behaviours of participants as they resolve their main concern.

3.4 PILOT STUDY

The pilot study was conducted in two phases because of difficulties in the field. The first four research encounters were considered a pilot study. The purpose was to refine the approach to the field (Yin, 2014), the language to be used, and to make sure that the research process would be appropriate for achieving the research aims; viz. to identify the main concern of the participants in the substantive area and how they continually go about resolving that concern. In this regard, the importance of no preconception (Glaser, 2012a) and managing the complexities of actually conducting the research in the healthcare setting (Breckenridge & Jones, 2009; Pope, 2005) were paramount.

3.5 DATA COLLECTION FOR THE MAIN STUDY

The initial pilot study had indicated that the approach to the field, the seeking of consent and the conducting of the open-ended interviews would secure good quality data from which a main concern could be identified and a conceptual account of the resolution of that concern (i.e. a core category) could be generated. By then, I knew that I was ready to proceed with the main section of the data-collection process. The data were derived mainly from 49 interviews with

doctors from various specialities, with varying levels of clinical experience and clinical management experience. The doctors interviewed included males and females (**Appendix 8**).

DATA SOURCES

Data were secured from three sources: interviews, observation and document analysis. In classic GT "all is data" p.8 (Glaser, 1998), which allowed for formal interviews, informal discussions, observations, and studies from documents to be treated as data for recording in field notes and later analysis.

Open-ended interviews provided the primary source of data. The interviews enabled me to develop an understanding of how the participants made sense of their workplace and the contradictions and tensions found there (Barley & Kunda, 2001). The initial interview framework differed from the interview schedule in the research proposal and the ethics applications because it evolved under the guidance theoretical sampling. The participants gave accounts of the issues that they faced, the tensions and congruencies between those problems and how they went about crafting their professional space within the context. It showed how their embeddedness shaped their multi-dimensional contingent and dynamic agency (Emirbayer & Mische, 1998; Greenwood & Hinings, 2006; Greenwood et al., 2011; Hwang & Colyvas, 2011; Seo & Creed, 2002).

I sought written informed consent from the participants before the interview (Appendix 5). Only a handful agreed to provide written informed consent. . This was strange because the image of doctors in an acute hospital is that of very brave people who rescue patients from the jaws of death. They wanted to remain anonymous. They were afraid. Forty-nine interviews were conducted and analysed. This was sufficient (Charmaz, 2006; Mason, 2010) to reach theoretical saturation. The interviewees represented participants from all specialities, age groups, genders, levels of experience, and hierarchical levels.

Given the initial difficulties of gaining access, the concerns of participants to remain under the radar and the constant uncertainties of an acute hospital environment, I used snowball sampling (Pope, 2002). Data were collected as field notes and analysed immediately after the interview or later in the day if the time allowed.

All interviews were conducted at the hospital. Initially, meeting times and places were agreed in advance but often became difficult as doctors were called away to deal with the immediate life-and-death priorities of an acute hospital. I decided that, to get the interview data to be available at short notice, for doctors I would make use of an insider who would gather the data when doctors were available. The main issue was to get the participants to speak about what mattered to them. Classic GT methodology would facilitate the patterning out of those concerns. I conducted a second pilot study with another five interviews to test how the interview was conducted by the insider and the field note processes. Difficulties were ironed out. I made myself available to the insider as soon as the interview had been completed. I coded and analysed the data soon thereafter, after having been briefed by the insider. The insider was very comfortable with the process because it enabled the collection of the data for the internal audit that meets the immediate concerns of the hospital. I kept a summary of the research encounters to keep track of the interviews (Appendix 8).

Another source of data was observation (Gold, 1958; Pope, 2005). It was a case of complete observer. This part of the data collection I could do by myself with maximum flexibility because the hospital is always open for business. The participants were aware that in hanging around, I was doing research and the

other staff were also aware of this. I relied on insiders to make introductions and all newcomers were informed of my presence and role. They were given the opportunity to have their actions and utterances deleted from the observation studies. People felt comfortable and after a while, I became part of the team, although I was just watching and listening. It helped that I did not make any notes during these times. I would make the notes after stepping out of the settings. Observations enabled me to see how the participants actually went about making sense of their workplace and how their relationships played out in context (Barley & Kunda, 2001) and how meanings were crafted inter-subjectively (Berger & Luckmann, 1967; Blumer, 1971; Hughes, 1971) between members of different professional groups who delivered care to patients. I could get a view of individual-level agency and the messiness and serendipity that it implies (Battilana & D'Aunno, 2009a; Hwang & Colyvas, 2011) rather than the manufactured purposefulness that retrospective accounts might present (Chia & Holt, 2009).

I also extracted documents – especially records of the Trust Board – from the website of the Trust and official documents from the Department of Health and its executive agencies. The Trust Board documents reflected how the hospital management framed the field-level logics that emanated from the Department of Health. Thus, the interview and observation data were triangulated – a process in which methods that examine the same phenomenon are combined (Denzin & Lincoln, 2011) – with organisational-level and field-level data as evidence of institutional complexity (Barley & Tolbert, 1997; Greenwood et al., 2011). I was able to retrieve minutes of monthly Board meetings for the past seven years and documents about clinical and financial strategies. Altogether, I retrieved about 50 documents over an 18-month period. From the documents I could extract contextual data for participant behaviours and choices (Merriam, 2009; Mills, Bonner, & Francis, 2006), and track significant changes (Bowen, 2009) in the evolution of the institution being studied. Thus, documents added a richer understanding of the research context of my study. Document analysis can be used as a source of data (Andrews, Higgins, Andrews, & Lalor, 2012; Glaser, 1963) in a GT study. I treated the documents as data that were written into the field notes and subjected to theoretical sampling and the constant comparative analysis methods for conceptual abstraction.

In qualitative research studies data from different sources are triangulated to minimise researcher bias and establish the credibility of the quality of the data (Bowen, 2009). Researcher bias is not a concern in classic GT because the methodology of constant comparison and theoretical sampling significantly reduces bias and the emerging theory transcends time, person and place (Glaser, 1998). Triangulation, in this study was not for confirmation but richness. Constant comparison, theoretical sampling and memoing ensured that if data from any of the three sources were relevant then it would earn its place in the emerging theory.

3.6 DATA ANALYSIS

The adoption of classic GTM is a commitment to a full set of mandatory procedures for data collection and analysis. Failure to carry out these procedures affects the quality of the GT.

"To skip a step, particularly the middle ones associated with memoing and sorting, is to produce a theory with less conceptual density, less integration, less conceptual qualification, too much descriptive and conceptual flatness in places, and missed connections obvious to the statute reader." p.16 (Glaser, 1978)

This study adhered to the classic method of data collection and analysis because I trust in emergence (Glaser, 1998, 2012a). I am inexperienced in conducting academic research and classic GT continually helps people like me to deliver PhDs that matter.

Data analysis took place on three levels: the fracturing and constant comparison of data until interchangeable indices emerge; the conceptualisation of data into concepts, categories and their properties around a core category; and, lastly, the integration of concepts and categories into a dense, conceptual theory of relationships between concepts and categories (Artinian et al., 2009; Glaser, 1998). This study generated a substantive GT. A formal theory is presented as part of the future research suggestions in Chapter 7.

DATA COLLECTION: NOTE TAKING

I did not skip any classic GT steps because I had to follow a research methodology that has continually delivered conceptually dense and deep, highly integrated theories (Glaser, 1978). During the interviews, data were collected as mind maps. This assured the participants that their words were not being recorded verbatim. Afterwards the mind maps were written up as field notes on A4 sheets with double spacing and wide margins (Appendix 9). The constant comparative method allowed for two things to happen: first, the empirical mass of data was reduced to manageable proportions and, second, the field notes were transformed into categories and concepts (Glaser, 1992). The second part followed much more easily than the first because, with the first, I had to go through a tunnel of confusion and uncertainty as to whether I was on track.

3.6.1 Constant Comparative Method

"The constant comparative method is the continuing interplay between data collection and analysis and violates the clear separation between data collection and analysis as in positivist research design." p.636 (Suddaby, 2006)

The aim of constant comparison is the development of interchangeable indices that allow the researcher to move from the chaos of empirically fractured flat data to abstract concepts, categories and properties that provide theoretical umbrellas for the underlying indices. Adherence to the constant comparative process is important for the development of complex and conceptually dense GTs.

"Using the constant comparative method gets the analyst to the desired 'conceptual power', with ease and joy. Categories emerge upon comparison and properties emerge upon more comparison. And that is all there is to it." p.43 (Glaser, 1992)

How many indicators are needed to saturate a concept? A concept should be at a higher level of abstraction than an indicator (Glaser, 2011; Glaser & Strauss, 2012). However, if it is too abstract it will incorporate too many indicators. If it is insufficiently abstract then it will embrace too few indicators and will not achieve conceptual density. Researchers construct

conceptual boundaries; hence, preconception always lurks in the shadows. However, it also illustrates the pragmatism and creativity in the GT methodology (Bryant & Charmaz, 2010; Suddaby, 2006). All concepts are provisional. The constant comparative process implies that concepts, with their properties and dimensions, have to earn their relevance in the theory by the systematic generation and analysis of data (Holton, 2007a). Constant comparison increases an analytic appreciation of the empirical data (Charmaz, 2006). The constant comparative process teased out theoretical links with existing data and provided leads for further data collection. In the constant comparative process, analytic questions were asked, hypotheses formulated, and hunches and assumptions recorded in theoretical memos. The search for additional data was grounded in the constant comparative process. GT uses theoretical sampling not selective sampling. In selective sampling, existing theory and hypotheses impose parameters for data collection.

3.6.2 Coding

The GT process consists of two coding stages: substantive and theoretical coding. Substantive coding, in turn, consists of two stages: open coding and selective coding. These stages are discussed in more detail below.

3.6.2.1 Open coding

Open coding is the fracturing and close analysis of data (events, actions, objects, interactions, gestures) from field notes. It is the first stage of the movement from the empirical mass of data to categories and concepts. In this study, coding was undertaken manually. Field notes were written on A4 sheets with a large right-hand margin. An example is attached as Appendix 9. Some researchers develop their own coding cards with reference numbers and indicators. I followed Glaser by coding in the margin to allow the relevant details to emerge slowly and pattern out whilst irrelevant details receded (Glaser, 2011; Holton, 2009). Memos recorded ideas on relationships between codes. These were later developed throughout the research process and sorted at the theoretical coding stage (Glaser, 1978).

The following rule of thumb was applied to avoid under-coding and over-coding (Glaser, 2011). An incident (i.e. a piece of data in a document or a field note) was labelled after asking the five basic questions (see next paragraph). A label needs to have more than one incident to earn the status of a substantive code to prevent the researcher from being overwhelmed by thin codes and the codebook from becoming too unwieldy (Holton, 2009). The incidents are then indicators of the substantive code. The fractured data were closely analysed for similarities and differences so that they could be named or coded. I labelled the data on a line-by-line or segment-by-segment basis in as many ways as possible; i.e. there are no constraints during open coding without any consideration of relevance (Glaser, 1978). Being open to the nuances in the data was important for the complexity and density of the GT at the end of the study. Key operating rules were constant vigilance of the slippery slope of preconception, tolerating confusion, not talking but jotting down memos and trusting in emergence as the data was being

worked through line-by-line. Some researchers have raised concerns that fragmentation results in the de-contextualisation of the data (Ereaut, 2002; Locke, 2001). Classic GT proves that if the methodology is followed without adjustments, whatever is relevant should emerge as such because it will have earned its presence in the theoretical framework.

I avoided impressionism and looking for themes, in this way avoiding the slippery slope into conceptual description (Glaser, 2001a). Asking the following five basic questions of every incident and writing codes in the margin allowed me to stay close to the data on a line-by-line basis:

- *"What is this study of?"*
- *"What category does this incident indicate?"*
- *"What is actually happening in the data?"*
- *"What is the main concern actually being faced by the participants?" and*
- *"What accounts for the continual resolving of this concern?"*

(Glaser, 1998; Holton, 2009)

Coding means looking for patterns in the data and keeps the analysis on a conceptual rather than a descriptive level (Holton, 2007a). The questions keep the researcher on track regarding the main concern of the participants (Artinian et al., 2009). Coding is a move away from the immediacy and concreteness of an incident, event and utterances to concepts and then theory (Strauss & Corbin, 1990). To code is to adopt a theoretical perspective on the data and to name or label that theoretical stance (Charmaz, 2006).

OPEN CODING IN THIS RESEARCH

The ways in which participants dealt with their main concern were coded as: asking questions, dismissing, undermining, pretending, complying with, keeping head down, faking, deflecting, agreeing, disagreeing, hanging in, playing for time, distracting, diverging, side-tracking, drawing away, parrying, fending off, blocking, drifting, deviating, staving off, altering course, objecting, grumbling, commenting, moaning, prevaricating, niggling, griping, nit-picking, protesting, trivialising, carping about, splitting hairs, chopping logic, picking fault, querying, complaining about, evading, deceiving, reneging, undermining, discrediting, toppling, unseating, dissolving, undercutting, weakening, dissimulating, misrepresenting, double-dealing, limiting, complying, assenting, following, deferring to, concurring, acquiescing, adhering, yielding, fulfilling, reconciling, assimilating, blending in, getting used to, combining, amalgamating, compounding, mixing, synthesising, going along, comparing, considering, thinking through, deliberating, reflecting, ruminating, chewing over, appraising, analysing, looking into, probing, assessing and musing on.

In each case, the empirical incidents were coded by gerunds such as the above to move from an incident, through to a code and a concept to a category to represent increasing levels of abstraction. Thoughts on relationships between were recorded in memos that were initially descriptive rather than analytical.

I was very muddled initially because of being mired in constantly asking the same five questions and things not appearing to go anywhere. I kept on producing gerunds that did not appear to advance the

research. I wanted to speak to someone, anyone, but always remembered what I had been taught in the GT workshops and books and from classic GT senior fellows not to talk but to tolerate the confusion and trust in emergence.

3.6.2.2 Coding and the use of software to aid the coding processes

In qualitative data analysis (QDA) and GTM, there are divergent views on the use of computer-aided data analysis software.

Using this software means that the coding is faster, large amounts of data can be analysed and data can be analysed more systematically, according to specific criteria. Also because the researcher does not necessarily do the coding and analysis manually, the results are arguably more credible (Gibbs, 2013).

Manual coding, however, retains the close link between the researcher and the data. GTM is a delayed action methodology (Glaser, 1998). Time must be allowed for preconscious processing as indicators slowly brew into abstract concepts and categories. Memoing is a deliberate recording of the process of abstraction. Fast coding and analysis can lead to non-grounded outcomes that can be linear, thin and lacking in conceptual density (Glaser & Holton, 2004). With computer-aided data analysis one can actually go a long way in the process without having a clue of what one has found (Pope & Mays, 2009). Manual coding is considered more efficient than computer-aided data analysis (Macmillan, 2005).

Classical grounded theorists do not necessarily completely follow Glaser with respect to his preference for manual coding. Some committed classical grounded theorists have found the *NVivo* 2.0 program useful for selective coding and the memoing process (Giske & Artinian, 2007). A combination of manual and computer-assisted methods in QDA would likely achieve the best results (Welsh, 2002). Welsh, like Giske and Artinian, advocates using software for memo management but finds it easier to figure out manually how themes and memos relate to one another on a large piece of card with pieces of paper and handwritten notes. In a review (Lewins & Silver, 2007) of some of the most commonly used software program for QDA, potential is informed by the features, strengths and weaknesses of the software options. The range of software programs is so diverse that no single program would fit every situation. Software is not neutral and its influence is contingent on the methodological know-how of the user in the context of particular software packages (Friese, 2011).

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Temperamentally, I preferred, and used, manual coding because of the close interaction with the data and continued involvement, which facilitates preconscious processing. However, I might explore the possibilities for the use of data analysis packages in a future project and contrast and compare the

"grounded theory" with a manually generated classic GT. For now, I just do not have the money or time to learn how to use a software package.

It is important to keep in mind the GT principles of remaining open and trusting in emergence. The application of specific criteria – as required by software packages, might result in forcing the data into predetermined frameworks. The main concern could be distorted and taint the understanding of how that concern is resolved.

3.6.2.3 Theoretical sampling

Classic GT is a general methodology that seeks to develop, through a process of induction, a theory that is "grounded" in the data from which it has been derived (Glaser, 2002a). Data collection, coding and analysis happen concurrently. As soon as the first data are "open-coded", the emerging ideas, hunches and concepts are used to determine where to look for the next data set. This process is known as theoretical sampling, as the data-collection process is directed by the emerging theoretical concepts (Breckenridge & Jones, 2009; Glaser, 1978). These concepts are initially imprecise and are subject to constant comparison so that they are refined and either earn their relevance in the theory or recede into irrelevance when they do not pattern out (Holton, 2007a). During open coding, theoretical sampling is a very broad process as the researcher seeks to identify issues in the substantive area that are of concern to the participants. As these concerns pattern out and a main concern emerges, theoretical sampling narrows down towards the clarification of the main concern and its continual resolution.

"It [theoretical sampling] focuses questions more and more on the direct emergence of the theory. Questions constantly change with the requirements of the emergent theory and theoretical sampling." p.157 (Glaser, 1998)

Theoretical sampling aims to clarify a pattern, concept or hypothesis. Later in the data-analysis process theoretical sampling can be used to verify category saturation (Artinian et al., 2009). Because of difficulties in conducting research within a hospital environment (Pope, 2002) theoretical sampling unfolded within snowball sampling constraints.

THEORETICAL SAMPLING AND ETHICAL APPROVAL

KEEP YOUR EYE ON THE PRIZE AND HOLD ON

Theoretical sampling requires a preparedness to go where the data leads. That means, in this case, seeking to identify the main concern of the participants and how they set out to resolve this concern on a routine basis. Institutions require specificity. The University required a detailed interview schedule for the proposal and ethics approval. The hospital required detailed research protocols that provide exhaustive details on the sample and what as the researcher I intended to do with them for me to secure access and ethics approval. These are potential slippery slopes for preconception. This matter has been very difficult to resolve. Barney Glaser argues that one must do what meets institutional requirements

(Glaser, 2001a; Xie, 2009) and then go into the field using classic GT methods. Where one draws lines can be a matter of judgement. Things are not always clear and do get messy, and confusing, often.

THEORETICAL SAMPLING AND DOCUMENT ANALYSIS

It is not possible to "instil the spill" (Glaser 1998, p.111) from documents in the ways one can do with interviews. However, the basic questions still guided the document analysis and served the purpose of the study, which was to identify the main concern and the variation in its resolution by the participants. The documents provided salient details of the structural, cultural and situational context of the main concern and its resolution (Bishop, 2006; Van den Berg, 2005). The emerging theory provides indications of where to search for documentary validation; i.e. data for the claims made by the participants. Hence, the documentary analysis was guided by the emerging theory. However, data from documents added richness when they proved to be relevant – through constant comparison and theoretical sampling- to the main concern and its routine resolution.

Since theoretical sampling guides further data collection under the direction of the emerging theory, this means that the researcher follows intuitions and hunches that are always recorded in memos. Close examination of the data, identifying similarities and variations, raises questions that are recorded on memos and directs targeted data collection. A process of iterative movement takes place between focused data collection, analysis and memo writing. This means that theoretical sampling helps to define conceptual content, boundaries, properties and theoretical relationships even between indices. Data overload is minimised because theoretical ideas are continually tested against empirical reality. Theory development is grounded rather than being flights of fancy. As the theoretical ideas are tested and the skills of the researcher improve, so confidence is gained (Charmaz, 2006; Glaser, 1998).

I wrote memos during the theoretical sampling process. These memos recorded the evolution of categories and, when diminishing returns on further data collection and analysis were reached, I made the pragmatic decision that theoretical saturation for that category had been reached (Glaser & Strauss, 2012; Suddaby, 2006). I then proceeded with data collection and analysis for other categories, all of which remained provisional and had to earn their place around the core variable or category. That theoretical vision guided the data collection and analysis strategy so that the outcome of the study would meet the criteria for a GT; i.e. fit, relevance, workability and modifiability.

3.6.2.4 Core category: its role and selection

The goal of the research was to generate a theory that fits with the concerns of participants, was relevant to their daily lives, works in their context and is modifiable (Glaser, 1998). Central to the generation of the theory is the core category, which, once identified, delimits further investigation around it, thus minimising data overload. The main concern is a very concrete answer to the five fundamental questions raised during open coding. It emerged after about 15 interviews and observation sessions. Along the way, there were a few pretenders to the status of main concern and it required significant theoretical discipline to stay on track. The

conceptual rendition of the main concern and its continual resolution took many (18) months. Gaining access to the hospital where this research was conducted and then meeting participants, together with the processes of constant comparison and theoretical sampling, took about two-and-a-half years.

The core category explains how the main concern is resolved and therefore it accounts for much of the variation in the pattern of behaviour of participants. Therefore, "the core category integrates the theory and renders the theory dense and saturated" p.93 (Glaser, 1978). The identification of a core category is the step that changes the analysis from mere description of concepts and themes to the development of a theory (Strauss & Corbin, 1990). Once I had identified the main concern, I consistently looked out for possible core categories via theoretical sampling and selective coding.

The core category must earn its position among the underlying categories; i.e. it must emerge from the data and meet criteria for the selection of a core category (Glaser, 1978; Strauss & Corbin, 1990). Among these criteria are the following:

- It must be central.
- That means it must, more than any other category, be related to many categories and their properties.
- That means it must be at the heart of the analysis.
- It occurs frequently in the data and can be seen as a stable pattern related to more and more variables.
- It relates meaningfully and easily to other categories.

If that happens, then the core category accounts for much of the variation in the data. Failure to occur frequently does not render a category useless. It only means that it is not the core category in this study.

The core category embraces the variation of the data better than any other category. Frequent occurrence and centrality suggest that the core category relates easily to all the other categories. However, this also means that saturation for the core category takes longer than for non-core categories. Non-core categories that appeared compelling initially were *"proceeding cautiously"* when the main concern was initially thought to be *dealing with ambiguity*. However, proceeding cautiously did not meet all the criteria for a core category as mentioned above. I had to review the main concern and its resolution. The main concern was labelled "managerialism" and *Rolling with the Punches* was found to be the category that best integrated the theory.

MEMO ON METHOD: NAMING THE CORE CATEGORY

This was the statement that jumped from the page when I was trying to decide on something that had more grab to serve as the fulcrum for the theory.

"Doctors are not inclined to take ill-considered decisions. As individuals, we have too much invested in the system, especially our pensions. So, we just try to make the best under the circumstances. You ***roll with the punches*** *and keep a knuckle-duster in case you need a knockout punch." (Surgeon nearing retirement)*

I then had to go back to the earlier data to code for *rolling with the punches*.

I decided to focus on *Rolling with the Punches* as core category for this PhD study. *Proceeding Cautiously* could perhaps serve as a core category for a post-doctoral study.

MEMO ON METHOD: HAVING TO CHOOSE BETWEEN *PROCEEDING CAUTIOUSLY* AND *ROLLING WITH THE PUNCHES*

Change in the NHS generated multiple ambiguities and paradoxes for the participants. This was a problem for them and they really needed to watch themselves as they decided to do what it took to survive day by day.

Managerialism as a way of seeing the hospital, talking about it and acting within it appears to be a more comprehensive statement of the participants' problem than dealing with ambiguity. *Rolling with the Punches* is an *in vivo* quote from a participant describing how he gets by and it resonated with the ways that other doctors dealt with their workplace realities. *Rolling with the Punches* emerged after I had gone some way towards adopting the *Proceeding Cautiously* category. The latter category still lacked some of the theoretical glue that held the other concepts and categories together. When the participant who used the phrase "*rolling with the punches*" said it, it was as if a light had gone on. His admission that exit was a difficult, if not impossible, option accurately sketched the constraints that the participants faced. They had to position themselves constantly to minimise damage, look for places to hide, keep a stiff upper lip and exploit gaps when they could do so. To continue the metaphor: sometimes one might not have the will to roll with the punches and one just takes the blows to the chin and the body. When I had identified the core category I went back to the data and with an open mind, though not an empty head (Dey, 1993), looked at whether the concepts would better fit either *Proceeding Cautiously* or *Rolling with the Punches*. *Proceeding Cautiously* was less central to the subcategories of *Stabilising Temporarily*, *Resisting*, *Limiting the Impact* and *Living with/Adjusting to change*. *Rolling with the Punches* integrated the latent patterns of behaviour better.

The core category should be immediately recognisable to participants who read the conceptual account of what was happening in the substantive area. It should have "grab" for them (Glaser, 1978). This later – in the audit presentation associated with this study – proved to be the case. It should be recalled that the study was registered as an internal audit with the R & D department of the hospital and the initial results were to be presented as an audit. The eyes of the participants lit up when they could see a pattern of behaviour that explained what was happening in their substantive context. This also served as an opportunity that qualitative data analysis would label as member verification of veracity. From a classic grounded theory perspective, member verification is unnecessary because the individual participant is aware

only of his/her understandings and responses. The grounded theory is an integrated pattern of responses to a shared understanding of a main concern. However, a grounded theory could provide a pattern within which the individual participant could theoretically make sense and find a place. This happened at this audit presentation.

Having identified the core category, further data collection was delimited to that which was relevant to the core category and those categories which were related to the core variable (Holton, 2007a). This is another classic GTM mechanism to prevent data overload. A classic GT core category aims to promote parsimony; i.e. the maximum variation in the data should be captured in as few categories as possible. Data collection continued until the core category was sufficiently elaborated and its properties, dimensions and relationships with sub-core categories identified. This process continued until the point of theoretical saturation, which is discussed below.

3.6.2.5 Selective coding

Selective coding means that open coding has ended and the analyst has discovered the core variable (Glaser & Holton, 2004; Holton, 2007a). Selective coding takes place after the main concern and its continual resolution (conceptualised as the core category) have been identified and confirmed; further data collection and analysis are limited to those variables that are related to the core category and the emerging theoretical framework (Glaser, 1978). This process facilitates the clarification of the theoretical logic, thus reducing the number of high-level concepts and categories. This in turn allows for a reduction of the number of categories, thus enabling theoretical integration and the emergence of a parsimonious theory. As this process unfolds and the theoretical bits and pieces start falling into place, a novice researcher can start believing. “Yes we can” might be a rallying cry to the highest office in a land but it also celebrates receding confusion and rising excitement in the emergence of a GT.

3.6.2.6 Theoretical saturation

Theoretical saturation was indicated when the process of constant comparison did not generate new directions for theoretical sampling and codes, and new data, attained through the process, did not add new insights (Charmaz, 2006). This is the point at which the researcher stops looking for new data. I stayed in the field long enough for the perspective of the participants to emerge (Glaser, 1992). This is a key process for lifting the study from the description of an empirical mass of data to a theoretical account of the underlying fractured indices. Otherwise, the saturation of preconception may be an unintended outcome.

The sample size in classical GT should be governed by saturation (Glaser, 1998; Glaser & Strauss, 2012). A healthy tension between the GTM and the judgements of the practitioner and researchers should prevent fundamentalist tendencies in choosing a sample size (Suddaby, 2006). One must nevertheless remain vigilant against premature cessations of fieldwork. In a survey of qualitative PhD studies (Mason, 2010), the sample size for saturation associated with

various research approaches is numerically analysed. For GT, the mean sample size appeared to be around 20-30 participants, and in GT studies theoretical saturation would not require more than 60 participants. This study required 49 participants. This point was raised more for information purposes rather than to specify a cut-off point for sampling. Initial open coding generated a write-up of four to six pages of notes of what I had heard, seen or read. Each line on a page could generate at least two or three open codes. Thus, one could end up with sixty to ninety codes per page. After a while, the codes were aggregated into categories, concepts and dimensions. Under the guidance of constant comparison, theoretical sampling and memoing, I reached a point where a data collection activity no longer generated six pages of notes with ninety codes per page. As I approached theoretical saturation, I only generated half a page to a page of notes and perhaps ten new codes. These new codes were reduced to three or five as theoretical relationships were explored with the existing coding bank. At that point, I felt I had probably reached theoretical saturation. Time and money might discipline one's fervour for new data collection and analysis.

The adequacy of theoretical sampling is reflected in the quality of the generated theory with respect to the level of theoretical integration.

3.6.2.7 Theoretical sensitivity and literature review

In classic GTM, the researcher consults the literature only after the main concern and its continual resolution has emerged; i.e. after the core variable has been identified.

Theoretical sensitivity involves the researcher's remaining "... sensitive to the data by being able to record and detect events happening without first having them filtered through and squared with pre-existing hypotheses and biases."p.3 (Glaser, 1978)

It meant thinking about the data in theoretical terms. The five questions that guided the open coding process in my study facilitated theoretical sensitivity since I maintained a theoretical stance with respect to the data and my ideas were grounded in data through constant comparison and memoing.

Theoretical sensitivity requires two things of the researcher: analytic competence and analytic temperament (Holton, 2007a). The analytic temperament must let the data "speak" through constant comparison (remaining vigilant about preconception, which is often deceptive), keep analytic distance and tolerate the confusion that is necessarily part of classic GTM while trusting in the power of the methodology to transcend the confusion. During the confusion, the researcher should just put pen to paper and write. This reveals preconscious processing, which is vital for conceptual emergence (Holton, 2010).

Literature was used to develop the theory that emerged from the collection and analysis of data. Literature in the substantive area under study was not reviewed at the beginning of the study as a precaution against the literature contaminating, stifling or hindering my efforts to generate categories (Glaser, 1992).

3.6.2.8 Theoretical coding

Theoretical codes are abstract statements that emerge during the process of sorting piles of mature memos that relate to a substantive GT (Glaser, 2013b). They integrate the substantive concepts with fit and relevance into a theory. Staying open and trusting in emergence facilitated remaining relevant at every stage of the classic GT.

"Without substantive codes, theoretical codes are empty abstractions" (Glaser, 2005, 2013b). Substantive codes are the conceptual umbrellas (i.e. concepts and categories) that provide shelter to the multitude of interchangeable indices in their embrace. Theoretical codes are conceptual connectors "... that develop relationships between categories and their properties" p. 38 (Glaser, 1992). Substantive codes provide abstract summaries of underlying fractured indicators. Theoretical codes link the substantive codes. The quality of the theoretical codes depends on the calibre of the substantive codes.

"Theoretical coding is needed to rescue the theory, to enable the theory to be brought into relief from the flatness of descriptive codes where ... theoretical codes implicitly conceptualise how the substantive codes will relate to each other as a modelled, interrelated, multivariate set of hypotheses in accounting for resolving the main concern." p.11 (Glaser, 2005)

Theoretical coding is the process by which the saturated concepts are brought back together and integrated into a theory. Theoretical codes are theoretical statements about relationships between substantive codes and concepts. The theoretical codes – which may arise from inside or outside of the substantive area – support the emergence of creative, original GTs that have grab rather than being mundane (Glaser, 2005; Holton, 2007a). They can confirm substantive codes, express relationships between these codes and refine categories and their properties (Holton, 2009).

Over the years, Glaser has defined a number of coding families with the aim of sensitising researchers to the possibilities for codes but the theoretical codes themselves have to emerge from the data rather than being preconceived and imposed (Glaser, 1998; Hernandez, 2009). The utility of Glaser's list has, however, been criticised (Kelle, 2007) as being either too advanced for novice researchers who lack wide theoretical knowledge or superfluous for experienced researchers who indeed have deep and wide theoretical knowledge. While Kelle's position is well argued, I chose to follow Glaser's coding categories because classic GT consistently delivers innovative GTs. Moreover, novices appear to flourish when they remain on the straight, narrow and increasingly well-trodden lanes of classic GT.

Theoretical codes can emerge from the wide reading of literature outside a substantive area being studied, *in vivo* codes, memoing and sorting of memos, and the development of theoretical models (Glaser, 1978, 2005, 2013b; Hernandez, 2009). *Rolling with the Punches* emerged as the *in vivo* core category that best accounted for the resolution of the main concern of the participants. It could also be defined as a basic social process (Glaser, 2005, 2013b). Theoretical coding clarified the relationships between the substantive codes and processes. It became clear

that *Weighing up* occurred continuously and often triggered changes in observed behaviours. Hence, time and change were involved in the theoretical code. It was not initially clear how they would relate. *Stabilising Temporarily* is a mode of behaviour that is adopted at the earliest stage of a career as a hospital consultant. Later on, the participant adopts a range of behaviours at various times, including *Resisting, Limiting the Impact* and Living with/*Adjusting to*. Thus, a basic social process (BSP) is the theoretical code that optimally links the emerging theoretical framework. It allows for a range of different behaviours, over time, through which participants resolve their main concern. Some of these behaviours may be considered to be negative (Glaser, 2005) but this study does not place moral judgements on behaviours. A classic GT identifies the main concern of the participants and then provides a theoretical map of their ways of resolving that main concern; i.e. the conditions, consequences, properties and processes involved.

These behaviours were not always linearly followed but zigzagged back and forth. This path depends on, amongst other factors, the make-up of the person and the material circumstances that prevail at the time. Each mode of behaviour is distinct and occurs at a particular point in time. Each stage also has distinct implications for subsequent stages. For the participant, the mode of behaviour may seem idiosyncratic but a sociological perspective may identify a pattern (Glaser, 2005). The acute hospital is but a set of varying conditions that reflect the main concern and its resolution. After having processed the ideas as sketched in this paragraph, I was able to understand that in this study the core variable *Rolling with the Punches* was also a BSP. Every classic GT has a core variable but it may not always have a BSP as a theoretical code. A BSP is a type of core variable but not all core variables are BSPs (Glaser, 2005, 2013b). The BSP unfolds into distinct phases over time, with at least two stages (Glaser, 1978, 2005). This is what the *Rolling with the Punches* variable does. A typology (Delbridge & Fiss, 2013; Snow & Ketchen, 2014) could also have been chosen as a theoretical code in this study but the dynamic perceptions and behaviours over time would have compromised the reliability and mutual exclusivity of the different types. Thus, I was persuaded that a BSP was the more appropriate theoretical code and that for my study it was the most suitable way to frame the connections between the various observed practices in an integrated conceptual pattern.

THEORETICAL CODING IN THIS STUDY

The main theoretical code, *Rolling with the Punches*, is a BSP with four different modes of behaviour that occur in different stages: *Stabilising Temporarily, Resisting, Limiting the Impact* and Living with/*Adjusting to* managerialism. I did not choose a typology as the theoretical code because I struggled to clearly demarcate the different types of behaviours and how the behaviours change over time.

The central process of *Weighing up*, which, as mentioned, occurred continuously and triggered changes in the observed behaviours, could be a cyclical loop that feeds back to all the other modes in the grounded theory.

The core category, *Rolling with the Punches*, appeared to work better as a BSP than as a typology. The BSP fit smoothly and required fewer variables. It provided a more parsimonious yet theoretically dense and complex account of how the main concern was resolved.

3.6.2.9 Memoing

A key GTM procedure is the writing of theoretical or analytical memos in the main "versions" of GT. During the constant comparative process, theoretical insights emerge. The researcher should always stop to record these as memos that are theoretical ideas about codes and conceptual relationships (Glaser, 1978). Memos are private and personal records of encounters with the methodology and the data, codes and categories and there are no rules as to how they should be written (Glaser, 2013a). The researcher registers what he or she feels about an incident, data, code or category, such as why is it important, what to do with it, how to enhance it and how to explicate its meanings and dimensions.

Memos are of three types:

- Observational notes (what the researcher observes in the field);
- Methodological notes (what the researcher is going to do in the field); and
- Theoretical notes (notes about theoretical ideas that emerge in the social context). p.61 (Bryant & Charmaz, 2010)

If the researcher suffers writer's block, memoing and free-writing help to get over the bumps in the road (Charmaz, 2006). Little increments of coding, constant comparison of indices, and analysing and collecting data germinate and mature and later blossom into theoretical memos (Glaser & Holton, 2004). A well-executed GT study is the result of hard work, creativity, experience and perhaps a bit of good luck (Suddaby, 2006).

The recording and management of theoretical memos were vital to the formulation of rich GT. As advised, I kept copies of memos on file and have a chronological set to visit and revisit as I carried forward the coding and analytic processes towards the generated theory (Charmaz, 2006). Memos are the theoretical glue that keeps the research together. But they are more like the glue on a post-it sticker because memos change and are shifted around. The basic goal of memos is to record freely conceptual ideas and intuitions, about patterns in the data, into a memo fund that can be easily sorted or grouped and written up, resulting in a complex and dense multivariate theory (Glaser & Holton, 2004).

Memo writing is a key step to raising the analysis to a conceptual level. It must be undertaken from the start of the data collection and analysis processes. Failure to write memos means that the study does not use classic GTM. The theoretical ideas in memos are vital to theoretical sampling and ensure that data collection remains guided by the merging theoretical ideas that emerge in the data. Memos are also the evolving record of conceptual links in the data.

Memoing, while collecting and analysing data, slows down the enthusiasm of the researcher so that conscious and preconscious processing can take place (Holton, 2007a).

MEMO ON MEMO WRITING IN THIS RESEARCH

Classic GT requires that there must always be time to write a memo. Memoing should not be delayed. Therefore, at each stage of the data-collection and analysis processes, I stopped to record memos for the memo bank. Stop, do not talk, and jot is the creed for memo writing (Glaser, 2013a). Most of the time, I gave each memo a date, a name and address of source in the data. At other times, I was just too tired and confused, so merely recorded the idea. I trusted in emergence when I tried to trace when and why I had recorded some of these memos.

During the open-coding phase, I accumulated over 500 memos. Some consisted of a few words or a few lines and sometimes – later – a few pages. Memos consisted of short notes about concepts and ideas on theoretical sampling. Examples of these memos can be found in Appendix 12.

Later memos were more developed as concepts were saturated and their dimensions and properties became clearer. I dated and labelled most of these memos to keep track of the evolution of theoretical insights.

During theoretical coding, I wrote memos to explore the relationships between concepts and a statement of theoretical relationships for an integrated theory. This phase involved the sorting and resorting of piles of memos to decide between *Proceeding Cautiously* and *Rolling with the Punches* as core categories. This process resulted in ***Rolling with the Punches*** being chosen as the core category that best resolved the main concern of the participants. The main concern is not the only concern nor is the core category the only way that the concern is resolved. It is a complex statement accounting for much of the variation in the behaviour of the participants.

3.6.2.10 Sorting and writing up

Theoretical coding and sorting of memos happen simultaneously (Holton, 2009). Theoretical coding is the abstract model that emerges as mature substantively coded memos are sorted, thus integrating the substantive codes (Glaser, 2013b; Glaser & Holton, 2004). As the researcher moves iteratively between data collection, coding and analysis, emerging ideas, questions and hunches about theoretical linkages between data and codes, codes and categories, and categories and core variable are recorded in memos. Early memos contain unstructured ideas and the constant comparative method leads to higher-level reflection that is captured in advanced memos (Charmaz, 2006).

When the researcher has established the point of theoretical saturation of the categories, the memos are sorted by category and compared (Glaser & Holton, 2004). As theoretical relationships were revisited and verified, so categories were consolidated and merged. Parsimony was facilitated as memos were integrated. The integrated theoretical relationships generated the main story line; i.e. the conceptual framework for the full articulation of the GT

through an integrated set of hypotheses. This process required paying close attention to the conceptual logic while being creative and allowing for serendipity and emergence to guide the process. Unexpected turns in the development of theoretical relationships resulted in further memos that refined theoretical relationships and the optimal location of concepts within the theory. In this way, the theory became dense, complex and parsimonious.

A researcher could also make cards with titles of memos and place them on a flat surface, such as a floor, table or against a wall, where they can be freely moved around. Clusters of cards and diagrams also make the story line clear (Charmaz, 2006). Charmaz suggests that various theoretical codes be tried for fit. However, this could allow the researcher to force preconceived and extant frameworks on the memo bank. To avoid this, I trusted in emergence, as slow, confusing, frustrating and tortuous as it sometimes could be. Following the classic GT steps without deviation or preconception and trusting in emergence had me reach the threshold where I had something meaningful to say.

GT advocates no preconceived outlines for writing. Theoretical sorting of memos is the critical step before writing. Memos are sorted by a deliberate reflection on theoretical links between categories, with the researcher continuously explicating that, which has so far remained implicit. Diagrams could make the relationships among theoretical categories clearer. In one study (Giske & Artinian, 2007), the researchers asked someone to draw a picture of the theoretical relationships that they had found because they had difficulty in putting the relationships into words. It took some time (13 revisions over a four-year period) before their final theoretical model was presented.

The aim of sorting is to develop a parsimonious yet rich and conceptually dense theory. Some researchers choose to use computers to sort their memos but this has the potential to blunt the creativity inherent in the GT process (Glaser & Holton, 2004). When sorting is largely completed –a pragmatic decision in the end – and the main conceptual account is ready to be told, with the fewest possible concepts, the widest possible scope, explaining as much variation in the phenomena under study as possible, then the researcher is ready to write the first draft of the theory (Charmaz, 2006). The researcher would have a GT that fits the data, works, is relevant and is saturated. It would meet the criteria for a classic GT. When one has gone through this process then there is likely an appreciation for the appropriateness of the criteria of classic grounded theory as opposed to those from different qualitative approaches to conducting research. Classic grounded theory is not superior to other research methodologies. It only claims its right as a general research methodology that can work with any type of data to generate an integrated set of hypotheses about a main concern and its routine resolution.

While the first draft of the theory is written only after the sorting of the memos is complete, writing up the GT should not be considered something that happens at the end of the study (Glaser, 2012b). It is a process that starts from the first days of the researcher's going into the field, taking field notes, constantly comparing, conducting theoretical sampling and not talking but stopping to write memos about concepts, categories, dimensions, properties, methods and

theoretical relationships between concepts. Once a core category and sub-core categories have emerged, more mature memos are written about the relationships between the concepts, thus integrating the concepts. When those mature memos have been sorted and even more memos written about that process, theoretical completeness follows and the final stage of writing up unfolds.

Writing up is not conducted from memory or a *tabula rasa* but is the writing up of the data, concepts and theoretical relationships that are already recorded in mature memos. The discipline of stopping to write memos leads to this point. Not writing those initially confusing, descriptive and sometimes nonsensical notes in the earliest days of the research and not constantly taking a theoretical stance with the basic questions will likely lead to the desperate plea: "How do I start writing?" A classic grounded theorist – even a novice – is prepared from the first hesitant steps into the field to write and is ready to write up a substantive GT at the point of theoretical completeness as mature memos have been sorted. A substantive GT is not a final or complete account of what is happening in a substantive area. The substantive GT is a conceptual account of latent patterns within a given data set.

MEMO ON METHOD: SORTING WITHIN THIS RESEARCH

I followed the classic GT method rigorously and built a considerable fund of memos from the first interviews and open, selective and theoretical coding. Memos on observations in the field and theoretical ideas about concepts and categories were also stored in the memo bank. Those memos that were related to the concepts were grouped together and questions were asked about the concepts and their dimensions and properties. Answers to these questions were recorded as memos. Memos that were relevant to more than one concept were duplicated and placed in more than one pile.

The theoretical coding involved the sorting of piles of memos and moving them about. The biggest pile of memos related to *Rolling with the Punches*. The piles of memos were a visible manifestation of how the core category was related to most of the other categories and how it took much longer than the other categories to saturate.

A requirement for sorting is patience. There are many mirages along the path. Confusion and exhaustion can lead to temptation to slip into preconception. Staying open is an on-going accomplishment.

MEMO ON WRITING UP IN THIS RESEARCH

During the writing-up stage I continued to write memos because in writing up the theory further ideas arise. A key consideration was to remain theoretical and conceptual rather than descriptive and comprehensive.

The theory had emerged from the processes of constant comparison, coding, theoretical sampling, and the identification of a main concern and the core category that resolves that main concern. This accounted for much of the variation in the pattern of behaviour of participants within the research context. Once the theory had stabilised around the core category and relationships between categories, theory dimensions and properties, the writing-up phase "began". Incidents from the data were used to illustrate components

of the theory without slipping into accurate description. The theory is an abstraction of the empirical mass of data.

It took me more than six months to sort out the theoretical codes and begin writing the draft. It was a bit longer than Glaser's time-frame (Glaser, 1998). Life got in the way of the PhD. I reached the readiness moment after about 18 months of working with the data.

I consulted the literature after the stabilisation of the emerging theory and the "beginning" of writing up. My aim was to look at the various issues that were raised by the emerging GT and then find how the theory is shaped and reshaped by literature from relevant substantive areas. I treated the literature as data for constant comparison (Glaser, 1998; Holton, 2009).

3.6.2.11 Formal or substantive theory

A GT is an analytical understanding of a problem in a substantive area (Charmaz, 2006). A GT study can generate one of two types of theory: substantive or formal theory.

In a substantive GT study, the researcher aims to develop a theory of what is happening in the data in one area of study (Glaser, 2012b; Glaser & Strauss, 2012). The present study generated a substantive GT of how doctors in public sector acute hospitals have resolved their concerns with the use of private sector management techniques for almost three decades (Ferlie, Lynn, & Pollitt, 2005; Pollitt & Bouckaert 2011; Simonet, 2013). The substantive GT emerges within the data set that the researcher has accessed. Theoretical saturation, theoretical completeness and the readiness to write are milestones for the substantive GT. It can also be a starting point for a formal theory through comparative analysis of different groups in other substantive areas so that its general implications can be clarified (Glaser, 2007; Glaser & Strauss, 2012). A formal theory does not emerge from a single case study. It emerges over time with sufficient data analysis, in a number of cases, over a number of years.

In the present study, the formal and relevant literature review was conducted after the GT had emerged and stabilised (Charmaz, 2006; Glaser, 1998). That was undertaken to check for similarity and difference to sharpen concept and construct formation and the hypothetical relationships between constructs. The GT delimited the literature reviewed to relevance to the emerging theoretical framework rather than popular scholarly literature on the relationships between doctors and managers.

3.7 CRITERIA FOR THE QUALITY OF A GROUNDED THEORY STUDY

This section discusses criteria for the quality of a GT study. These issues (in Section 3.7) are not central to a classic GT study (as discussed in Section 3.8) and are included for the sake of comprehensiveness.

3.7.1 Respondent Validation

Some researchers who use GT rely on respondent validation (Silverman & Marvasti, 2008) to counter researcher bias and subjective interpretation during analysis. However, the introduction of respondent validation can be seen as just another level of data that require further analysis (Elliot & Lazenbatt, 2005; Emerson & Pollner, 1988; Seale, 2000). A GT study is a conceptual rendition of what the participants do as a group; therefore, the individual participant may not recognise the conceptual account of his or her own behaviour (Glaser, 1998). Hence, from a classical GT perspective there are some reservations about respondent validation.

GT does not require the researcher to go back to respondents for validation (Elliot & Lazenbatt, 2005). Given the difficulties in conducting research in a healthcare environment (Breckenridge & Jones, 2009; Pope, 2005), I considered that respondent validations would likely be too difficult to obtain. If GT is done well then the iterative processes of theoretical sampling, constant comparison and memoing enable the researcher to routinely check that the emerging findings do fit and are relevant to the data (Glaser, 1998). Categories, properties of and emergent theoretical linkages are contingent until they earn their place in the emerging theory. The emerging fit between the emerging theoretical constructs and new data analysis should be sufficient to ensure validity. The data and research process are described in sufficient detail in this thesis to demonstrate the claimed fit between data and theory.

The best argument for the validity of a GT is the affirmation by a knowledgeable person that the GT explains how the world of the participants works. When categories do provide frameworks that tie together disparate experiences, participants are often better able to manage their substantive contexts. The understanding of main concerns and their continual resolution opens up possibilities for participants to understand what is happening in their world (Artinian et al., 2009).

In the application for ethics approval and access for my study, I stated that respondent validation would be used. Actually, my main reason for doing so was for the purpose of securing multiple entries to the research site. When the results of the audit were presented to a group of doctors at the hospital, their responses validated the theory, although the audit was not necessary from a GTM perspective.

3.7.2 Consistency Checks

An outside competent and interested person (e.g. fellow PhD candidate or person with experience in GT) could carry out consistency checks by taking a sample of text and category descriptions. The person could then take the category descriptions and look for text from the sample that fits the categories. Similarly, an independent coder – perhaps a trusted friend (Costa & Kallick, 1993) – could also take the sample text, develop codes and make comparisons (with the codes assigned by the researcher) for coding consistency. Codes can then be refined.

The independent coder would look at the consistency of the analytical process and the outputs to deliver dependability and confirmability judgements (Lincoln & Guba, 1986).

However, classic GT does not require a third person to confirm the quality of the analytical process and outputs. Concepts, categories and properties are subject to constant comparison, theoretical sampling and memoing, which constitute a constant process of verification during the theory-generation process (Glaser, 2001b). They have to earn their places in the theory and are adjusted as new data are collected and analysed. Given the interpretive nature of the research and the epistemological stance of the researcher, consulting a third person could have been a risky and inconclusive option. It helps to draw a distinction between talking to an aggressive, uninformed critic and a knowledgeable, diplomatic and sensitive critic (Glaser, 1998). Sometimes talking too early can result in unintended forcing and preconception of the data. This is a potentially difficult issue from the time that a PhD student chooses classic GT as research methodology until the defence of the dissertation. I trusted my academic supervisor and Fellows at the Grounded Theory Institute for advice rather than a non-grounded third person.

3.7.3 Internal Consistency

Do the various parts of the theory fit together and explain the data? If GT has been performed properly then internal consistency should follow. Internal consistency can be undermined by preconception and researcher bias (Glaser, 2012a; Glaser & Strauss, 2012) and inquirer bias (Patton, 2015). The constant comparative process is a way of reasoning and dealing with the preconceptions that constitute the issue of reflexivity. Biases can be recorded as memos and earn their way into the emerging theoretical framework (Glaser & Holton, 2004).

Internal consistency was also ensured through the way the participants were chosen and the data collected and analysed. Despite using snowball sampling, with the aim of following theoretical sampling, research participants were still chosen from all demographic categories associated with permanently employed hospital consultants at the chosen acute NHS trust. This facilitated triangulation (Denzin & Lincoln, 2011; Patton, 2015) across, for example, different sites of the same hospital trust, specialities, length of employment, gender and level of involvement in management. The hospital trust consists of a number of different providers that have been amalgamated over time. They are often a few miles apart and operate almost independently. This meant that the participants spent too little time with the researcher to be explicitly affected by the research and the researcher (Giddens, 1984; Landsberger, 1958). Moreover, data were collected from different sources; i.e. open-ended interviews, ethnographic observation and document analysis. Data were collected and comparatively analysed, under the guidance of theoretical sampling, for the main concern and its routine resolution. Rigorous adherence to the full package of classic GT procedures promoted internal consistency. As noted earlier, triangulation is a qualitative data procedure that is not requirement in classic grounded theory. The constant comparative, theoretical sampling and memoing processes by themselves dealt with the issues of researcher or participant bias as well as data analysis skewing of data.

3.7.4 Reliability

"Reliability" refers to the consistency with which instances are assigned to the same category by the same observer on different occasions (Hammersley & Atkinson, 2007).

Reliability was achieved through a systematic and clear documentation of the research processes, especially the data-selection, analysis and synthesis procedures. However, it should be emphasised that in classic GT the aim is a conceptual account of a phenomenon and not accurate description. The patterns – reliably generated through a process of constant comparison and theoretical sampling – are always open to extension and modification by new data (Glaser, 2001a).

3.8 CRITERIA FOR JUDGING A CLASSIC GROUNDED THEORY STUDY

Classic GT has its own criteria by which to judge the quality of a GT. These standards are: conceptual fit, workability, relevance and modifiability (Glaser, 1978, 1998; Glaser & Strauss, 2012).

3.8.1 Fit

Fit is an aspect of external validity and shows the match between the concepts and the incidents that they represent. "Fit" refers to the extent to which the theory corresponds with the substantive context from which the data has been derived. I tried to remain open throughout the research process; I trusted in emergence, avoided preconception and forcing as far as possible, and was constantly committed to the full package of classic GT steps. The process has to be that one moves from data collection to the conceptualisation of a core category and its subcategories through constant comparison, theoretical sampling and saturation, sorting and writing up of mature memos, which are constantly tested, confirmed and welded together with a theoretical code into a parsimonious theory. The theory is grounded in the data from which it has been derived and thus provides a suitable theoretical account of the variation in the underlying data. The fit of a GT can be tested for emergent congruence by constant comparison with new data from a new situation. Fit is probably the most important of the four criteria for a classic GT (Artinian et al., 2009; Glaser, 1998).

3.8.2 Relevance

Relevance means that the concepts are appropriate for what is actually happening in the substantive area. It emerges with fit. The GT is relevant, suitable and significant if it allows the main concern of the participants and its continual resolution to emerge during the research. Since a GT is about the identification of the main concern of participants in a substantive area and its continued resolution, it is the participants who should be the judges of the relevance of the theory. When a GT is relevant to participants it has grab (Glaser, 1978, 1998; Holton, 2008).

3.8.3 Workability

"Workability" refers to the capacity of the theory to explain and interpret what is happening in the area under study and predict what is likely to happen. The theory paints a picture that is readily recognised by those who inhabit the substantive area because it refers to the main concern and how participants actually go about the daily resolution of that concern. The theory is a conceptual account of what is happening in a substantive area, the process by which the main concern is framed and how it is resolved routinely. It works.

3.8.4 Modifiability

"Modifiability" refers to the capacity of the theory for adjustment when existing data are compared to new data. A GT is not a statement of truth or a final pronouncement about what is going on in a substantive area. More data can always be considered. Its inductive logic of inquiry leads to a tentative set of integrated hypotheses that is grounded in data. As new data are considered, the processes of constant comparison, theoretical sampling and memoing are activated again. This ensures that the existing theoretical framework should earn its place in the light of new data and modifiability reflects that animate quality of a GT. A conceptual account of a main concern and its resolution is abstract of time, place and people and is modifiable by data from a new situation. In such a context a GT can be tested for emergent fit (Glaser, 2001a). A GT is therefore dependable (Glaser, 1998, 2001a) and has potential for future development (Artinian et al., 2009).

For access purposes, this GT was originally framed as an audit – with further development as a PhD study – for ethical approval purposes. This was a requirement from the Research and Development Office of the hospital trust where the research was conducted. The approval process included a condition that the initial results of the audit had to be presented to some of the hospital consultants. This was achieved with the presentation of the GT before the literature review was started. When the audit was presented to the department in which the original audit was registered, it already had "grab", it fitted the consultants' experiences and was relevant to them. It allowed them to see what was happening in a patterned way, and why and how it was happening. It also provided socially legitimated options for the consultants to deal with their main concern. That was a moment to savour. As painful as their daily experiences were to them, the GT had empowered them. It also was an encouraging milestone for a novice grounded theorist. One could call this an instance of member verification but that would be another nod qualitative data analysis that is not necessary in classic grounded theory methodology. Institutional requirements might sit more comfortably with these acknowledgements.

3.9 AUDIT TRAIL FOR THE STUDY

An audit trail can add rigour and transparency to qualitative research (Bowen, 2009) as a way of revealing the methodological and theoretical decisions made during the research process. An audit trail is usually not considered necessary for a classic GT study because classic GT has its

own procedures for delivering rigour, accuracy, credibility and validity. Auditing is a requirement in descriptive studies whereas conceptualisation is abstract of time, place and person (Glaser, 2014). A classic GT study that follows all the procedures of the methodology should meet the criteria by which to judge the quality of the study: conceptual fit, relevance, workability and modifiability. However, Bowen argues that an audit trail can promote trustworthiness and credibility in GT because the methodological and theoretical decisions made throughout the research process would be transparent and open to scrutiny. It should be noted that the concerns that Bowens raises are probably more related to QDA concerns with accuracy (Glaser & Holton, 2004).

Table 3.1: Audit trail for the grounded theory study (adapted from Bowen, 2009)

Research Phase	Evidence	Location
Ethical approval and oversight	Association of Social Anthropologists of the Commonwealth Ethical Guidelines for good practice	Appendix 1
	Summary of Research Governance Framework for Research within the Hospital Trust. Ethics Approval for oversight purposes from acute NHS Trust * Identifying details for the trust have been redacted.	Appendix 2
	University of the Witwatersrand Human Research Ethics Committee (Non-Medical) Clearance Protocol Number H110911	Appendix 3
	Participant Information Sheet	Appendix 4
	Consent for Interview Form	Appendix 5
	Consent for Participant Observation	Appendix 6
	Initial Interview Guide. Semi-structured for face-to-face interviews. Evolved as the study progressed.	Appendix 7
Literature review	The initial literature review related to context for the study, existence of the problem and methodology to meet institutional requirements. Relevant literature was reviewed after the emergence of the GT of the phenomenon under study.	Chapter 2 Chapter 5
Participant selection	Participants were limited to permanently employed, full consultants (some consultants are employed on sub-consultant grades and were excluded). They had to be knowledgeable and willing to talk about their working lives.	
Data collection and storage	Primarily in-depth, open-ended face-to-face interviews. Data were collected and analysed simultaneously under the guidance of constant comparison, theoretical sampling and theoretical saturation. Data were stored separately in both computer and hardcopy files. Confidentiality and anonymity applied.	
Raw data	Field notes, site documents and archival material	
	Summary of research encounters	Appendix 8
Partially processed data	Example of field notes from interview/observational	Appendix 9

Research Phase	Evidence	Location
	study	
	Example of open-coded data from interview/observational study	Appendix 10
	Example of open-coded data from group meeting/observational study	Appendix 11
	Examples of early memos	Appendix 12
	Example of process of abstraction from field notes, to open codes and selective codes and final concept	Appendix 13
Conceptual/Theoretical framework	Main concepts in the theory	Appendix 14
Trustworthiness techniques	Triangulation (multiple sources of data; i.e. interview, observation and document analysis about the same phenomenon) of data collection. Participants were chosen from various demographic categories under the guidance of theoretical sampling. Demographic details were not preconceived as relevant. Aimed to speak to as wide a range of consultants as possible so that the main concern and its resolution could be determined from a wide range of situations within the substantive context. Open-ended interviews and ethnographic observation data, site documents, archival data. Explication of process of abstraction from raw data to emerging theory.	
Final write-up of research report	Included context, conceptual definitions, research design, research methodology, data collection and analysis (including coding process). Detailed discussion of classic GT methodology and processes. Comprehensive account of the emerging theory. Integration of the relevant literature. Detailed description and discussion of the GT. Illustrations (tables, charts and figures). Limitations and contributions (theoretical, empirical, methodological) of the study. Implications for management practice. Recommendations for future research. References and appendices.	Chapters 4, 5, 6 and 7

CHAPTER 4 ROLLING WITH THE PUNCHES: A GROUNDED THEORY

4.1 INTRODUCTION

This chapter is a presentation of the main contribution of this research study. It was developed using the GTM as described in Chapters 2 and 3. The GT *Rolling with the Punches* identifies the main concern of doctors who work in the publicly owned acute hospital sector of the NHS and provides a theoretical framework of how they go about resolving that main concern in their everyday activities in the workplace.

The data were obtained from open-ended interviews with 49 diverse hospital consultants. The emerging theory accounts for the preponderance of behaviour in the substantive area, with the prime mover of this behaviour being the main concern of the participants. A GT is an abstraction and conceptualisation of data into concepts and categories, which are integrated into a theory. The theory is not true or false but is a set of plausible and grounded hypotheses about what is happening in a given substantive area. The theory of the current study was found to meet the criteria of classic GT in that it fits the data, it works (i.e. it substantially explains a preponderance of behaviour in the substantive area) and, given that the theory fits and works, it is relevant. The GT, however, is not a final statement. It is only a conceptual abstraction based on the data available at the time. It has the potential to be modified as new data become available. This means that it meets the criteria of a well-crafted GT; i.e. it fits, it works, is relevant and is modifiable (Glaser, 1992).

This chapter is structured as follows:

- The first part of the theory introduces and explains the main concern of participants; i.e. managerialism within the acute hospital.
- Next is an explanation of the on-going *Weighing-up* process, which lies at the heart of resolving the main concern.
- Thereafter, the chapter presents the core category *Rolling with the Punches* and its related categories of *Stabilising Temporarily* and a typology of *Rolling with the Punches*' behaviours: *Resisting, Limiting the Impact* and Living with/*Adjusting to* the change.

The experience of managerialism is primarily individual but it also has social dimensions and changes over time. Thus, the *Rolling with the Punches* GT is a multi-level dynamic theory of the interaction between the participant and the environment.

4.2 THE MAIN CONCERN

"Acute hospitals have to achieve a 5% efficiency saving (ignoring accumulated deficits; i.e. historic efficiencies not made), with flat income streams; reduce bed capacity as care is to move into the community, whilst maintaining operational performance, quality and safety. ... Hospitals face an insurmountable task that requires systemic solutions. The rationalisation of services and hospitals is needed. The system needs to be fixed; i.e. social, community, primary acre as well as housing." (Hospital CEO, consultant)

The main concern of the participants is managerialism, which is an increasing use of private sector approaches in the delivery of public sector healthcare. These changes affect the structuring of the work environment, what is being done and also how it is to be done. Managerialism challenges the consultants' sense of self, personally and professionally.

Doctors feel that they have lost control over their workplace. In every area, non-clinical managers make the decisions.

"It used to be clinicians driving the bus and administrators helping them.

We used to control our time and budgets. Today we do not have control over either of these. Managers take the liberty of telling us what to do and when to do it." (Consultant microbiologist)

"The people who make the decisions have never sat in front of a patient." (Consultant radiologist)

"In the hospital today we drown under the management-inspired paperwork, policies, procedures, guidelines, targets, reports, reorganisations, re-disorganisations, mission statements, sprinkled with business bullshit of corporate this and corporate that. I do not care about these things. I want to help patients." (Consultant surgeon)

Doctors deal with real people, who come through the doors of the hospital with hopes and fears associated with illness, but feel that the patient has been lost despite the clamour around patient-centredness. Doctors find that they are working in a world that speaks a different language. This language provides consumers (i.e. patients) with choice, money following the patient, payment-by-results and purchaser-provider split. They work in an environment of transparency, accountability, targets and performance-management, benchmarking and league tables. The hospital is portrayed as being open 24/7/365 and as a cost- and profit centre. Doctors feel that bureaucratic appraisals, clinical governance and revalidation have replaced their peer-to-peer accountability processes.

"Hospitals have been experiencing a Cultural Revolution of money, management and targets before anything else." (Consultant physician)

The economic fundamentalism of management clashes with the ways that doctors frame who they are and why they actually arrive at work every day. "Managerialism" refers to the negative impact of these changes in the way the hospital is spoken about, how it functions and how those who work in it are expected to function. Managerialism is about the consequences of *"hitting the target, ticking the box and missing the point" (Consultant cardiologist).*

4.3 RESOLVING THE MAIN CONCERN

4.3.1 An Overview of "Rolling with the Punches"

Doctors resolve the main concern of managerialism by *Rolling with the Punches*. It is the core variable of the GT that emerged through the constant comparative analysis of, and theoretical sampling for, the data. This pattern of behaviour is a basic social psychological process that explains how the participants try to ameliorate the robust managerial transformation of where they are working, what they are doing and how they go about doing their work. It emerged from an analysis of the ways in which the participants spoke of and behaved in their workplaces.

Rolling with the Punches is a pattern of behaviour that is composed of five interacting elements: *Weighing up, Stabilising Temporarily, Resisting, Limiting the Impact* and *Adjusting to*. The behavioural components of the theory lie on a continuum from resistance to total compliance.

- ***Weighing up***, the link between all the stages, is concerned with identifying and assessing what is happening in the environment;
- ***Stabilising Temporarily*** is a stage that is gone through by almost all newly qualified consultants;
- In ***Resisting*** doctors decide that they will try to use managerialism against itself or slow it down;
- This stage is followed by ***Limiting the Impact,*** in which participants have a greater acceptance of managerialism with intentions of finding ways around its reach;
- The final stage is ***Living with/Adjusting to*** managerialism. In this stage, participants decide to live with the robust approaches, systems and techniques of the private sector in the publicly owned acute hospital.

4.3.2 Weighing up

Weighing up is a fundamental on-going assessment in the process of *Rolling with the Punches*. The process of interpreting and determining the significance of what is happening is overwhelmingly and primarily personal but it has a social dimension as well. This makes it a multi-level process. Moreover, it can lead to change in the mode of behaviour over time. Although *weighing up* is on-going, it does not always lead to a change in the mode of behaviour. The content of the weighing-up activity is different, depending on the extant mode of behaviour. A particular managerial approach or technique could lead to a change in response from a participant or it could lead to no change at all. If it leads to a change, then some stages or modes of behaviour could be skipped. Thus, the same participant can take different positions on the same issue without necessarily feeling uncomfortable. *Weighing up* is a two-phase process: making sense of the change and doing something about it.

4.3.2.1 Making sense of the change

Doctors come to work with a strong sense of who they are, what they have come to do and how they should go about doing it. They generally believe that they should be at the heart of whatever happens in a hospital. Patients come to hospitals because they are concerned about their health and clinicians are the people who can address their concerns. Doctors, as individuals and as a group, see themselves as intellectually and creatively above everyone else in the hospital. As far as their dealings with patients are concerned, they feel that they should be free to exercise their clinical judgement in the best interest of each patient.

Doctors come from different personal and social backgrounds and have commitment structures, which make it very difficult to take collective action. They have a shared need to provide a solid middle-class standard of living for their families. Moreover, given their stage in career and life, they may have children at school at a later stage than many other people. So participants look at the changes in the environment and compare them to their own personal and professional needs, norms and interests. These constitute the filters through which changes in the environment are processed.

The changes have been in the making for more than two decades. Thus, managerialism is a long-term challenge for these doctors. Very few aspects of hospital life are unaffected. In terms of their world, managerialist intrusions are chronic and pervasive.

"A & E is managed by dashboards and targets. Managers and the Trust Board watch the clock whilst clinicians deal with patients and their concerns." (A & E consultant)

"New technologies mean that patients who ten years ago had no options are now being treated. Patients also have rising expectations of the type and timing of their care. So doctors are facing increasing and relentless pressure to keep up with the rising demand and unending targets whilst trying to deliver the quality of care that we believe patients deserve." (Consultant paediatrician)

"The NHS is still like the old utilities that are funded by the taxpayer. The aim is to turn them into competing privately owned franchises that are driven by profits. That requires the turning of fixed costs associated with consultants into variable performance-related costs. We are threatened with long-term job insecurity." (Consultant surgeon)

In trying to interpret what is happening, doctors take account primarily of their own needs, priorities, past experiences and commitment structures. However, their primary reference group is often made up of people from their speciality. Hence, their immediate colleagues also shape their views. They do not respond to the managerialist technique, or approach, itself but in terms of what it means to them; i.e. is it benign, a threat, a passing fad or something serious? That meaning is projected into the future as a possible outcome that could be positive, negative, neutral or unclear. This shapes their initial mode of behaviour. The interpretations of significant others and actual outcomes are among the feedback loops that can influence perception at a later stage.

The sense-making process is not a linear process where all the facts are gathered, comparisons made, positives, negatives considered, then options clarified, and choices made. On the contrary, it is a more intuitive process. Meanings are discovered as the doctors go along.

4.3.2.2 Doing something about it

"There are no right or wrong responses to the changes in the hospital. There is only your own response given your own situation. If you are a relatively younger consultant, then you might have greater flexibility. If you are a bit older, then your commitments do not allow for as much change. So you do what you can to get by." (Consultant oncologist)

Perception of the managerialist intervention shapes their response not the intervention itself.

"Doctors are not inclined to take ill-considered decisions. As individuals, we have too much invested in the system, especially our pensions. So, we just try to make the best under the circumstances. You roll with the punches and keep a knuckle-duster in case you need a knockout punch." (Consultant surgeon nearing retirement)

Just the way that they go about doing their work, primarily as individuals, makes it difficult for doctors to do things in concert with other doctors. Moreover, professionally, they would be largely unwilling to take actions that could undermine a core element of their profession; i.e. the trust that patients have in them. They have very little room to challenge the status quo without harming themselves. It hardly matters how upset they may be about what is happening; they will not readily do things that could be considered ill judged by others. They are, after all, doctors. Hence, they will do the best that they can under the circumstances; i.e. *rolling with the punches*. They will look for the small ways, embedded in their daily professional roles, in which they can express their dissatisfaction. Their pragmatism means that the taking of certain types of actions, those that might be openly confrontational or could arguably put patients at risk, would be out of bounds. They will take actions that are largely consistent with their ideas of clinical autonomy and medical professionalism. Managers do not diagnose and treat patients. The doctors know that they have significant latitude when the patient is in front of them.

In hospitals, nothing is as calm as it seems. Managers and doctors do not fight openly in the corridors, theatres or wards. Uninformed people may not even be aware of the daily struggles that take place. There is intense jostling for power and influence between protagonists. Managers can constantly complain but doctors do not refuse to see their patients. Doctors, in turn, do not openly rebel, so management does not have much evidence to go by. Doctors meet their commitment to the patient in the room and beyond that they resist.

Whatever they decide to do, there must always be an exit plan.

In summary, the *weighing-up* process is central to *Rolling with the Punches*. It is the means used by participants to take what is happening and align that with their own needs, values and priorities. This frames the meaning of the issues for them. That meaning is primarily individual but also has a social dimension. That meaning is projected as a potential consequence that also

is measured up against actual consequences later. Thus, meaning can change as a result of social interaction and time.

Then they decide what to do about it. However, this is hardly a revolution and the banging of bedpans in the corridors. Doing something about it involves a number of discreet attempts to hold on to how things ought to be for the time that the participant is working in the hospital. The *weighing-up* process is multi-level (i.e. individual and social) and dynamic (i.e. it involves change over time). This process informs the behaviour of the participants.

4.3.3 Stabilising Temporarily

This is the behaviour pattern of newly qualified consultants in their first or second appointment in a hospital. Generally, consultants stay in one place or two places over the length of their consultant careers.

Stabilising Temporarily refers to their "keeping head above water" (newly appointed radiologist). The transition from being a registrar (who could call on a consultant when needed) to the consultant on-duty and on-call is substantial. It means being the most senior clinician in the area with responsibility for diagnosis and treatment of patients. They can call on their peers and seniors but as a consultant, they need to be, or become, clinically competent and get through the work. These pressures mean that despite their awareness of issues in the environment, they are unlikely to get involved. The key goal during *stabilising temporarily* is to become clinically credible and develop a good reputation at work. They will not help themselves or anyone else if they are eloquent on the broader medical-political issues but they are unable to finish their allocated work or their work is of dubious clinical quality. Hence, they just keep their heads down and work the extra hours, days and weekends to get through.

Their personal pressures such as having a young family despite being not so young themselves, due to the years of training that it takes to become a consultant, mean that they have to pay a mortgage and pay bills for a car or two, private school fees, and a holiday or two per year. They often try to provide these things while having insufficient time to spend with their families as they try to keep their heads above water. *Stabilising temporarily* is about getting through, fighting exhaustion, developing clinical credibility and looking forward to having a private life at some point.

"Long days and nights build up sleep debt and fatigue that do not benefit the doctor or the patient." (Consultant)

Clinical competence is also a gateway to the private work network that could relieve some of the consultants' financial pressures. It is also a phase in their career when some newly qualified consultants develop relationships with senior clinicians, who can become mentors and sounding boards. Clinical experience and ways to interpret and respond to managerialism are communicated from the older generation to the newly qualified consultant. While keeping their heads down during this phase, they are also tweaking the *weighing-up* process.

4.3.4 Resisting

"In our hospital, Trust finances and targets come first. Patient safety and quality of care are afterthoughts to the management. That is unacceptable." (Consultant radiologist)

Acute hospitals deal with people who often are at the boundaries of life and death. As sedate as these may seem, there are frequent interruptions of emergencies, loss, grief and fear. Hospitals are complex places where things are finely balanced. Whatever happens in one place can have consequences elsewhere. A hospital, therefore, is hardly a place where dropping tools because one has an issue with a particular management mechanism will be welcomed. Participants cannot readily take positions because they could potentially put patients at risk with radical and apparently ill-considered actions. Hence, professionally and socially, doctors are constrained from taking radical or ill-considered action. They place a high premium on the trust that the public has in them. Doctors could not engage in outright sabotage because it would go against the "does no harm" oath to which they swear professional allegiance.

In the *resisting* mode, doctors seek either to subvert or to slow down the managerialist intervention. *Resisting* is a pattern of behaviour that has two associated strategies: subverting and quibbling. The difference between the two is a degree of overtness and subtlety. The next subsection clarifies the concepts "subverting" and "deflecting".

4.3.4.1 Subverting

Subverting in this study means working to undo, undermine and undercut the managerialist threat to autonomy. This includes autonomy over the organisation of work, relative status, distribution of power, ability to deliver the best care, and the social norms of the profession or the participant as a person. Subversives are often well prepared. They study the relevant issues and present a formidable case, which managers and some of their peers can find scary. The subversive is one who takes a tool such as clinical governance and uses it to emphasise peer-to-peer accountability rather than clinician-to-non-clinician accountability. The dissenter is one who argues that the environment should be safe not only for patients but for doctors as well. For the dissenter, therefore, doctors should not give in to ever-increasing intensification of demands from managers. This person would remind doctors that, when things go wrong, they are held to account and that having been under pressure is not a valid excuse when a doctor is subject to a fitness-to-practice inquiry.

*"I have complained about the lack of bedside or mobile suction in our wards for some time. Only ITU, HDU and 1 other ward have 100% bedside suction. On numerous occasions I had graded it as bad and it likely went into an audit. But when I graded it as extreme, things happened. The management went ape sh*t. But one must be careful not to overdo it." (Consultant physician)*

The increasing use of guidelines and protocols reminds doctors that they have decreasing room to exercise independent judgement. The dissenter would argue that the European Working Time Directive (EWTD) applies to all doctors and not just junior doctors. Dissent takes place

within the moral constraints of daily work in a hospital. When attempts are made to reduce, for example, SPAs, the subversive doctor will reject these attempts by arguing that the SPAs are needed to support reflective clinical practice to improve services to patients. The same subversive will also back up the claims to provide material support for their positions.

There are further constraints to subversive options. Doctors, as a group, are not known to act in ways that put them at risk. They are a cautious group of people and tend to avoid "extremes" in dealing with social problems. They would expect that their colleagues would not easily join in action that might be considered ill advised, imprudent, crackbrained or foolhardy, particularly involving taking a stand in unison. So there are limits to the support that a subversive doctor could expect.

"What pisses me off most is the lack of balls and togetherness amongst doctors. We undermine each other, backbite, bitch, whine and moan about things in corridors and offices but do nothing about anything. We openly express our unhappiness about those who shit on us but no one does anything to stop this."

Another version of this is the argument:

"*Why bother? Resistance is futile."*

Generally, it is very hard to be an underground dissenter; i.e. a subversive. Doctors are often afraid of being caught. They have a lot invested in the system. Falling foul of the NHS can be professionally and personally disruptive and costly. The system has its ways of getting back at those who dare to step out of line. The NHS is largely a monopoly provider of healthcare services. Some hospital consultants do provide private healthcare services but they remain a small part of the overall healthcare delivery system.

Even if things become very bad and one decides to become a whistle-blower, professional and private consequences could be at least very unsettling, if not devastating.

"A whistle-blower will be hit hard by the management team, ostracised, put on indefinite leave, suffer reputational damage and reported to the General Medical Council. It is for the very brave." (Consultant)

Subverting is a very lonely path to follow.

"I have seen some people who were brave enough to take a stand against staff shortages, gaps in the rota, poor cooperation between departments and poor staff morale. People who take a stand and take on the management are demoted, silenced, disciplined and gagged. Doctors even frame these issues in terms of patient safety." (Consultant)

4.3.4.2 Quibbling

Quibbling means raising hair-splitting criticisms, moaning and groaning, and finding faults that others might overlook, with the aim of slowing down and impeding inapposite managerialist measures.

"I might not be able to stop this but I can whinge, yell, bleat but I am a prolific incident form filler. The ward management and clinical governance people do not always like me but I am concerned about patient safety and the quality of the service…" (Consultant oncologist)

The person adopting this behavioural strategy spends an inordinate amount of time on questioning issues of authority and legitimacy. Matters are seldom settled in meetings. On the contrary, this person is adept at agreeing and smiling in meetings and then in offices and corridors seeking to build coalitions that will revisit and possibly slow down if not overturn decisions.

Given the institutional memory of prior change initiatives and strategies that might have worked, quibblers wait for a change initiative to be sufficiently slowed down that it grinds to a halt, for the next change initiative to start or for the change to blow up. The belief is that managers and changes come and go while consultants have jobs for life. This strategy seems to be a more nuanced way of resisting passively.

"Managers come and go but being a consultant is a job for life." (Consultant)

"We have to find innovative ways to say NO." (Consultant microbiologist)

Consultants have become consummately skilled in putting spokes in the wheels of managers. Once a manager fails to move an initiative (or the invariably unending, sometimes contradictory set of initiatives) along, despite their lack of control over clinicians, these managers move on. These initiatives then die a quiet death before another ingenious management scheme is brought to life.

Those doctors for whom *resisting* is a viable mode weigh up whether things are as they had hoped or feared and whether the outcomes are as they had projected. They take account of the behaviours of the advocates of the managerial initiative and the positions adopted by their peers. They then review their own perceptions and may make adjustments to how they see things and what they do next.

Doctors who resist may find that there are *"quiet whispers in the ear that there are no prizes for doing the right thing. You will only be labelled as a troublemaker and be ignored." (Consultant nearing retirement)*

4.3.5 Limiting

In the *limiting* mode, greater acceptance of the inevitability of the changes is present than in the *resisting* mode. What matters is a degree of acceptance of and resignation to the changes but with the intention of finding ways around these changes. With the *resisting* mode there is opposition, with the aim of either subverting the managerial intervention or slowing it down. With limiting, the opposition is still there but it is moderated by a degree of acceptance and the attempt to create a detour around, avoid and stay away as far as possible for as long as possible. Some participants may choose first to resist passively but find that this does not work for them. Others may choose the *limiting* mode after *stabilising temporarily* because of their own distinct

personal inclinations, experiences, priorities and values. *Limiting* means looking for ways around problems. It involves lying low and faking ("facading"). The one-to-one engagement between the doctor and the patient could be said to facilitate this mode and its strategies.

"We can bleat and yell as much as we like but we will get only what the NHS will give us." (Consultant)

"The medical establishment has to sell the changes and in return they keep their clinical excellence awards and final salary pension schemes." (Consultant)

4.3.5.1 Lying low

Lying low is a pattern of behaviour aimed at limiting the impact of the change. This involves strategies such as taking cover, staying out of sight, not being noticed, going to ground, keeping quiet and walking in the shadows. This is a pattern of behaviour that seeks to buy time as one plays one's cards close to one's chest. A participant may be inclined to abide by the change, or even not abide but still have the freedom to exercise a limited choice. The key is not to be noticed by the advocates of change or by those from one's peers who may oppose the managerial initiative or those who are still sitting on the fence.

Medical practice allows sufficient room for this type of behaviour. Doctors see patients largely on an individual basis. Doctors often deal with patients behind closed doors with no one else around. What happens in theatres, some wards such as intensive care units (ICUs) and multi-disciplinary teams (MDTs) are more team based. But low-flying doctors have sufficient room in their daily practice to buy time either to comply or not comply without drawing attention to this.

4.3.5.2 Faking it

Masquerading is a strategy that involves making a show, giving the appearance of, going through whatever motions may be needed, or pretending to be complying. It is a paying lip-service strategy. People who adopt this strategy appear to say and do what is expected of them. They go to the right meetings, say the appropriate things enough to be noticed and agree as required. This is, however, all play-acting and pretending. They comply sufficiently not to be labelled as a troublemaker but not enough to be labelled an early sell-out by some of their peers. Doctors are aware of the constraints that people may face but they expect a bit of a fight even if they fake it for a little while at least.

This is a positioning strategy. Whereas flying low is about buying time to make up one's mind, faking it is about situating oneself so as to take advantage when the direction that the wind blows becomes clearer. *Faking it* means doing one thing in public and, sometimes, making one's feelings known in private.

The unending stream of meetings between managers and doctors where things are easily agreed on yet seldom executed thereafter allow for many occasions and circumstances for faking it.

As they go about their different roles as hospital consultants, doctors weigh up what is happening regarding managerial interventions and how this affects them. *Limiting the impact* weighing up is about how well the participant is doing at lying low, with the aim of buying time to decide which way to go, or faking it as a positioning strategy to take advantage of whichever way the wind is blowing. In the latter case the participant is more inclined to believe that management is likely to get its way so it does not help to store up trouble for oneself. If limiting the impact does not work as a strategy then there is an even greater acceptance of the inevitability of the managerial direction in which the hospital administration is going.

4.3.6 Adjusting to/living with Change

This is a mode of behaviour at the compliance end of the continuum. It is a defensive posture. It involves a re-examination, re-evaluation and reassessment of one's own subjectivities; i.e. priorities, values and beliefs. The main reason for adopting this mode of behaviour is that managerialism has been an on-going issue in hospitals for so long and the person who adopts this mode of behaviour believes that there is nothing one can do to stop or limit the impact of the change. Given that one cannot easily change jobs, this person believes that making the best of things is the way to go. Adjusting to, or living with, managerialism may require surrendering or changing one's perspective of the situation or even one's self-definition. But it means finding a new reason for going to work.

"It is a case of we are where we are. I have to move forward." (Consultant)

Adjusting to the change involves the strategies of *going with the flow*, *complying substantially*, *complying fully* and *waiting it out*. This pattern of behaviour is about following the path of least resistance. It seeks out open doors rather than banging on closed doors.

The individuals that adopt this mode of behaviour develop a keen sense of which way the wind is blowing and they prepare their sails accordingly. They make the very best of what is available. Many who take up lower-level clinical management jobs adopt this mode of behaviour. They take these jobs to know what is coming so that they can position themselves and protect their clinical sub-area. Those who do substantial amounts of private work may also take up this position. For them, it is important to know where things are going, be in the right place at the right time and be ready to take advantage of any opportunity that arises. They also cannot afford to be seen as being on the wrong side of management because private work often encroaches on NHS time. Even if the individual may have some residual reservations about the changes, their overriding interest is to maximise opportunities.

On the other hand, some people who adopt this behavioural mode may be just too tired and stressed to confront management changes. They have been ground down and the fun and joy in their work have long evaporated. They focus on doing the best that they can for their patients and on being available for their colleagues.

"Increased workloads and managerial interference and just being ignored over the years have left me exhausted. Sometimes it is like treading water and struggling to keep afloat. Coming to work is not always great."

4.3.6.1 Complying substantially

In this reconciling pattern of behaviour, the participant decides to comply with, surrender to and abdicate in favour of increasing and chronic managerialism. *Complying substantially* involves yielding to and falling in line with the proposed changes. However, compliance may not be 100%. The participant may not necessarily believe in the managerial project or in the competence of non-clinical managers but complies as is required. The participant could be someone who for all intents and purposes is compliant but is seething on the inside or has a heavy heart. However, some participants who adopt this strategy often shut out the anxiety that they experience.

"I cannot afford to rock the boat. I am the breadwinner as my husband earns substantially less than me. We have a mortgage and young children." (A & E Consultant)

"I choose to be a blade of grass in the wind and not an oak tree. How I feel is unimportant. When you work for the NHS you sign over your life." (Consultant physician)

"Banging your head against the wall achieves sweet f!k all. After a while you just give up on informing the CEO, MD and CD. You just do what you have to or move on in the hope that the grass is greener elsewhere. It is unlikely though." (Consultant surgeon)*

4.3.6.2 Complying fully

"I hope that this interview is anonymous." (Consultant paediatrician)

For some participants the fear of retaliation was visible in eyes overflowing with emotion. These participants may choose to do exactly as is required. Sometimes participants follow the rules completely either because they believe in them or because they are "dotting their I's" and "crossing their "t's". In the first instance, it is clear that they are fine with the change. Some people can work in any environment as long as they can deal with their patients, which is what validates them. They go to work for the sake of their patients. Whatever else happens they choose to tolerate it. For others who comply fully there may be a degree of resistance but for some reason they follow the changes to the letter.

The rise in litigation often means that participants adopt this posture as a means to defend themselves proactively. They fully comply with, for example, guidelines and protocols, despite some of their colleagues resisting "cookbook medicine". Fully complying, despite diminishing clinical autonomy, and affirming the managerial turn in hospital administration keeps one in the clear. It can result in less-than-optimal care or even more expensive care for patients. However, the overriding concern is surviving day by day and rolling with the punches. Others may follow the letter but not the spirit. One therefore could have an underground resistance operating in the citadels of compliance.

"*Working to rule, spending the necessary time with all the documents to slow down the system whilst technically promoting patient safety. However, time is money and money makes the hospital take notice." (Consultant)*

This mode of behaviour is different from the quibbling strategy in the *resisting* mode. Quibbling takes a more direct position. The two modes are positioned at different ends of the resistance-compliance continuum.

4.3.6.3 Waiting it out

"You can take being knocked back only so many times. After that you stop complaining about issues. Being accused of not being corporate sticks." (Consultant physician)

"My life at work can be described as working without enthusiasm. They have sucked the life out of me. I am no longer always the doctor that I had aspired to be." (Consultant surgeon)

"If you are working in an under-resourced area, after banging your head against the wall for so long then if you focus only on your work then you are accused of being indifferent. Yet no matter how hard you work you cannot do your job properly. There are problems with avoidable arrivals, some internal inefficiencies, and delayed discharges. Arrivals and discharge are the biggest problems." (A & E Consultant)

Waiting it out is a compliance strategy that is adopted by more experienced consultants, who often suffer from change fatigue and have become cynical or just plain tired of trying. They have given up on resistance, having banged their heads against the rising managerial wall for years on end, without much to show for it. They decide to do their best for their patients and be available for their colleagues, who may need their assistance. Beyond that they do not care. They have had enough. They are counting the days until they can proverbially hang up their white coats and stethoscopes. Even though they may have almost two decades to go, they are waiting for the day when they can draw their pensions. As for the regular meetings called by managers, they often arrive late. Their apologies are understandable because patients are the hospital's priority and there are always difficult cases to handle. Those who are aware know that it is waiting-it-out resistance but the management cannot do much about it because it is

framed in terms of professional norms and values. The adoption of this strategy also means that participants will hardly say anything in meetings. They have said enough over the years and have found that managers disregard their ideas and do whatever they want to do. Their silence is taken as consent but they have sufficient professional wiggle room to mask their private dissent.

"The vast majority of older consultants, including myself, are busy working out an exit strategy to retirement. We cannot wait to go." (Consultant nearing retirement)

"I have been an A & E consultant for more than 20 years. During nights and weekends on-call I can spend a long time on my feet. As I am getting older it can take a week or more for me to feel normal again. The future, the next 20 years before I will be allowed to retire, does not look too bright, does it? We are getting older and more tired and we are told to be more like a major supermarket chain, open 24/7. Guess what, hospitals are open 24/7." (A & E Consultant)

Table 4.1, in Section 4.4 below, summarises the GT that emerged from the data. In the left column is the weighing-up process, with the observed patters (modes) of behaviour in the right column.

4.4 SUMMARY

Table 4.1: Summary of the grounded theory: Rolling with the Punches

	OBSERVED PATTERNS OF BEHAVIOURS
	STABILISING TEMPORARILY
	RESISTING
	• Subverting
WEIGHING UP	• Quibbling
• Making sense	**LIMITING THE IMPACT**
• Deciding what to do	• Lying low
• Mode-shifting triggers	• Faking it
	ADJUSTING TO CHANGE
	• Going with the flow
	• Complying substantially
	• Complying fully
	• Waiting it out

Managerialism; i.e. performance management, financial management, standardisation of clinical practice, transparent accountability and competition between providers, emerged as the main concern of consultants in publicly owned acute NHS hospitals. Doctors are finding that the environment in which they practise is changing, they are increasingly losing control over diagnosis and treatment decisions and they are losing control over their profession. These changes pose challenges to the ways in which they see themselves and their roles in the hospital and the broader healthcare debate. The participants are dealing with this managerial turn in publicly owned acute healthcare hospitals by adopting a behaviour pattern that can be described as *Rolling with the Punches*. This pattern of behaviour is composed of four different modes of behaviour: *Stabilising Temporarily, Resisting, Limiting the Impact* and *Living with/Adjusting to* the change. The mode that the participants adopt is contingent on triggers that are dynamic over time. These triggers stimulate the key weighing up process. *Weighing up* involves two activities: interpreting the significance of what is happening and deciding what to do about it. Significance is a function of the personal filters of doctors because these determine meaning for them and shape what they can do. Doing something can involve more of the same strategy within a mode of behaviour or it can result in mode and strategy shift.

In the *Stabilising Temporarily* mode, the doctors just want to get through their work and develop the clinical leadership skills that are required of the duty consultant. In *Resisting* mode doctors try to subvert or slow down the increasing managerialism. In *Limiting the Impact,* they actively seek to constrain the impact of managerialism on themselves. Doctors adopt *limiting the impact* behaviours when *resisting* is not an option or is no longer feasible. *Adjusting to* (*Living with*) managerialism is the fourth mode of behaviour and is one in which they largely give up the fight and choose various compliance strategies. The mode of behaviour chosen depends on the on-going process of weighing up, which is the connecting link between the various modes. One mode of behaviour is not necessarily better or worse than any other. GT does not make value judgements about what people do. It only identifies patterns of behaviour.

The *weighing-up* process goes on all the time as doctors go about their daily work. They are constantly evaluating the changing situation at work against their own personal needs, values, priorities and prior experiences and they project potential outcomes of what is happening. The evaluation process determines their mode of behaviour and the tactics within that mode. This weighing up can lead to their staying in the same mode or changing strategies or modes. In each mode, the weighing up is different. The triggers for mode shifting may be the actual outcomes, the behaviours and choices of close colleagues and managers or even changes in personal circumstances. Mode shifts can lead to problems at work with either colleagues or managers but doctors avoid doing things that put their continued employment in the NHS at risk. They are always *Rolling with the Punches*.

This GT does not claim to represent all of the ways in which doctors are behaving. It is a theoretical account of the multiple ways in which doctors are dealing with their main concern. It

is a theoretical account that explains a preponderance of the behaviour of doctors. As a theory it fits, it works, is relevant and modifiable (Glaser, 1998). However, since a GT transcends time, place and person (Glaser, 2003), further research is needed to establish whether the theory fits other substantive contexts; whether its principal concepts continue to fit, work and remain relevant; and how the theory could be modified to optimise the emergent fit.

The next chapter presents the literature review.

CHAPTER 5 LITERATURE REVIEW

5.1 INTRODUCTION

It should be noted that one could skip this chapter and proceed to Chapter 6 after having read Chapter 4. That would avoid the idea of obvious repetition between Chapter 5 and Chapter 6. However, the two Chapters serve different purposes. Chapter 5 reviews the literature that had been delimited by the grounded theory in Chapter 4, on a standalone basis. Chapter 6 integrates the grounded theory (Chapter 4) and the literature review (Chapter 5).

This literature review develops a relational view of what it means to be a hospital consultant in a wicked, complex institutional environment. It argues that the contradictions, tensions, ambiguities and paradoxes in the acute hospital are constructed and not given. From the literature, our understanding of the theoretical implications for the individual actor at the intersection of the aforementioned issues requires a close examination and appreciation of structure, agency and observed behaviours as contingent, fluid and historicised. It opens new practice-oriented ways of theorising and researching about structure, agency, institutional logics and institutional work. From the literature review emerges a conceptual model of structure, agency and routine practices that shows how unstable and complex structures shape, constrain and stimulate various interacting dimensions of agency. These dimensions underpin observed practices with a loop backwards again, with modes of practice instantiating agency, which, in turn, iteratively creates structures.

This literature review does the following:

- It provides a short overview of the classic GT perspective of the doing of a literature review.
- It examines the social organisation of healthcare as a wicked problem because of fundamental and inalienable difficulties in organising healthcare delivery. The acute hospital, which is the workplace of the hospital consultants, is framed as a complex adaptive system. Wickedness and complexity theory are important because of the linear, rational and reductionist management approaches that have been used to organise healthcare delivery over the past three decades. Wickedness and complexity are then situated within the context of the institutional complexities of the managerial transformation of the acute hospital. These two issues pose fundamental challenges to the performance-management system within the managerial acute NHS hospital.
- It reviews literature on professionalism and the sociology of professions and examines an institutional approach to professionalism to show how medical professionalism is to be understood contrapuntally in light of other competing logics in the institutional field. It shows how there is not really a pure unadulterated medical professionalism but

rather a medical professionalism within an organisational context that is fundamentally different from that of a sole practitioner running a corner shop.

- It takes some conceptual tools from the Foucauldian toolbox to see how structures shape and frame agency. The focus is on changes in the technologies of control over time. These technologies of control are not necessarily hegemonic in that as much as they shape and constrain agency they do stimulate and leave room for resistance. So from Foucault the literature examines power and resistance. Resistance is forensically studied at the points where technologies of control are translated into policies and procedures.
- It examines literature on routine resistance to see how people respond to technologies of control when the elites do indeed have the power of retaliation. Thus, it studies everyday agency within a context of power.
- It takes a close look at institutional theory because this theory has become a significant lens through which to study organisations.
    - An archetypal approach to institutional theory provides a useful conceptual tool for framing the relative extents and ways in which structures, decision-making systems and interpretive schemes have changed or not. This is an important section because it provides a sense of the flux, contingency and historicity of structures, power and agency. However, one will not really get a clear picture of the difficulties with changing interpretive schemes until one takes account of some of the ideas from wickedness, complex adaptive systems, Foucault's power and resistance, routine resistance and the next section on institutional complexity.
    - The section on institutional complexity shows how an institutionally complex field with a constellation of logics creates structures that are fluid and potentially contradictory, thus shaping, constraining and stimulating the agency of actors in complex and non-linear ways. Relations between institutional logics are not considered as given but are *constructed* as congruent or contradictory.
    - A more multi-dimensional, interactional, and therefore nuanced, understanding of agency follows since it underpins the modes of practice and observed behaviours. This literature review is that of a GT study. It started from the patterns of observed behaviours and these weave their way back as instantiations of a multi-dimensional and dynamic conceptualisation of agency, which iteratively feeds back as the micro-iteration of the institutionally complex structures that are found in the institutional field. It, thus, explicates the nature of intentionality by taking a closer look at institutional work; i.e. creating, maintaining and disrupting institutions within the context of the earlier parts of the literature review.

5.2 A CLASSIC GROUNDED THEORY APPROACH TO THE LITERATURE REVIEW

This literature review was an opportunity to reconnect the study of organisations, the sociology of professions and institutional theory. In contrast to non-classic GT studies, I did not begin the study with a review of these bodies of literature at all and embedding research questions within existing bodies of knowledge. As was described in Chapter 3, the place and role of a literature view are different in GT studies. The main literature review was conducted after principal elements of the theory had emerged. It may be useful to recall the classic GTM view of literature.

"Grounded theory's very strong dicta are

a) *Do not do a literature review in the substantive area and related areas where the research is being done,* and

b) When the grounded theory is nearly completed during sorting and writing up, then the literature search in the substantive area can be accomplished and woven into the theory as more data for constant comparison." p.360 (Glaser, 1998; Holton, 2008).

Thus, I did not study the literature until the GT had emerged and I was writing it up. This ensured that the main concern and its continual resolution remained the focus of the research and not my preconceptions as the researcher or the preconceptions of other experts in the field. The GT, *Rolling with the Punches*, delimited the literature review. It ensured that time was not wasted on literature that was potentially irrelevant. It also promoted possibilities for consulting literature from a wide range of substantive areas – as is evidenced in the introduction to this chapter – thus enhancing the possibilities for novel insights from the literature (Holton, 2009). Literature was considered as data to be compared to the emerging theory (Glaser, 1998). The literature was reviewed after conceptual memos had been sorted and the core category – *Rolling with the Punches* – had emerged.

During the literature review, I consulted a number of databases via the Wits University gateway to electronic resources. Given the complexity of the theory, I identified a number of substantive areas of study that could be relevant to the GT. These included organisational theory, institutional theory, sociology of professions, organisational change, role ambiguity, paradox, resilience, stress and coping, routine workplace resistance, NPM, professional boundaries, medical dominance, medical regulation, medical autonomy, professional self-regulation, institutional logics, wicked problems, routine resistance, critical organisational theory and discourse theory. They were not all identified from the start but emerged as the literature review proceeded. Most of the literature was from refereed journals. Some government documents and reports for quasi-government agencies and think-tank reports for government and its agencies were also consulted.

I examined areas where the literature supported the emerging GT and other areas where there were tensions and which therefore required adjustment of the GT through the addition of new concepts and/or reframing of theoretical codes (Glaser, 1998). A GT is not a statement of truth but a probability statement of relationships between concepts. Thus, it should be modifiable in the constant comparative process with new data. The openness of classic GT means that I could look for literature in multiple substantive areas that might be relevant to the emerging GT.

5.3 WICKED PROBLEMS, COMPLEXITY AND SYSTEMS THEORY

This section of the literature review examines wicked problems and complex adaptive systems.

Problems can be seen as being on a continuum from tame to messes to wicked problems (Austrailian Publis Service Commission, 2007; King, 1993). Tame problems are problems where the definition of, and solution to, the problem can be readily agreed on even if it is very difficult to get to that agreement. Reductionist linear approaches can be used in which data is gathered, the problem is framed, options are identified and a solution is chosen and implemented; e.g. working out the chemical components of air pollution (Conklin, 2006b; King, 1993). Messes are problems that require a systems approach to solve them because one needs to understand how these problems fit in with other parts of the system. An example of this type of problem would be vehicle congestion on highways (King, 1993). There are no easy answers to messy problems, so calls for "taking the tough decisions" may have more rhetorical than practical value. Wicked problems (Conklin, 2006a; Rittel & Webber, 1973) are messy problems with significant social and political complexity (King, 1993). Linear, reductionist, mono-disciplinary, expert-driven approaches are inappropriate ways to "solve" wicked problems. In the discussion below better ways of dealing with wicked problems are discussed.

In order to understand the behaviours of hospital consultants, it is useful to examine:

- The wickedness (Conklin, 2006b; Rittel & Webber, 1973) of the social organisation of healthcare (Raisio, 2009; Vartiainen, 2005);
- Healthcare as a complex field (Macfarlane, Barton-Sweeney, Woodard, & Greenhalgh, 2013) with intricate links with non-medical issues such as socio-economic status, stressful life events, social relationships and isolation (Wallace & Wallace, 1997). It helps to see problems as being on a continuum from tame to messes to wicked problems (Austrailian Publis Service Commission, 2007);

1. The hospital as a complex organisation (Godfrey, Nelson, Wasson, Mohr, & Batalden, 2003; Karasek, 1979; Nelson et al., 2003; Nelson et al., 2002; Shiell, Hawe, & Gold, 2008).

5.3.1 The Organisation of Healthcare Delivery as a Wicked Problem

The social organisation of healthcare delivery could be considered to be a simple problem to which rational, linear – or tame – solutions could be applied (Austrailian Publis Service Commission, 2007; Rittel & Webber, 1973). This is what the NPM managerial approach (Clarke

& Newman, 2006; Hood, 1991) healthcare delivery in the NHS suggests. One's approach would be to employ experts from the private sector, develop good models of demand, take account of available resources, set priorities and then manage the numbers (Raisio, 2009; Vartiainen, 2005). Better (i.e. private sector) management presumably leads to a better healthcare delivery system. This has, of course, been the approach in the NHS since the 1980s (Griffiths, 1983). Despite more than three decades of private sector management since the Griffith management revolution (Greener, 2002; Veronesi, Kirkpatrick, & Vallascas, 2013a), the NHS is still saddled with huge problems of how to organise the delivery of high quality, efficient and effective healthcare (Appleby, Thompson, & Jabbal, 2015). An alternative to the linear, tame, reductionist approach to healthcare organisation is that of wickedness (Conklin, 2006b; Rittel & Webber, 1973). "Wickedness" in this context does not refer to a moral deficiency but rather to the cognitive ambiguity, uncertainty and social complexity of the problem "definition", potential "solutions" and the implications for hospital consultants on a day-to-day basis as they go about their work of treating patients.

Cost pressures, demographic and technological (IT), led to NPM public sector management reforms (Dent, 2003; Ferlie et al., 1996b; Hood, 1991). Hospitals are targets of such reforms because of their central role in healthcare delivery, the high proportion of the healthcare budget that they absorb and the difficulties in coordinating the administrative, caring and curing roles that they embody (Glouberman & Mintzberg, 2001). Low socio-economic status (Phelan, Link, & Tehranifar, 2010), stressful life events – including chronic strain and trauma – (Thoits, 2010), social relationships (Umberson & Montez, 2010) and social construction of illness (Conrad & Barker, 2010) are some of the non-health factors that influence health (Wallace & Wallace, 1997). This makes it unclear how better management of the acute hospital will be sufficient to improve the way the institution functions and provide appropriate outcomes for patients. Health status is affected by housing, transport, education, social welfare and poverty-relief policies (Paton, 1995). How do better management techniques of the broader healthcare system and in the hospital address the problems posed by patients who are obese, are socially isolated, live in toxic neighbourhoods, have substance abuse issues and perhaps suffer domestic violence? Management reforms are not only rational planning exercises that could be designed and implemented by groups of experts (Roberts, 2000) as the independence, interdependence, non-linearity and emergence make management reforms difficult (Barach & Johnson, 2006; Holland, 1992).

As noted earlier, tame or simple problems are those where the problem definition, the solution and the implementation processes are clear and unambiguous. Simple problems are also called "Type 1 problems" (Roberts, 2000). These are the types of problems that can be disaggregated, solved in parts and left to a few experts (King, 1993). Even building a most modern passenger aircraft can be seen as a tame problem. It is, indeed, technically complex but the project – as a whole – can be broken down into a number of constituent tame problems. As each individual problem is solved then the problem as a whole is solved. Messes require that one takes cognisance of the inter-linkages between parts to get an idea of how the whole functions (King,

1993). For messes, it may take time to understand how things fit together but agreement is possible. For as long as it is possible to develop consensus on what the problem is and what a solution might look like, then in the end linear, rational, albeit holistic, approaches can still be used (King, 1993). When problems are such that the definition and proposed solutions depend on one's perspective then no optimal solution is possible. Consensus on problem definitions and solutions that involve multiple stakeholders from different constituencies is unlikely. Wicked problems have a single irreducible feature of radical dissensus (Raisio, 2009, 2010) and consensus is not possible (King, 1993). It is found in other situations as well. For example, how does one tackle issues such as crime, child poverty, terrorism and global warming? Conklin summarises Rittel and Webber's criteria (1973) into six features while retaining the essence of their characterisation (Raisio, 2010), as detailed below.

1. You don't understand the problem until you have developed a solution.

A wicked problem is one where the cause of the problem, and therefore its solution, depends on one's perspective (Rittel & Webber, 1973). Wicked problems do not have a set of off-the-shelf solutions for them. Every solution that one attempts helps to clarify the problem at hand. Hence, an understanding of the problem and possible solutions are mutually implicated (Conklin, 2006a). Thus, what are the causes of ill health?

2. Wicked problems have a "no stopping" rule.

Wicked problems do not have an end-point where the problem is solved. One usually stops when resources run out (Conklin, 2006b). In healthcare, reforms have usually followed one after the other (Raisio, 2009; Vartiainen, 2005). In the NHS, there is a history of managerial interventions in the healthcare system that has resulted in a policy hybrid due to the multiple, often contradictory attempts by experts to address the issue of the social organisation of healthcare delivery (Allen, 2002; Checkland, Snow, McDermott, Harrison, & Coleman, 2011; Crilly & Le Grand, 2004; Exworthy, Powell, & Mohan, 1999; Ferlie & McGivern, 2013; Kirkpatrick, 1999; Sullivan & Skelcher, 2002a). And an optimal solution has not been found. In fact, it might never be found.

3. Solutions to wicked problems are not right or wrong.

Solutions to wicked problems are never right or wrong. Some solutions are just better or worse than others. No objective way to determine the quality of a solution exists because there are multiple stakeholders – with their own objectives, criteria and priorities – with equally valid perspectives (Conklin, 2006b). Patient choice (Pollock et al., 2011). Provider competition (Bartlett, Propper, Wilson, & Le Grand, 1994b; Le Grand, 2009a; Propper et al., 1998) militates against the need for cooperation in dealing with wicked problems. One-size-fits-all, universally applied performance management systems do not deal with the complexity and embeddedness (Greener, 2003; Pollitt, Harrison, Dowswell, Jerak-Zuiderent, & Bal, 2010) associated with wicked problems in healthcare organisation.

4. Every wicked problem is essentially unique and novel.

Social complexity makes superficially similar problems actually unique. Small details can be significant. Given the multiple perspectives – each of which contains a grain of the truth (Roberts, 2000) – at play, small may be relative when it comes to wicked problems.

5. Every solution to a wicked problem is a "one-shot operation".

Despite the difficulties in defining the problem, one has to try to solve the problem in terms of what one believes the solution to be. The planner has no right to be wrong (Rittel & Webber, 1973). Every intervention has consequences that may be difficult to undo and changes the nature of the problem and the solutions that follow.

6. Wicked problems have no given alternative solutions.

Given the difficulties in defining what the wicked problem might be, it becomes hard to see what possible solutions could be tried. The problem and the solution are mutually constituted. Interventions in wicked problems cannot be tested before they are implemented. Feedback loops and sub-problem interactions often lead to waves of unintended consequences (Conklin, 2006b; Weber & Khademian, 2008). Widening a highway to ease traffic congestion might do exactly that but it could also result in even more traffic congestion. Similarly, building a hospital is based on certain assumptions and once that hospital has been built one has to deliver healthcare within given physical constraints. Hence, one needs to have the broadest input from relevant stakeholders (Checkland, 1999; Raisio, 2009, 2010). Wicked problems demand a preparedness to deal with uncertainty, ambiguity and discovery (Klein, 1999, 2011).

5.3.2 Summary of Literature on Wicked Problems

The wickedness of problems does not mean that one should despair (Raisio, 2010). On the contrary, it requires that one acknowledge the nature of the problem at hand and learn to structure interventions accordingly (Austrailian Publis Service Commission, 2007; Shiell et al., 2008).

Wicked problems defy rational and linear approaches and require an ability to deal with ambiguity and uncertainty. These problems cannot be tamed (Conklin, 2006b; Roberts, 2000) let alone solved by experts. A process that starts with defining the problem, gathering data, determining options, deciding on a solution and implementing the solution, and ends with evaluating the solution is inappropriate in dealing with wicked problems (Conklin, 2006b). Yet, that has been the case with the provider competition, patient choice and money following the patient, bureaucratisation, standardisation, targets, sanctions, performance management, transparent accountability and the use of audit technologies in the management of the acute hospital. Wicked problems are social problems because appropriate ideas about the problem and the solution are likely to emerge in an approach that is open, collaborative, consultative and

emergent because there are no final problem definitions or solutions. The management of wicked problems requires the application of an open collective mind (Weick & Roberts, 1993), collective intelligence (Zara, 2005), a shared understanding (Conklin, 2006b) and public deliberation (Raisio, 2010).

The process of dealing with wicked problems suggests managing by discovery rather than managing by objectives (Klein, 1999, 2011). Wicked problems are best addressed by involving all relevant stakeholders. They require a process that allows all who have material interests in the matter to be involved in framing and considering the relevant policy options and to consider the merits of each option patiently and unhurriedly in the light of multiple and often conflicting values, beliefs, assumptions and priorities (Raisio, 2010). With wicked problems, every perspective can be considered to contain a grain of truth (Roberts, 2000) and the best solution is merely an on-going accomplishment of dialogue and deliberation. At this point one should stop and take account of my philosophical and epistemological perspectives that I had outlined in Chapter 3. The deliberate involvement of all stakeholders allows one to better manage the inherent fragmentation that is associated with wicked problems (Conklin, 2006b). Experts can play a role in that they could help to frame and work with the inputs of the different stakeholders, who are likely to come from different sectors and organisations (Austrailian Publis Service Commission, 2007). But experts cannot lock themselves up in a room when they set out to reach solutions after which smoke emerges from the chimneystack. Since the 1980s significant stakeholders have been excluded from the healthcare policy-making process (Kirkpatrick & Ackroyd, 2003b; Klein, 2013). Between 2000 and 2014 healthcare reform in the NHS experienced a revolving door between healthcare policy-making structures and management consulting firms (Leys & Player, 2011; Oliver, 2014). Wicked problems involve changes in behaviours of people (Austrailian Publis Service Commission, 2007). The deliberative involvement of all stakeholders in the processes of farming the problems and the solution (Raisio, 2010) is indispensable to making progress with wicked problems.

5.3.3 Complexity Theory

Concepts from systems analysis could be used to analyse complex organisations (Checkland, 1981; Perrow, 1986). These include subsystems which act independently and in parallel, while constantly reacting to what is happening in other subsystems and in so doing shaping the behaviour of the whole system (Holland, 1992; McKelvey, 1999). Decisions are made independently within each self-organising subsystem so that the overall behaviour of the system is the result of the decisions made and reactions to what is happening within subsystems (Waldrop, 1994). A water molecule is made of one oxygen atom and two hydrogen atoms. When millions of water molecules are put together in the same container, they acquire a collective property (i.e. liquidity) which a single water molecule on its own, does not have. Liquidity is an emergent property (Waldrop, 1994). Emergence means that the whole structure is more than the sum of its parts (Checkland, 1981). Independent subsystems interact with one another and have linkages with, and feedback loops to, other similarly independent subsystems.

Hence, a non-linear relationship exists between inputs and outputs so that small inputs can have significant outputs. Also, large inputs could have negligible outputs. Cause and effect relationships are not readily identified in a complex adaptive system. Figure 5.1 illustrates the dynamics of a complex adaptive system.

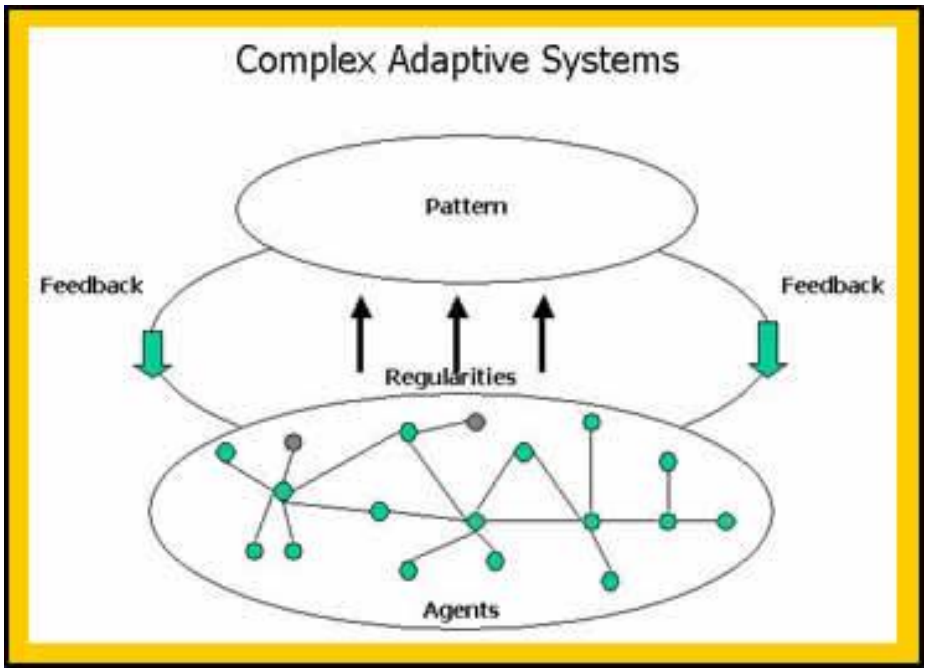


Figure 5.1: A simple representation of the components of a complex adaptive system (Fryer, 2001)

Healthcare systems operate as complex adaptive systems. The community, primary, secondary and tertiary healthcare subsystems function independently and interdependently. Feedback loops between subsystems ensure that whatever happens in any one subsystem affects every other subsystem. Non-linearity between inputs and outputs and emergence characterise the behaviour of the system as a whole (Anderson, 1999; Edgren, 2008; Gatrell, 2005). A process of dynamic exchange of information and mutual adaptation (Waldrop, 1994) takes place between the healthcare and the broader system of government within which it is embedded. Many of the things happening in social welfare, transport, education and housing affect the healthcare system. This was discussed in Section 5.3.1 on wickedness. Complex adaptive systems operate with very few simple rules. They are self-organising systems; hence, command and control strategies do not easily work in this type of environment. The implications of a complex adaptive systems approach make it difficult to see how rational, linear, reductionist NPM techniques might solve some of the intractable issues of resource utilisation and coordination in healthcare (Glouberman & Mintzberg, 2001; Mintzberg & Glouberman, 1997).

An acute hospital, similarly, is an interdependent network of hierarchically embedded, autonomous, self-organising subsystems or clinical and non-clinical micro-systems (Godfrey et

al., 2003; Kauffman, 1993; Nelson et al., 2003; Nelson et al., 2002). Self-organisation, non-linearity and emergence are fundamental features of its spatio-temporal rhythm (Carley, 1998; McKee & Healy, 2002; Shiell et al., 2008). In order to act on a complex system, one must first recognise the fact and the nature of that complexity (Checkland, 1999). Self-organisation, interaction, feedback loops and non-linearity have implications for how one conceives the imposition of structure and order (Dooley, 1997). This makes the history of the complex system irreversible and the future unpredictable (Holland, 1999). Studying the past to determine causal relationships may not be particularly helpful for complex systems.

A key text about professional bureaucracy argues that significant power is vested in the hands of professional experts and managers play only a supportive role (Mintzberg, 1978). The overriding assumption in this text is that professional and administrative values were incompatible and that professional values were dominant. A hospital is a professional bureaucracy with a multitude of professional groups that take frontline roles in organising and delivering services to clients while being loyal to their subgroups rather than the organisation as a whole (Crilly & Le Grand, 2004; Dickinson, Ham, Snelling, & Spurgeon, 2013b; Martin, Currie, & Finn, 2009). The managerial hospital turns the power relations of a professional bureaucracy upside down.

Wickedness and complexity raise issues for our understanding of healthcare reform. As theoretical lenses, they challenge fundamental assumptions about the ways in which healthcare delivery should be organised. It brings into sharp relief the roles of hospital doctors in that process. Ambiguity, paradox, non-linearity, emergence and living with uncertainty abound within wicked problems and complex adaptive systems. How appropriate is the business-like culture of performance management (C. & Bouckaert, 2011; Exworthy, 2010a; Smith, 2002b)? How does one reconcile wickedness and complexity on the one hand with performance indicators, targets, benchmarks and league tables (Carter, Klein, & Day, 1992; Healthcare Commission, 2004) on the other hand?. Over time the one-size-fits-all performance management culture has been criticised (Sheaff et al., 2003; Talbot, 2009) but to no avail. The English NHS performance system has remained centrally controlled and it does not take into account the wickedness, complexity and embeddedness of the organisations and actors. The result is that the system is "gamed" at local levels or if actors do comply with the centrally imposed demands then local priorities are distorted (Bevan & Hood, 2006; Exworthy et al., 2010b; Greener, 2003).

Over time, in a complex organisation like an acute hospital multiple logics have settled one on top of the other within the acute hospital (Exworthy et al., 2010b; Reay & Hinings, 2009; Sullivan & Skelcher, 2002b). This is that one creates an unstable, ambiguous and sometimes absurd business environment (Eisenhardt, 2000). The resultant paradoxes imply that the efforts to control the clinical frontline with vertical accountability measures, lateral standardisation of clinical practice and an increased commercial orientation may not be as complete as the policymakers and managers may have intended. The wickedness (Austrailian Publis Service Commission, 2007; Conklin, 2006b; King, 1993; Raisio, 2009; Rittel & Webber, 1973; Vartiainen,

2005) and systemic adaptive complexity (Holland, 1999; Waldrop, 1994) of the organisation of healthcare delivery systems have perhaps not been adequately recognised in the managerial hospital. Rationalisation, standardisation and commodification (Harrison & Ahmad, 2000a; Kuhlmann, 2006; Timmermans & Berg, 2010) appear to clash fundamentally with wickedness and complex adaptive system features. These are some of the inputs into the framing of both the main concern and its routine resolution.

The next section of the literature review examines some of the literature on professionalism.

5.4 PROFESSIONALISM

This part of the literature review focuses on medical professionalism. It examines professionalism not in terms of abstract debates (Levenson, Atkinson, & Shepherd, 2010; RCP, 2005) but as it is enacted and instantiated in the real world by doctors themselves. *Rolling with the Punches* is a GT of medical professionalism in the managerial hospital. It therefore delimits the examination of the literature for this study. The routine enactment of medical professionalism is viewed as an instantiation of the resolution of the main concern of the participants of this study.

5.4.1 Medical Professionalism as a Logic

Professionalism can be seen as a logic; i.e. "socially constructed, historical patterns of material practices, assumptions, values, beliefs and rules" (Thornton & Ocasio, 2013; Thornton, Ocasio, & Lounsbury, 2012). It provides legitimated rules of the game and criteria for appropriate, goals, the means to achieve them and suitable behaviours. Hence, professionalism should be studied as a form of institutionalisation (Muzio et al., 2013; Suddaby & Viale, 2011). It has normative value over and above its technical value (Muzio et al., 2013; Selznick & Rosen, 2011). This review of medical professionalism examines critical issues from the sociology of professions within an institutionally complex organisational context (Battilana & Dorado, 2010; Greenwood et al., 2011; Pache & Santos, 2010) with its constellation of logics (Goodrick & Reay, 2011). From a macro-institutional perspective one could map how these logics are embodied as structures that shape and frame the agency of hospital consultants, which in turn underpins their everyday behaviours (Battilana & Dorado, 2010; Greenwood et al., 2011; Kraatz & Block, 2013; Pache & Santos, 2010; Pache & Santos, 2013b; Smets et al., 2012). This study examines medical professionalism as it is routinely enacted on the clinical frontline in the acute hospital from the perspective of the everyday behaviours of the professionals themselves because this is what the GT revealed. How do their modes of behaviour (Smets & Jarzabkowski, 2013a) as material practices, assumptions, values, beliefs and rules (Thornton & Ocasio, 2013) represent and instantiate medical professional agency (Delmestri, 2006; Emirbayer & Mische, 1998; Powell & Colyvas, 2013; Powell, 2008)? Furthermore, the study explores how their multi-dimensional and dynamic agency (Emirbayer & Mische, 1998) iteratively creates the content and contours of medical professionalism as a structure and logic (Suddaby & Viale, 2011) within

a complex environment. How does medical professionalism contrapuntally (Said, 1993) find its character within a context of wickedness, complex adaptive systems, institutional complexity and a constellation of logics?

Rolling with the Punches is an embedded account of medical professionalism. It concurs with the need to conduct studies at the coalface of institutionalism (Barley, 2008) and for the close analysis of the behaviours of the inhabitants of institutions, who are the heartbeat of institutionalism (Hallett & Ventresca, 2006). Thus, the focus has been on these inhabitants' ways of talking and behaving in the face of managerial rationalisation, performance management, and financialisation of the service, standardisation of clinical practice and commodification and commercialisation of hospitals.

Professionals and the organisations in which they work play an important role in contemporary knowledge-based societies (Brock et al., 2014; Muzio & Kirkpatrick, 2011; Scott, 2008c). Liberal professions – in western societies – are historically based on professional autonomy; collegiality; self-regulation of the definition, organisation and evaluation of their work; and occupational control (Cooper & Robson, 2006; Reihlen & Mone, 2012; Suddaby, Greenwood, & Wilderom, 2008). Professionalism is an identity that is acquired through rigorous training to master a body of knowledge, further in-service training and socialisation (Exworthy & Halford, 1999). Autonomy has been justified on the basis of an indeterminate expertise that requires professional knowledge to understand it (Abbott, 1988; Freidson, 1994). However, sociologists have failed to agree on a definition of what are the criteria of a profession except to agree that they constitute a way of working and control that is different from that found in hierarchical and industrial work settings (Evetts, 2003, 2012).

Professionalism that is enacted within an organisational context (Faulconbridge & Muzio, 2008; Muzio & Kirkpatrick, 2011; Suddaby & Greenwood, 2009; Suddaby & Viale, 2011; Waring & Currie, 2009) is constrained by goals such as organisational efficiency (Flynn, 1999). How is professionalism instantiated on an everyday, routine basis so that its meanings emerge from social interaction (Blumer, 1971; Hughes, 1971) as the material enactment (Thornton et al., 2012) of a professional logic amongst a constellation of logics (Goodrick & Reay, 2011)? The meanings of medical professionalism are not given but are crafted in social interaction (Berger & Luckmann, 1967; Blumer, 1971; Hughes, 1971) on a routine basis from the interdependencies and contradictions (Battilana & Dorado, 2010; Friedland & Alford, 1991b; Pache & Santos, 2010) in an institutionally complex workplace (Greenwood et al., 2011). Medical professionalism would be but one of the logics that are carried by the participants (Delmestri, 2006; Jepperson, 1991; Zilber, 2002) and it would have traces of wickedness, complex adaptive systems and institutional complexity (Goodrick & Reay, 2011; Greenwood et al., 2011; Smets & Jarzabkowski, 2013a). Thus, medical professionalism will emerge as fluid, non-foundational, contingent, relative and historicised (Muzio & Kirkpatrick, 2011; Noordegraaf, 2011; Thomas & Hewitt, 2011; Waring & Currie, 2009). This is why there may not be one way, or a best way, to be a medical professional within the managerial acute hospital.

5.4.2 Sociology of Professions

The sociological study of professions covers three major eras as detailed below.

The functionalist perspective dominated the first era from the 1950s (Etzioni, 1969; Goode, 1957; Parsons, 1954; Turner & Durkheim, 1957). Functionalists, especially Parsons, hold the view that professions play an important role in bringing order and structure to parts of complex and modern societies. Since it can be argued that professions are more than just technical approaches to problems (Selznik, 1957), therefore they have roles as institutional logics (Thornton & Ocasio, 2013). As institutional logics, professions are "socially constructed historical patterns of material practices, assumptions, values, beliefs and rules by which individuals produce and reproduce their material subsistence, organize time and space and provide meaning to their social reality" p.804 (Thornton & Ocasio, 1999). In the 1970s, the functionalist perspective was criticised for having adopted an uncritical view of the roles of professions in society (Turner & Samson, 1995). Functionalists have also been censured for uncritically adopting the views of the professions and for ignoring the importance of power and the protection of professional interests and privilege.

The second era – from the 1960s onwards – was suspicious of the functionalist perspective. Instead, it critically examined the functionalist perspective with accounts such as professional domination (Freidson, 1970, 1985, 1994), the professional project (Larson, 1979a), the jurisdictional disputes that involve professions (Abbott, 1988) and the idea of a congruence of interests between knowledge and power. Concerning the latter, it focused on how a *knowledge-power nexus* (Foucault, 1977) operates to shape and control the subjectivities and choices of autonomous individuals (McHoul & Grace, 2002; Miller & Rose, 2008) through procedures that rationalise, standardise, commercialise and commodify delivery procedures. Professional norms shape the choices and behaviours of those within its jurisdiction (Fournier, 1999; Reed, 2002). Professional projects could be integral to the enterprises of the state and, similarly, knowledge elites often serve the interests of power (Johnson, 1972). This was arguably the case with the establishment of the NHS as a key part of the welfare state after World War II (Clarke & Newman, 2006). The managerial transformation of the hospital continued the project of the creation of the congruence between power and professional interests. The NHS as a professional bureaucracy (Mintzberg, 1978) was an example of an organisation in which professionals played a dominant role in delivering services and organisation control and were deemed essential to the stability of the state (Ackroyd, Hughes, & Soothill, 1989). Thus, it represented a congruence of the interests of the state and the medical profession (Klein, 2013). The sociology of professions in this era sketches a canvass that goes from an instrumental view of professions to a critical perspective of a group of very skilled people who seek to find ways of meeting their own private interests while claiming to serve a public interest agenda. The dominance perspective, within the critical accounts of professionalism, however, does not account for the challenges of professionals working within organisations (Brock et al., 2014; Suddaby & Viale, 2011).

The third era – from the 1980s onwards – is concerned with the enactment of professionalism within organisations. Organisations have become primary spaces for the enactment of professional agency (Brock et al., 2014; Cooper & Robson, 2006; Suddaby & Greenwood, 2009). How do the issues raised in the critical sociology of professions (Abbott, 1988; Freidson, 1970, 1985; Johnson, 1972; Larson, 1979b) play out as organisational issues around contestation for resources, spaces, routines and practices that frame routine work practices (Faulconbridge & Muzio, 2008; Muzio et al., 2013)? Moreover, how does the managerial professional workplace – increasing formalisation, standardisation, transparent accountability and commercialism (Clarke & Newman, 2006; Cooper, Hinings, Greenwood, & Brown, 1996; Hood, 1991) – reshape professional concerns such as autonomy, occupational control and collegiality? How does collegial, self-regulating medical professionalism find its content and boundaries within a corporate and managerial hospital (Ashburner, Ferlie, & Fitzgerald, 1996; Dent, Howorth, Mueller, & Preuschoft, 2004; Kitchener, 1998; Reay & Hinings, 2005, 2009; Scott, Ruef, Mendel, & Caronna, 2000)? Does it necessarily lead to deprofessionalisation (McKinlay & Stoeckle, 1988), proletarianisation (Haug, 1973, 1988) or restratification (Freidson, 1985)? What about the possibilities of coexistence, mutual reconstitution, sedimentation and hybridisation (Cooper et al., 1996; Goodrick & Reay, 2011; Reay & Hinings, 2009)?

The persistence of professional forms of organisation among workers with expert knowledge is found in the literature (Crilly & Le Grand, 2004; Currie & Suhomlinova, 2006; Dickinson et al., 2013b; Kipping & Kirkpatrick, 2013). The question is not whether the constellation of logics (Goodrick & Reay, 2011) is compatible in the abstract (Besharov & Smith, 2013) but how the relationships between logics, including professionalism, are constructed at the coalface of institutionalism (Barley, 2008) by the inhabitants of institutions (Hallett & Ventresca, 2006). How do the carriers of the logics (Delmestri, 2006; Jepperson, 1991; Zilber, 2002) understand their professionalism within a constellation of other logics (Goodrick & Reay, 2011)? How are the meanings of professional autonomy, control and collegiality negotiated in the routine, everyday lives of medical professionals? That is the focus of this section of the literature review: how professionalism is routinely institutionalised (Smets & Jarzabkowski, 2013a; Smets et al., 2012; Thornton et al., 2012) in this institutionally complex environment (Greenwood et al., 2011). Professional autonomy is a paradoxical phenomenon (Clifford, 1981; Thomas & Davies, 2005). It invites surveillance because it works in opposite directions from the vertical accountability and standardisation of professional practice (Cooper et al., 1996) of the managerial hospital. Yet, it is also a site of resistance for an organisation that depends on expert frontline staff; i.e. street-level bureaucrats (Lipsky, 2010), to deliver services to patients.

Since the organisation is a primary site for professional agency (Ackroyd & Muzio, 2007c; Cooper & Robson, 2006), and also for the contest between multiple logics (Greenwood et al., 2011; Pache & Santos, 2010), it becomes necessary to consider more closely what happens when the public interest, professional self-interest and the corporate purpose (Christmas & Millward, 2011; Evetts, 2003; Saks, 2014) within a constellation of logics (Goodrick & Reay, 2011) and institutional complexity (Greenwood et al., 2011) collide. What happens when NPM

managerialism (Ashburner et al., 1996; Flynn, 1999; Hood, 1991) – with its focus on efficiency, transparency and accountability – encounters professional autonomy and discretion (Clarke & Newman, 2006; Kitchener, 1999a) at the coalface (Barley, 2008), and the beating heart (Hallett & Ventresca, 2006) of institutionalisation? In a Foucauldian manner, one could examine how medical professionalism functions on an everyday basis (Rabinow, 1984) rather than on what the features of medical professionalism or the new medical professionalism might be (Levenson et al., 2010; RCP, 2005). That invites one to examine closely medical professionalism as an interactional phenomenon (Blumer, 1971; Hughes, 1971; Smets & Jarzabkowski, 2013a; Smets et al., 2012).

Professionalism has been described as a "third logic", which differs from that of the public sector hierarchical bureaucracy and consumerist market structures (Freidson, 2001). Yet, the NHS has also been described as an amalgamation of different organisational forms (Exworthy et al., 1999; Kirkpatrick, 1999; Sullivan & Skelcher, 2002a). How does medical professionalism – as a logic (Thornton & Ocasio, 2013) – find its voice contrapuntally (Said, 1993) within institutional complexity (Greenwood et al., 2011; Kraatz & Block, 2013) and the constellation of logics (Goodrick & Reay, 2011). From a macro-institutionalist perspective, logics shape, constrain and stimulate agency (Battilana, Leca, & Boxenbaum, 2009; Emirbayer & Mische, 1998). That agency is reflected in the enactment of medical professionalism as routine practices (Smets & Jarzabkowski, 2013a; Smets et al., 2012). A number of calls have been made for a more nuanced account of the agency (Delmestri, 2006; Hwang & Colyvas, 2011; Powell & Colyvas, 2013; Thomas & Davies, 2005; Yu, 2013); i.e. how do actors locate themselves within their social contexts?

In seeking to explain the patterns of behaviour of the participants, this section of the review of the literature looks back from observable practices to examine medical professionalism as the material enactment of multiple logics, which may be interdependent or contradictory (Besharov & Smith, 2013; Friedland & Alford, 1991a). Routine practices involve everyday improvisations that dynamically cast and recast relationships between logics (Smets & Jarzabkowski, 2013a; Smets et al., 2012). This is the real world of the people who animate institutions. Their modes of practice represent their agency that, through their iterative practices, creates a medical professionalism. This section of the literature review is delimited by the GT to a coalface medical professionalism as a phenomenon that routinely expresses the everyday working lives of the actors and how behaviours reflect their agency and the structures in the field. Thus, methodological congruence occurs between GT and the stance taken with respect to the literature review. It is a view that is grounded in practice (Smets & Jarzabkowski, 2013a; Smets et al., 2012) as an instantiation of agency (Delmestri, 2006; Emirbayer & Mische, 1998; Powell & Colyvas, 2013), which, in turn, by addressing tensions and contradictions in the workplace, frames answers to questions and iteratively creates structures (Berger & Luckmann, 1967; Giddens, 1984; Hughes, 1971; Strauss et al., 1963).

Somehow, the new medical professionalism (Christmas & Millward, 2011; Levenson et al., 2010; Rosen & Dewar, 2004) does not appear to deal well enough with the messiness associated with

institutionalism, wickedness and complex adaptive systems. Another concern is the inadequacy of the conceptualisation of the sociological impact of the reorganisation of medicine (Timmermans & Oh, 2010) as deprofessionalisation (Haug, 1973, 1988), proletarianisation (McKinlay & Arches, 1985; McKinlay & Stoeckle, 1988) and McDonaldisation (Ritzer, 1996; Ritzer & Walcak, 1988), on the one hand, and professional restratification (Freidson, 1988) and the adoption of clinical-managerial hybrid roles (Currie, Finn, & Martin, 2009; Muzio & Kirkpatrick, 2011; Noordegraaf, 2007b) on the other hand. The aforementioned accounts do not seem to come to grips with the situational improvisations and compromises (Emirbayer & Mische, 1998; Smets et al., 2012) that characterise medical professionalism as a day-to-day practice. Clarity is lacking about medical professionalism as institutional work (Lawrence, Leca, & Zilber, 2013; Lawrence & Suddaby, 2006) that is carried out in a context where institutional complexity (Greenwood et al., 2011) is not resolved and is not a temporary phase (Reay & Hinings, 2005, 2009). Medical professionalism is therefore routinely accomplished as a going concern (Hallett & Ventresca, 2006; Hughes, 1971) where historicised, contingent social conventions link social structures and social interactions.

This GT started with the people who enact their professionalism on a routine everyday basis. A practice perspective (Jarzabkowski, Matthiesen, & Van de Ven, 2009a; Jarzabkowski, Smets, Bednarek, Burke, & Spee, 2013b) of medical professionalism places it within an organisational context. Congruence exists between the GT perspective and a practice perspective on medical professionalism being enacted as a logic within a constellation of logics (Goodrick & Reay, 2011) on an everyday basis in ways that address participants' the main concern; i.e. managerialism (C. & Bouckaert, 2011; Exworthy & Halford, 1999). Institutional complexity (Besharov & Smith, 2013; Greenwood et al., 2011), the wickedness of the healthcare organisation (Raisio, 2009; Vartiainen, 2005) and the workplace that is a complex adaptive system (Holland, 1999; Waldrop, 1994) contribute to the fluid, contingent and historicised content and boundaries of medical professionalism.

Taking a closer look at the routine enactment of a medical professionalism embedded in the context outlined above suggests that the binary conceptual account (Gleeson & Knights, 2006; Numerato, Salvatore, & Fattore, 2012) of this professionalism may be inadequate. The hospital consultants are not in a privileged position outside the messiness that is described above. They are part of the context and have to juggle the tensions, paradoxes and agreements between competing demands on a daily basis. Closer inspection of routine instantiation of medical professionalism shows that to some extent three things have reshaped medical professionalism. The first is the rationalisation of managerial control in quality-control procedures, service design and resource allocation decision-making within a metrics-based performance management system (C. & Bouckaert, 2011; Clarke & Newman, 2006; Farrell & Morris, 2003; Harrison & Ahmad, 2000b; Hood, 1991; Power, 1999). The second is the standardisation of clinical practice through clinical guidelines, clinical pathways, protocols and national service protocols (Mooney, 2009; Timmermans & Berg, 2003; Timmermans & Kolker, 2004; Timmermans & Oh, 2010). And the third is the continued reliance on market-based competition

between providers. Perhaps it is less a case of deprofessionalisation than of reprofessionalisation (Evetts, 2003). In the latter case medical professionals combine organisational and professional logics (Blomgren & Waks, 2015; Reay & Hinings, 2009) to greater or lesser degrees.

It should be remembered that the meanings of professionalism are not given but are crafted in social interaction (Berger & Luckmann, 1967; Blumer, 1971; Hughes, 1971; Strauss et al., 1963). Some hospital consultants internalise the managerial framework (Doolin, 2002; Levay & Waks, 2009) of the hyper-rationalised hospital (Germov, 2005). They adopt the transparency agenda and audit culture of the managerial hospital (Harrison & Ahmad, 2000b; Power, 1999). These doctors manifest the self-monitoring conduct expected by management (Miller & Rose, 2008). Deprofessionalisation, proletarianisation and McDonaldisation suggest an almost complete surrender of agency. This does not appear to be the case with hospital doctors (Kirkpatrick & Ackroyd, 2003b; Levay & Waks, 2009; McNulty & Ferlie, 2004; Nancarrow & Borthwick, 2005). The managerial hospital has reshaped – rather than completely eliminated – their autonomy into a bounded or soft autonomy (Levay & Waks, 2009). For some, their professional power and authority have weakened (Deem, Hillyard, & Reed, 2007; Farrell & Morris, 2003). Other hospital consultants remain resistant to the managerial hospital (Ackroyd, Kirkpatrick, & Walker, 2007b; Dent, 2003; Kirkpatrick & Ackroyd, 2003b; McNulty & Ferlie, 2004). Between these two positions lies a range of behaviours that hospital doctors exhibit. Some choose to blur the "boundaries" between their professional identity and the organisational imperatives of the managerial hospital (Kurunmäki, 2004; Noordegraaf, 2007a, 2011; Noordegraaf & Steijn, 2014b). They create an organisational professionalism (Correia, 2013a; Faulconbridge & Muzio, 2008; Kitchener, 2000; Kuhlmann et al., 2013; Muzio, Hodgson, Faulconbridge, Beaverstock, & Hall, 2011). Restratification also emerges (Freidson, 1985) in the healthcare sector in general. Some doctors are with those who develop technologies of control (Deem et al., 2007; Miller & Rose, 2008; Reed, 1999). Other doctors assume hybrid clinical-managerial roles within the hospitals. Thus, interests overlap between an administrative/policy elite and a knowledge elite on the outside of the hospital and the clinical rank and file. This is a state of affairs with its own problems (Davies & Harrison, 2003; Dickinson et al., 2013b; Iedema, Degeling, Braithwaite, & White, 2004).

One gets a sense of medical professionalism in the managerial hospital as a range of behaviours that instantiate what this type of professionalism may mean but no real clearer sense of how and why professionals do what they are doing (Correia, 2013a). This issue is explored in the next sections of the literature review.

5.5 FOUCAULT

This section of the literature review deals with the exercise of power and resistance and arose after I had metaphorically rummaged through Foucault's conceptual toolbox and taken a few tools for use in this study (O'Farrel, 2005). This was potentially a precarious move because the resulting conceptual bricolage could be dismissed as not-Foucauldian. A Foucauldian

perspective is a rather treacherous thing. It might even be non-existent. However, I crossed the Rubicon and scoured a Foucauldian toolbox, took a few concepts and went ahead to see where it could lead.

The managerial hospital could be seen as an exercise of systemic power (Lawrence, 2008). Its rationalising, performance managing, standardising, commodifying and commercialising technologies aim to structurally shape, control and frame the collegial and self-regulatory behaviours of autonomous professionals. The intention of these technologies is to deliver a cost-effective and consistently high quality healthcare service (Harrison & Ahmad, 2000a; Waring & Bishop, 2013). However, where there is power there is resistance (Foucault, 1977). Thus, to understand the behaviours of hospital consultants, an examination of how power operates, functions and flows within the healthcare sector, in general, and the acute hospital, in particular, should be conducted. In Section 5.4, the discussion on professionalism I sketch a picture of a fluid, complex and ambiguous collegiality and self-regulation. Social structures intend to frame agency and behaviours without succeeding in being hegemonic (or perhaps even intending to be hegemonic). There is thus leave room for interpretation, agency and resistance. In those small spaces, the crafting of medical professionalism takes place.

For Foucault, *power* is not a thing or an object that is located in a centre but is a diffuse, ubiquitous feature of human activities (Foucault, 1979). The fact that power is everywhere does not mean that it is hegemonic but rather that it is embedded in social relations (Foucault, 1988). Power, as relational and interactional, functions to legitimise and delegitimise. This perspective suggests that individuals are not subjects to which power is applied, or over whom power is exercised, but rather they are carriers of power within social networks (Clegg, 1989; Townley, 1993). Routine, everyday interactions produce and reproduce social relations of power. An appreciation of power as relational requires a close examination of how it functions within social contexts. It is fluid, contingent and dynamic. Power may advantage some groups and disadvantage others (Clegg, 1989; Foucault, 1977) at certain times and in particular contexts, and it can then shift. Power as a social interactional phenomenon is a controversial issue in the literature (Dennis & Martin, 2005). The ubiquity of power and its embeddedness in relations and mundane practices may result in its not being readily recognised (Townley, 1993). So power may be everywhere and yet appear nowhere.

Foucault links *power* and *discipline* (Foucault, 1979, 1988). Discipline involves the power that is inherent in the techniques, practices and procedures' control found in ordinary relations within a given context. Power is not only negative (i.e. it does not only repress or constrain). It is also productive and is aimed at the shaping of the identity of a target (Clegg, 1989; Knights & Willmott, 1989). Disciplinary power involves the internalising of external rules by autonomous subjects. The Benthamite Panopticon – the guard tower that makes it possible for guards to observe inmates on a "continuous" basis in the architecture of a prison – forms the basis on which an inmate conforms to expected norms. The mere possibility of being seen, without knowing whether one is actually being observed, changes the way the individual sees himself or herself (Foucault, 1977). That awareness alone may render the actual use of physical force and

material constraints superfluous. Permanent visibility and scrutiny may be sufficient to ensure compliance with expectations (Foucault, 1979, 1988). The rationalised, standardised, commodified, managerially controlled, market-oriented and performance-managed hospital, with its focus on efficiency, budgeting, accounting and financial management (Power, 1999) and performance management systems (Harrison & Ahmad, 2000a; Hood, 1991; Power, 1999), can be considered to be an instance of the operation of an electronic Panopticon (Zuboff, 1988). The political and administrative centre is keeping a close watch on day-to-day clinical frontline work. The activities of professionals are made visible and therefore they can be subjected to norms as in evidence-based medicine (Timmermans & Berg, 2003; Timmermans & Kolker, 2004; Timmermans & Oh, 2010). The managerial gaze aims to reshape clinical autonomy.

Another Foucauldian tool is a knowledge-power nexus that blurs the boundary between knowledge and power. Since the late 1990s, congruence between the interests of the state and its senior civil servants on the one side and the medical elite from the teaching hospitals on the other has re-emerged (Pollock, 2005). The relationship between a segment of the professional elite, the academic clinicians, and the policy elite is based on a shared interest in monitoring and controlling the periphery. Knowledge elites, instead of being an alternative centre of power to the state, find a congruence of interests with the state in seeking to control the periphery (Johnson, 1972; Miller & Rose, 2008). A proliferation of technologies of control is designed by these knowledge elites; e.g. the introduction of budgeting accounting and auditing procedures that make clinical practice and the financial consequences of clinical decisions visible. The formulation of clinical guidelines and protocols standardise clinical practice and audits. Clinical governance procedures reframe professional indeterminacy. There is perhaps the instantiation of a restratification (Freidson, 1985) of the medical profession where, inside the acute hospital, the adoption of hybrid clinical-managerial roles reflects the knowledge-power nexus in the broader healthcare system (Waring, 2014). The boundaries between power and expertise are blurred (Faulconbridge & Muzio, 2008; Muzio & Kirkpatrick, 2011; Noordegraaf, 2007a; Waring, 2014; Waring & Currie, 2009). These are willing hybrids (McGivern, Currie, Ferlie, Fitzgerald, & Waring, 2015) who use their positions to challenge “out-dated” professionalism.

A question could be asked whether the Weberian iron cage has changed to a Foucauldian gaze (Foucault, 1977; Reed, 1999)? The change from the directly managed hospital to a quasi-market trust (Kitchener, 1998) or the public administration hospital to an NPM hospital (Fitzgerald & Ferlie, 2000a; Fitzgerald & Ferlie, 2000b). Later it changes to managed care networks (Goodwin, Perri, Peck, Freeman, & Posaner, 2004; Guthrie et al., 2010). The changes continue, even later, to foundation trusts (Allen et al., 2010; Directorate, 2005; Foucault, 1977; Reed, 1999). The political centre would be increasingly steering the periphery indirectly (Miller & Rose, 2008). Thus, a congruence of the interests of a professional elite and the power of senior civil servants and politicians – a knowledge-power nexus (Burchill, Gordon, & Miller, 1991; Miller & Rose, 2008) – has resulted in the development of sophisticated technologies to monitor, control and discipline the clinical rank and file, whose routine practices spend the healthcare budget of the NHS. The reorganisation of healthcare delivery – which is a major concern of countries

belonging to the Organisation for Economic Cooperation and Development (OECD) (Hood, 1991; Waring & Currie, 2009) – is aimed at the delivery of an efficient healthcare system. This requires tackling the paradox of clinical autonomy and the ways in which clinicians deliver healthcare (Doolin, 2002; Thomas & Hewitt, 2011).

Before the 1980s, the government lacked the tools to monitor and control the periphery (Klein, 2013). The command and control structures of the public sector professional bureaucracy were aimed at enabling ministers to account to Parliament about how public money was being spent. Crude performance indicators were derived from the Financial Management Initiative, in which every government-spending project had to have clear objectives and performance indicators to determine whether those objectives were being met. Furthermore, ministers in the Health Ministry had annual performance review meetings with chairpersons of the Regional Health Authorities to determine whether the priorities of government were being followed and whether value for tax funds was being delivered. The Hospital Advisory Service and the Health Service Commissioner were further attempts to influence clinical practice. The service-mix was always controlled by regulation from the centre. The key issue is that before the development of IT in the 1980s, the tools to pierce the veil of clinical autonomy were not available. The majority of hospital consultants were dismissive of general management (Griffiths, 1983, 1992). There were always tensions between the social aspirations and the affordability of the NHS (Klein, 2013). Oversight in the NHS did not start with NPM (Clarke & Newman, 2006; Hood, 1991; Power, 1999). The history of the NHS is a dichotomy of a political centre seeking transparent accountability on the spending of taxpayer funds and a medical profession finding ways to retain its clinical autonomy (Exworthy et al., 2010b; Klein, 2013). It is a service that is funded primarily from tax revenues and delivered mainly through public sector organisations. Private sector organisations delivered a small percentage – less than 2% in 2008 – of local elective health procedures (Audit Commission, 2008).

The impact of the NPM in the 1980s and 1990s (Clarke & Newman, 2006; Ferlie, Ashburner, Fitzgerald, & Pettigrew, 1996a; Hood, 1991) coincided with the general management proposals of Griffiths (Griffiths, 1983, 1992). The Department of Health was broken up and operationally independent NHS provider organisations were created. A quasi-market (Le Grand, 2009a; Mulligan, 1998) was initiated to imitate the operations of competitive markets (Department of Health, 1989). The relationship between the hospital and the hospital consultants changed from one based on trust to one based on employment contracts (Ferlie et al., 1996a; Hood, 1991). IT in addition to a performance-managed general management infrastructure in the hospitals allowed performance indicators to become more sophisticated as health economists played a bigger role in testing the effectiveness and efficiency of clinical decision making (Klein, 2013). These ideas began to shape an emerging audit-based performance-management system (Exworthy, 2010a; Power, 1999). For managers, contract management, budget management, efficiency and targets became the order of the day. Beds, wards and theatres were closed. Qualified nursing staff numbers were cut and cheaper healthcare assistants trained to replace them. Unused and under-utilised assets were sold off due to an efficiency charge. Costs were cut

to meet the statutory requirement to balance the budget of the hospital (Pollock, 2005). The ensemble of institutions and processes of control were being refined. The periphery was coming into clearer focus.

By the late 1990s the stubbornness of waiting lists; geographic variations in the availability of, amongst others, specialist cancer, chronic heart disease, in vitro fertilisation (IVF), hip replacement and cataract treatments; scandals; and a rise in clinical negligence litigation resulted in a focus on tighter performance management (Bevan & Hood, 2006; Propper et al., 2008). The wickedness (Conklin, 2006b; Rittel & Webber, 1973) of the social organisation of healthcare delivery (Austrailian Publis Service Commission, 2007; Raisio, 2009) was not readily acknowledged. Variations in the quality of treatments resulted in a quality agenda that included clinical governance as a responsibility of the Board of Directors rather than the clinicians. Elite professionals drafted national service frameworks and clinical guidelines (Timmermans & Kolker, 2004; Timmermans & Oh, 2010). Professional practice was being made visible by the knowledge–power nexus. Professional behaviour was being normalised and deviations deemed punishable. Moreover, because of concerns over quality (Abbasi, 1998; Dixon-Woods, Yeung, & Bosk, 2011; Kennedy, 2001; Smith, 1998), inspectorate machinery that is more sophisticated than the Hospital Advisory Service Inspectorate and the Health Service Commissioner was put in place. The aim was to determine the extent to which the clinical periphery was complying with the quality agenda and machinery (Care Quality Commission, 2009; Healthcare Commission, 2004; Patterson & Lilburne, 2003) It also reflects the fragmentation of the technologies of control (Miller & Rose, 2008). The delivery of healthcare by an integrated vertical bureaucracy has fractured into purchasers, providers, regulators, inspectorates and special health authorities such as the NICE (C. & Bouckaert, 2011; Pollitt, Talbot, Caulfield, & Smullen, 2005). The language of healthcare had changed. Health authorities became purchasers. Patients became consumers. Providers became competitors. Budgets, contracts and cost control replaced a concern for social justice, universality and comprehensiveness.

Control was no longer being exercised through command and control hierarchies as in the directly managed hospital (Fitzgerald & Ferlie, 2000b; Kitchener, 1998) or the public administration hospital (Fitzgerald & Ferlie, 2000b) or networks, (Addicott, McGivern, & Ferlie, 2006). Command and control was replaced by a combination of techniques, processes and procedures that aim to shape the choices and behaviours of targeted organisations and individuals (Foucault, 1979; Miller & Rose, 2008). The centre therefore exercises control over the periphery from a distance in ways that hopefully make the exercise of physical control superfluous (Miller & Rose, 2008). The targeted individuals, ideally, would internalise the aims of the control processes and therefore make the "right" choices (McKinlay & Starkey, 2000). The political elite and its executive agencies enforce regulations with respect to financial management, performance management and transparent accountability while the professional elite drafts the clinical guidelines, national service frameworks and protocols. Clinical behaviour on the periphery is thus standardised. Financial services accountability systems enable the recording, monitoring and evaluation of professional behaviours, which allow for evaluations to

be made and disciplinary action to be taken where needed. The behaviours of the subject are made known. However, the aim is that the mere awareness of evidence-based standards of clinical practice and the state of being under "constant surveillance" would encourage the clinical rank-and-file to adopt compliant and docile behaviours. Corrective interventions should therefore not be needed.

An electronic Panopticon (Zuboff, 1988) replaces the physical Weberian bureaucratic/Benthamite Panopticon. The managerial hospital is a hyper-rational institution (Germov, 2005) of observation, measurement and performance appraisal. But have the hospital doctors been transformed into compliant, self-surveying, self-controlling subjects of a managerial agenda? Have hospital consultants internalised the imperatives of the disciplinary power? Have the transformation and intensification in the technologies of control (observation, measurement, performance appraisal, audit and clinical governance) managed to produce hospital consultants who do as the policymakers intend? Have hospital consultants adopted the clinical guidelines and protocols that normalise practice? Have doctors prioritised efficiency to the extent that the managerial hospital wishes? How do the technologies of power take account of the wickedness of the problem that they seek to address, the dynamic complexity of the social system in which the electronic Panopticon and the knowledge-power nexus operates? Does the *microphysics of power* tame the negotiated order by which the participants live? Does the target of the pervasive, silently operating managerial disciplinary power become more visible and more docile?

Auditing techniques from the financial sector (Power, 1999; Timmermans & Kolker, 2004) have been imported by a knowledge elite, in concert with political and economic power, into performance-management systems and evidence-based clinical practice (Timmermans & Kolker, 2004; Timmermans & Oh, 2010). Self-surveillance procedures such as medical audits and clinical governance (Donaldson, 2001; GMC, 2013; Officer, 2006) have become statutory responsibilities of the local governing agents. Have these resulted in a more confessional and reflective self-governing hospital consultant? Do technologies of control settle the struggles over meanings, language, symbols and legitimacy within the hospital? Do hospital consultants uncritically comply with scientific bureaucratised practice (McDonald & Harrison, 2004; Timmermans & Berg, 2003)? If not, how do they play out sociologically? Have more than three decades of managerial control, metric-based performance management, market-based competition, standardisation, bureaucratisation, audits and surveillance led to internalisation of managerial norms, values and priorities? Does it appear that hospital consultants are in agreement on these matters? What does the continuous steering of professional practice through protocols; guidelines and audits do to the content and boundaries of professionalism?

After all, norms and standards are not new to the medical profession. Are proletarianisation, deprofessionalisation or restratification sufficiently nuanced and comprehensive conceptualisations of their ways of dealing with prescriptions, audits and accountability? Does the range of practices instantiate the normalised behaviour of a docile subject who has been "proletarianised" or "deprofessionalised"? Or have some creative responses come into play with

restratification? Where are the multiple shades of restratification and hybridisation? In the previous section, I argued that the binary conceptualisation does not really capture the complexity of behaviours and intentions.

As mentioned above, where there is power there is resistance (Foucault, 1977). Power creates and provokes the resistance that alerts one to the existence of power and attempts at the reconfiguration of power relations. From the literature on professionalism, it is known that professionals have historically resisted managerial interference in the organisation of their work (Flynn, 1999; Harrison & Ahmad, 2000a; Reay & Hinings, 2009). Disciplinary power, when expressed as rules, has to be interpreted by subjects. This implies agency and discretion (Clegg, 1998), which, in turn, means varying hybrid responses to managerial control, market-based competition and metrics-based performance-management systems (Ashforth & Johnson, 2001; Ferlie, McGivern, & FitzGerald, 2012; Fitzgerald & Dufour, 1998; McGivern et al., 2015; Noordegraaf, 2013).

The next section casts the consequences of some Foucauldian conceptual tools (Knights & Willmott, 1989) in a more nuanced light. It examines the multiple roles that participants in a work situation might adopt in relation to disciplinary power (McCabe, 2011; McKinlay & Starkey, 2000). It is important to remember that this GT study examines the exercise of power – as an instance of the participants' main concern – and resistance – as the way of resolving that concern – within a context that is institutionally complex (Greenwood et al., 2011). The GT is concerned with a constellation of logics (Goodrick & Reay, 2011) that includes professionalism, hierarchy, and networks (Exworthy et al., 1999; Kirkpatrick, 1999) and markets, management and metrics (Farrell & Morris, 2003). No single logic dominates (Greenwood, Díaz, Li, & Lorente, 2010; Kraatz & Block, 2013) but power circulates as a number of sedimented and often contradictory logics (Cooper et al., 1996; Greenwood et al., 2011; Kirkpatrick & Ackroyd, 2003b). Within these contradictions and contestations, the managerial gaze is likely to be less than hegemonic and the absence of professional subservience may mean that there is resistance of a professional kind. This is discussed in the section that follows.

5.6 ROUTINE RESISTANCE

Another theoretical angle that clarifies the sociological impact of the reorganisation of healthcare delivery (Timmermans & Oh, 2010) is that of everyday or routine resistance (Prasad & Prasad, 1998; Scott, 1985). This study began with a GT of behaviours of hospital consultants in the managerial acute NHS hospital. Their routine, everyday behaviours are situated improvisations (Jarzabkowski et al., 2013b) and rather non-dramatic (March, 1981) instantiations of their interpretations of rules of the game (Clegg, 1998; McCabe, 2011). Their understandings and behaviours are aimed at shifting the microphysics of power (Foucault, 1979). The examination of literature on routine resistance begins with the tracing of a line of sight from modes of behaviour as instantiations or representations of agency – and how the latter seeks to reconfigure the power relations within the given context – and institutional logics and complexity. The GT imposes that limitation on the literature review.

Scott (1985) examined the power relations between rich landowners and poor peasants in a Malay village. Two Foucauldian ideas related to power are central to his argument. These are the relational view and ubiquity of power. Power is embedded in the complex web of routine social relations and its ubiquity does not necessarily imply its hegemony. It is everywhere but where it becomes a technique or a procedure there will be gaps that can be exploited for resistance or collaboration. Power as relational and ubiquitous is pertinent in an institutionally complex environment (Greenwood et al., 2011).

Scott (1985) examines what peasants do in the timeframes between instances of open conflict to defend their interests. He studies behaviours such as foot-dragging, false compliance, feigned ignorance and gossip. A casual observer might pass over critical meanings associated with these actions (Jermier, Knights, & Nord, 1994; Prasad & Prasad, 1998, 2000). He reframes what could be interpreted as bad or uncooperative behaviour as "weapons of the weak". Distinguishing features of these actions are that they are individual, unorganised and spontaneous. The ambiguity that is inherent in the weapons of the weak means that those who employ them have sufficient wiggle room so that they are not clearly defined as being in open rebellion. From Foucault, Scott takes the idea that power is embedded in social relations and is pervasive. Resistance aims to reconfigure power relations. The absence of drama (March, 1981) in resistance does not imply the absence of resistance. The effect of the actions of an individual might not substantially change the relations of power in the short-term but in the longer-term the cumulative impact – of the myriad of routine resistance activities by many individuals – should check the material realisation of the ambitions of the powerful. For the individual, however, everyday resistance makes a situation just a bit more bearable. Scott directs attention away from what appears obvious in the public encounters between the powerful and the weak with his ideas of a "public transcript" and a "hidden transcript" (Scott, 1990). The underlying idea is that there is more to the encounter than meets the eye. The public transcript is an account of the interactions between the powerful and the weak that conform to the dictates of power. Fear of retaliation rather than false consciousness informs the public behaviours. Impression management is a survival skill in the encounters between the powerful and the weak (Scott, 2008b). The public encounter or transcript is inherently inauthentic as it reveals only those elements – of the relationship between the dominant and the subordinate groups – that are safe to unveil. Despite hidden anger and boiling fury, a peasant may smile at the landlord as if all is well.

The *hidden transcript* is an account of the feelings and thoughts of the weak when they are beyond the gaze and reach of the powerful. Thus, there is more to the relationship than meets the eye. The tensions between the public and private transcripts reflect the internal politics of the weak. It is possible to argue that the hidden transcript is nothing more than private grief, but that could be a mistake as it is encoded and requires organic knowledge to decipher (Scott, 1990). The dominant may see consensual relations between themselves and the weak, but subterfuge and impression management present the absence of obvious dissent, as compliance while resistance is evident to those in the know. The collective hidden transcript provides a

logic of action (Bacharach & Mundell, 1993) that allows marginal groups to resist domination. The hidden transcript contains the seeds of resistance because in a protected environment it reframes the inauthenticity of the public transcript when overt, organised dissent is not a viable option. Even though the hidden transcript does not offer possibilities for radical transformations in the economic relations between the groups, it allows the weaker groups to fight within the available constraints so that the worst elements of their situation are alleviated.

Scott (1985) argues that the peasants challenge the ordinary manifestations of their exploited status with routine resistance that may not be spectacular at all. Open rebellion is merely a failure of routine resistance and it occurs when things become completely unbearable. Everyday resistance precedes and sustains collective and organised resistance. Scott's theory of routine resistance is a close look at the ordinary actions taken by weaker parties, on a day-to-day basis. These activities could otherwise be ignored because theoretical lenses may be biased towards organised, public and overt dissent. However, routine resistance has been criticised as being "decaf resistance" (Contu, 2008) as it serves as a safety valve for the relations of domination. Routine resistance allows "resistors" to feel that they are at least doing something whilst in reality nothing changes at all (Fleming & Spicer, 2008).

Despite the aforementioned criticisms, Scott's theory of routine resistance allows for a more nuanced understanding of relationships and encounters between dominant and marginal groups. It can be seen as a continuum from compliance to open rebellion resistance and with public and private dimensions. Meanings are not always clear. Ambiguity and complexity are to be decoded in private structures to which the powerful have limited access. The theory suggests that one should just pause and look a bit closer for there might be signals that an observant eye and an attentive ear could pick up. A struggle might just be taking place.

This particular turn towards routine resistance has also been reflected in debates around resistance in other workplaces. The neglect by academics of employee resistance in the modern workplace and the assumption of the efficacy of managerial control have been criticised because the structural conflict between capital and labour remains intact (Ackroyd, 2007a; Ackroyd & Thompson, 2003b; Thompson & Ackroyd, 1995) These scholars call for the return of the insubordinate, headstrong and obdurate worker who had theoretically almost disappeared under the influence of managerial surveillance and control. Dissent and resistance are enacted whether management scholars recognise them or not. Workers going slowly, absenteeism and wasting time, subversive humour as discourse (Taylor & Bain, 2003), stealing by workers in hotels, catering and in the docks (Mars, 1982) and sabotage (Brown, 1977) are taking place despite the lack of attention by management scholars. Workers are doing things that they are not supposed to do and are finding ways to break the rules and undermine managerial control. Dissenting behaviours affirm the agency of workers. These close examinations of awkward behaviours shift attention from organised and overt industrial action to the unorganised, spontaneous subterranean struggles that individuals undertake. Organisational studies scholars, through writing, have largely privileged the managerial perspective and interests over those of the workers (Ackroyd & Thompson, 2003a, 2003b; Jermier et al., 1994).

Labour process theorists, despite giving a rich account of employee behaviour, have been criticised for being too deterministic and for failing to account for the everyday, routine ways in which employees make sense of the complexities of the workplace (Thomas & Davies, 2005; Weick, 1995). The everyday, informal and spontaneous ways (Jermier et al., 1994; Knights & McCabe, 2000) in which workplace contradictions are being addressed have apparently escaped labour process theorists. A "Foucauldian" turn on power expands our understanding of workplace resistance by taking a closer examination of the agency and motivations of individuals. It shines a light on how they routinely negotiate and seek to transform meanings and contradictions embedded in power relations in the workplace (Doolin, 2002; Kuhlmann et al., 2013; Smets et al., 2012; Thomas & Davies, 2005; Waring & Currie, 2009). The emphasis shifts from a structural, deterministic account of power and resistance – labour process theory- to a closer examination of the micro-politics of resistance as individuals reflexively engage in on-going processes of confronting, adapting to, and compromising with existing power relations, thus subverting dominant discourses, meanings and understandings.

The adoption of a routine resistance lens allows one to address calls for the reconnection of the sociology of professions with organisation studies (Muzio & Kirkpatrick, 2011; Noordegraaf, 2011; Suddaby & Viale, 2011). The adoption of this lens links the sociology of professions, organisation studies and institutional work (Lawrence et al., 2013; Lawrence & Suddaby, 2006). A routine resistance perspective could facilitate a closer inspection of how professionals respond to managerial controls within organisations because organisations have become primary arenas for professional agency (Ackroyd & Muzio, 2007c; Cooper & Robson, 2006; Faulconbridge & Muzio, 2008). Given that organisations are also principal arenas for the enactment of multiple logics (Battilana & Dorado, 2010; Greenwood et al., 2011; Pache & Santos, 2010), a routine resistance perspective allows one to begin to see how embedded actors routinely engage those multiple logics (Jarzabkowski et al., 2013b; Smets & Jarzabkowski, 2013a). Routine resistance examines the institutionalisation processes from the bottom-up (Barley, 2008; Powell & Colyvas, 2013). The routine resistance perspective allows a miner's perspective to emerge about institutionalisation from the coalface (Barley, 2008). Routine resistance lenses allows for the hearing of the voices of those who make up the heartbeat of institutionalism (Hallett & Ventresca, 2006). The mutual implication of power and resistance (Foucault, 1979; Prasad & Prasad, 1998; Scott, 1985) directs attention to the mutual constitution of structure and agency (Berger & Luckmann, 1967; Blumer, 1971; Giddens, 1984; Hughes, 1971). It studies the institutionalisation process from the perspective of its material enactment (Thornton et al., 2012). A routine resistance perspective opens a way to understanding how organisational hybridity (Battilana & Dorado, 2010; Besharov & Smith, 2013; Pache & Santos, 2010) is resolved in the real lives of people as they go about their daily business at work (Jarzabkowski et al., 2013b; Smets & Jarzabkowski, 2013a). People integrate the wickedness (Austrailian Publis Service Commission, 2007; Rittel & Webber, 1973) of the social organisation of healthcare delivery, the hospital as a complex adaptive system (Barach & Johnson, 2006; McKelvey, 1999; Rickles, Hawe, & Shiell, 2007) and the multiple logics within the

hospital in a routine, everyday, non-dramatic manner (March, 1981; Smets & Jarzabkowski, 2013a). What are the implications of these insights for the conceptualisation of the impact of the social reorganisation of the delivery of healthcare (Timmermans & Oh, 2010; Waring & Bishop, 2013)? Is the binary account (Gleeson & Knights, 2006; Numerato et al., 2012) a sufficiently nuanced account of medical professional responses in the managerial hospital (Kirkpatrick & Ackroyd, 2003a; McNulty & Ferlie, 2004; Muzio & Kirkpatrick, 2011; Suddaby & Viale, 2011)?

A routine resistance perspective invites one to look beyond what one sees. So it suggests that the range of behaviours that were conceptualised as deprofessionalisation, proletarianisation and restratification (Section 5.4.2), might not yet be the whole story. There is perhaps a narrative that unfolds away from the glare of the managerial gaze. A more detailed examination of other parts of neo-institutional theory literature (Section 5.7) helps to clarify some of the issues raised earlier. The GT described in Chapter 4 is likely enriched by ideas of routine resistance and public and hidden transcripts.

5.7 INSTITUTIONAL THEORY

This section of the literature reviews neo-institutional literature that has a bearing on the behaviour of hospital consultants in the acute hospital sector of the English NHS.

"Institutions … control human conduct by setting up predefined patterns of conduct, which channel it in one direction as against the many other directions that would be theoretically possible." p.57 (Berger & Luckmann, 1967)

Institutions shape, constrain, control and stimulate human conduct. Institutional theory has become the main theoretical perspective for conceptualising organisations (Greenwood, Oliver, Suddaby, & Sahlin-Andersson, 2008; Munir, 2015; Walsh, Meyer, & Schoonhoven, 2006). Institutions are symbolic systems of meaning by which people structure space and time in meaningful ways (Friedland & Alford, 1991b). This theoretical lens examines how human behaviour is shaped, constrained, directed and transformed by social structures. However, the institutional world is not given and fixed but has a socially constructed objectivity (Berger & Luckmann, 1967; Hughes, 1971). Human behaviour is institutionally embedded within historicised, contingent and fluid structures. How do the behaviours of actors affect the contingency of institutions?

Institutional theory started with a focus on organisations having meaning and purposes beyond meeting their technical tasks (Berger & Luckmann, 1967; DiMaggio & Powell, 1983; DiMaggio & Powell, 1991; Meyer & Rowan, 1977; Selznick, 1957). This is especially important in this study because of the nature of the acute hospital as a workplace. The doors are always open for the whole day on every day of the year. Then the neo-institutionalist phase looked at the impact of the broader environment on organisations (DiMaggio & Powell, 1983; DiMaggio & Powell, 1991; Meyer & Rowan, 1977, 1983). In mature sectors of society, legitimised ways of doing things emerge over time (DiMaggio & Powell, 1991) with usually one dominant template for conducting affairs prevailing (Greenwood & Hinings, 1993; Scott et al., 2000). Three

mechanisms promote homogeneity in institutional sectors or fields (DiMaggio & Powell, 1983): coercive (e.g. state regulation), normative (expectations of what are proper and reasonable ways to behave) and mimetic (e.g. copying good practice). When states regulate changes in the ways in which sectors are structured, the modifications take place quickly (Barley & Tolbert, 1997). The power of isomorphic pressures is such that alternative ways of doing things or behaving are not even considered (Zucker, 1977). An alternative view is that the role of the state – as an institutional actor – is not necessarily efficient in achieving fundamental change (Kirkpatrick & Ackroyd, 2003b; McNulty & Ferlie, 2004). With respect to this study, the impact of the broader environment on the hospital is important because the macro-environment plays a significant role in shaping some of the fundamental dilemmas faced by the hospital consultants. That broader environment is wicked and complex (Battilana & Dorado, 2010; Cooper et al., 1996; Currie & Suhomlinova, 2006; Exworthy et al., 1999; Greenwood et al., 2011; Pache & Santos, 2010; Thornton et al., 2012).

This section is relatively longer than the other sections of the literature review because it serves as a theoretical canvass for the rest of the literature review. The stability of institutions could be illusionary when history is considered (Bjerregaard & Jonasson, 2014; Kaghan & Lounsbury, 2011; Suddaby, 2015). Hence, the processes of institutionalisation can be recognised as historicised, contingent and in flux (Berger & Luckmann, 1967; Hughes, 1971). Institutions do shape and constrain the choices of actors, be they organisations, groups or individuals. Contingency, flux and historicity create space for the return of people into the institutionalised processes as they interpret, modify and coordinate their activities with other inhabitants of institutions (Hallett & Ventresca, 2006; Jepperson, 1991; Zilber, 2002). In this way, people create the institutions by social interaction (Blumer, 1971) as they set out to address immediate, practical problems (Jarzabkowski et al., 2013b; Smets & Jarzabkowski, 2013a). This study started with the behaviours of people as they set out to resolve their main concern. Thus, an account of how the macro-institutionalisation process created the micro-institutional problems that the participants seek to resolve on an everyday basis is appropriate. This mainly structural archetype theory account of institutional change in the NHS reflects the initial taken-for-grantedness of institutions and the agents responding to them (Emirbayer & Mische, 1998; Jepperson, 1991). The second section (Section 5.7.2) introduces a more detailed and nuanced examination of structure, agency and manifest behaviours within the context of wickedness, complexity, circulation of power, routine resistance and institutional complexity. It explores structure, agency and manifest behaviours as on-going accomplishments (Emirbayer & Mische, 1998; Friedland & Alford, 1991b; Lawrence & Suddaby, 2006; Smets & Jarzabkowski, 2013a).

5.7.1 An Archetype Approach to Institutional Theory

5.7.1.1 Introduction

Institutional theory has become a significant theoretical lens for the study of organisations (Suddaby et al., 2008). This is especially true in studying change in complex organisational fields

like healthcare (Macfarlane et al., 2013; Reay & Hinings, 2005, 2009). The NHS healthcare environment can be said to be institutionally complex (Greenwood et al., 2011; Smets et al., 2012) because of the constellation of logics (Currie & Suhomlinova, 2006; Exworthy et al., 1999; Goodrick & Reay, 2011; Kirkpatrick, 1999; Noordegraaf, 2013). Institutional logics prescribe what is considered legitimate behaviour and provide taken-for-granted templates of appropriate goals and means to attain them (Lounsbury, 2007; Thornton & Ocasio, 1999, 2013; Thornton et al., 2012). In complex environments, organisations are likely to face multiple, often contradictory, demands arising from institutional complexity (Battilana & Dorado, 2010; Friedland & Alford, 1991b; Kraatz & Block, 2013; Pache & Santos, 2012; Reay & Hinings, 2009) Effecting organisational change is difficult in environments such as healthcare. The wickedness of healthcare organisation (Austrailian Publis Service Commission, 2007; Conklin, 2006b; Raisio, 2009; Rittel & Webber, 1973; Vartiainen, 2005) makes it difficult as was discussed earlier. Another muddling feature is the hospital as a complex adaptive system (Checkland, 1981; Dooley, 1997; Ferlie & Dopson, 2005; Godfrey et al., 2003; Nelson et al., 2003; Nelson et al., 2002; Shiell et al., 2008).

One early neo-institutionalist approach to explaining the dynamics of radical change in healthcare systems has been that of archetypes (Chreim, Williams, & Coller, 2012; Greenwood & Hinings, 1993; Kitchener, 1998; Kitchener, 1999b; Kitchener & Mertz, 2012). A key issue to note in this literature is the significant investment in structural and decision-making systems' change. At the same time one should notice how the underlying professional logic has proved difficult to dislodge (Crilly & Le Grand, 2004; Dickinson et al., 2013b; Kirkpatrick & Ackroyd, 2003b; McNulty & Ferlie, 2004). This draws attention to the role of people in the institutionalisation process (Barley, 2008; Friedland & Alford, 1991a; Hallett & Ventresca, 2006; Smets & Jarzabkowski, 2013a; Smets et al., 2012; Thornton et al., 2012; Zilber, 2008). In fact, much of the earlier institutional theory had focused on structural responses to institutional complexity (Greenwood et al., 2011; Smets & Jarzabkowski, 2013a) but had failed to account for a level of institutional behaviour at levels below the organisation (Kraatz, 2009; Kraatz & Block, 2013; Lok, 2010; McPherson & Sauder, 2013). This draws attention to how embedded actors interpret, contest and symbolically interact with and create social structures.

5.7.1.2 Elements of the archetype

A number of scholars have taken an archetype approach to explaining organisational change (Brock, 2006; Cooper et al., 1996; Greenwood & Hinings, 1993; Greenwood & Hinings, 2006; Greenwood, Hinings, & Brown, 1990; Malhotra, Hinings, Cooper, & Greenwood, 2005). This approach has also been used as a theoretical lens in the study of radical change in public services (Ferlie et al., 1996b; Kirkpatrick & Ackroyd, 2003b). Change in healthcare delivery systems have also been examined from an archetype approach to institutional change (Chreim et al., 2012; Dent et al., 2004; Ferlie, 1999; Kitchener, 1998; Scott et al., 2000).

This approach to institutional theory sees the organisation as an integrated set of structures and decision-making systems that are reflective of a single underlying interpretive scheme (Greenwood & Hinings, 1993; Scott & Meyer, 1994). The interpretive scheme is the combination of ideals, values and beliefs that infuse the structures and systems with meaning (Bartunek, 1984; Ranson, Hinings, & Greenwood, 1980b). Within a sector there would usually be a dominant archetype (Greenwood & Hinings, 1988; Hinings et al., 2003). Given the idea of multiple institutional logics (Friedland & Alford, 1991b; Kraatz & Block, 2013; Oliver, 1991), one might question the notions of institutional field stability and coherence and the dominance of an archetype that has dominated earlier accounts of archetype change (Greenwood & Hinings, 1993; Scott et al., 2000). Those early isomorphic accounts of neo-institutionalism arguably have under-accounted for institutional complexity (Greenwood et al., 2011). Thus the earlier accounts of archetype change within healthcare can be critically re-examined (Crilly & Le Grand, 2004; Exworthy et al., 1999; Goodrick & Reay, 2011; Kirkpatrick, 1999; Reay & Hinings, 2005; Scott et al., 2000). Sometimes institutional complexity is a temporary phenomenon (Battilana & Dorado, 2010; Kraatz & Block, 2013; Pache & Santos, 2012). In other instances, it might be more enduring (Greenwood et al., 2011; Reay & Hinings, 2009; Zilber, 2011).

The challenges for organisations and people can be contingent on the type of institutional pluralism that exists in their organisation (Besharov & Smith, 2013). This complicates the key issues of conformity or isomorphism with dominant archetypes and the tensions around legitimacy, efficiency and decoupling (Meyer & Rowan, 1977; Tolbert & Zucker, 1983). Institutional pluralism makes change processes is just a bit messier (Lawrence, 2008; Oliver, 1991). Archetype accounts of institutional theory argue that over the medium- to longer terms congruence occurs between the structures, systems and the interpretive scheme (Brock, Powell, & Hinings; Greenwood & Hinings, 1988; Greenwood & Hinings, 1993). Archetype incoherence is a temporary phenomenon as, in a mature institutional field, there is a tendency towards a dominant coherent archetype (Greenwood & Hinings, 1993; Scott et al., 2000). As was briefly mentioned earlier and is discussed in more detail later, these assumptions in earlier archetype studies have proved to be difficult to sustain. However, this approach is still a useful way to analyse changes in professional services organisations (Brock, 2006; Brock, Powell, & Hinings, 1999, 2007).

5.7.1.3 Dynamics of archetype change

Archetype change can arise from within the broader institutional field or within the specific sector (Battilana, 2006; Fligstein, 1997; Greenwood, Suddaby, & Hinings, 2002; Hinings, Greenwood, & Cooper, 1999). Institutional field pressures may have made certain modes of organisation of professional services inefficient and hard to justify; e.g. in law firms (Brown, Cooper, Greenwood, & Hinings, 1996; Malhotra & Morris, 2009; Pinnington & Morris, 2003), accounting firms (Brock & Powell, 2005; Malhotra, Morris, & Hinings, 2006) and architecture firms (Pinnington & Morris, 2002). Increasingly, corporate and managerial modes of operation have replaced professional norms (Cooper & Robson, 2006). The idea of a professional

bureaucracy (Mintzberg, 1979) and professional forms of organisation that rely on expert knowledge workers (Adler, Kwon, & Heckscher, 2008; Zardkoohi, Bierman, Panina, & Chakrabarty, 2011) had become hard to justify in the period under review from the 1980s onwards (Ackroyd et al., 2007b; Clarke & Newman, 2006; Hood, 1991; Pollitt, 1998). The professional organisation suffered a legitimacy crisis in being characterised as self-interested, inefficient and unaccountable (Ackroyd et al., 2007b; Brock et al., 1999).

The critical appraisals of professionalism noted earlier (see Section 5.4) were applied to professional bureaucracies in the public sector. The professionals stood accused of contributing to the problems of bloated public service organisations (Clarke & Newman, 2006; Ferlie & Fitzgerald, 2002; Pollitt & Bouckaert 2011). The UK government was looking for ways to cut the costs of the delivery of healthcare and reduce the influence of the medical profession in policy making (Kirkpatrick & Ackroyd, 2003b; Klein, 2013). Developments in IT, a better educated public and changes in expectations of the public from the delivery of public services and a financial crisis contributed to a changed relationship between the state and the medical profession. Until the 1980s the tools to control the medical profession were non-existent (Klein, 2013). The question of whether the state has managed to change the ways in which hospital consultants think and behave has been the subject of numerous studies (Crilly & Le Grand, 2004; Currie & Suhomlinova, 2006; Dickinson et al., 2013b). This is an important issue in archetype change. The question is: what does a change in archetype involve?

5.7.1.4 Successful archetype change

Successful archetype change requires a radical, parallel and simultaneous change in all three components of the archetype, with a particular focus on the interpretive scheme (Greenwood & Hinings, 1993; Hinings & Malhotra, 2008). It is a complicated and complex process that involves a combination of precipitating and enabling dynamics (Hinings & Malhotra, 2008). The precipitating factors include institutional pressures, the patterns of value commitments and interests. The enabling dynamics include supportive power dependencies and a capacity for action. The institutional pressures are already noted above as the factors that delegitimised the professionalised bureaucracy. The interests reflect whether major stakeholders hold the view that their concerns are served by the status quo or not. If the status quo were not functional then that would be a driver for change. Value commitments can be reformative, indifferent or competitive. Those with reformative value commitments would be interested in changing the ways in which things are done. With indifferent value/commitment patterns the relevant parties do not particularly care whether change happens or not. With competitive value commitment structures some participants would likely be for the status quo and others for change. The supportive power dependencies take account of the power differentials within sectors and organisations. Different stakeholders have differing capacities to persuade the organisation to follow their preferred course of action (Greenwood, Walsh, Hinings, & Ranson, 1980a). The capacity for action includes having a clear view of what the alternative archetype might be, being able to manage the transition to a new archetype and having the skills to

operate in that new archetype. Successful archetype change requires several issues to come together.

The two major players in the English NHS are the government and the medical profession (Klein, 2013). The government, in the 1980s, because of its fiscal crisis and the possibilities that IT afforded, was inclined to change the professional bureaucracy (Exworthy et al., 1999; Kirkpatrick & Ackroyd, 2003a; Pollitt & Bouckaert 2011). The interests of the government would be better served by an archetype that would prioritise the control of costs, efficient delivery of services and transparent accountability. The medical profession did not share their enthusiasm for the new priorities (Klein, 2013; Pollock, 2005). This meant that the value commitments were competitive (Greenwood & Hinings, 1996).

Hospital doctors have for many years shown a lack of interest in assuming managerial roles in the English NHS hospitals (Griffiths, 1983, 1992). Before the 1980s, geographical area-based health authorities determined health needs of populations, allocated the funds and determined whether government priorities were met. All along the way, they relied on medical professionals, who made significant input into the process. Doctors had a right of veto in the policy-making process (Klein, 2013). The Treasury always had concerns about the affordability of the NHS. So the managerial hospital did not emerge only in the 1980s as might be inferred from the NPM literature (C. & Bouckaert, 2011; Hood, 1991). For a long time skirmishes took place between the government and the medical establishment over the organisation and delivery of the health service.

A Hospital Inspection Service – reporting to the Secretary of State on shortcomings in the delivery of healthcare – did not have authority over doctors. The Health Service Commissioner, established in 1964 to investigate patient complaints, could not deal with issues that involved clinical judgement. Attempts to get doctors to consider the resource implications of their clinical decision making, such as the Cogwheel Report and the Hospital Activity Analysis, did not have significant impact on the clinical practice of hospital doctors (Gray et al., 1991; Klein, 2013). The Treasury implemented a Financial Management Initiative, in which every government spending-programme had to have clearly stated objectives and performance indicators. Ministers would hold annual performance reviews with regional health authorities to determine whether the government agenda was being implemented and whether tax funds were being spent efficiently. The difficulty was that the tools were not yet available to obtain the data and hence the medical profession had to be relied on for their impressions of these issues. Rudimentary data had been collected since 1956 but sophisticated analysis was not possible. Thus, before the 1980s, the focus was on controlling inputs into the NHS; e.g. the numbers of doctors, nurses and beds. How resources were being spent was a black hole to the government, which paid the bills.

5.7.1.5 The Griffiths general managers

The 1983 Griffiths managerial revolution was a step taken by the government to realise its ambition of a more managed and efficient healthcare system. Administrators, who generally acted as diplomats between clinicians competing for scarce resources, became general managers who would be appointed on performance-related employment contracts (Klein, 2013; Pollock, 2005). Managers assumed responsibility for running hospitals efficiently. Griffiths tried to encourage doctors to become general managers. Doctors believed that Griffiths, a supermarket managerial executive, could not tell them how to run a hospital (Griffiths, 1983, 1992). The Griffiths Report did not have input from the medical profession. The government ignored the medical profession in crafting healthcare policy for the first time (Ackroyd et al., 2007b; Kirkpatrick & Ackroyd, 2003b). This was strange given the wickedness of healthcare service organisation and the complexity of the hospital as a primary delivery vehicle for healthcare services (Roberts et al., 2012). The number of senior managers in the NHS increased from 1 000 (1986) to 26 000 (1995) and the cost of administration increased from 5% to 12% of the NHS budget over the same period (Pollock, 2005). No agreement has been reached on the implications of the Griffiths Report. Some researchers argue that the Griffiths general managers increased the control by the Department of Health on the clinical frontline and increased efficiency (Exworthy et al., 2010b; Harrison & Ahmad, 2000b; Klein, 2001b). The government also required hospitals to focus on their core business of healthcare delivery and forced them to put out for competitive tendering the delivery of cleaning, catering, laundry services and charges for car parks (Exworthy et al., 2010b; Pollock, 2005; Pollock & Whitty, 1990). The medical profession was opposed to these changes but they felt that they still had the upper hand (Dickinson et al., 2013b; Kirkpatrick & Ackroyd, 2003b). Their interests remained with the professionalised bureaucracy (Crilly & Le Grand, 2004; Currie & Suhomlinova, 2006).

Other researchers take a different view on the efficacy of government actions. The government was, and remains, constrained because it does not necessarily have the power to change the archetype fundamentally. It can force through changes in the structures and decision-making systems but it cannot force a change in the beliefs and the value system (Kirkpatrick & Ackroyd, 2003b; McNulty & Ferlie, 2004). Moreover, at the time, it lacked the capacity for action (Hinings & Malhotra, 2008). The government did not have a clear view of the new archetype that it wanted to impose. Also it did not have the skills to operate that new archetype. Added to the aforementioned deficiencies, it did not have the capacity to manage the migration from the professionalised bureaucracy to what was later called the quasi-market archetype (Kitchener, 1998; Kitchener, 1999a) or the NPM archetype hospital (Fitzgerald & Ferlie, 2000a). The Conservative government decided to place much of the public-service delivery in the hands of executive agencies (Exworthy et al., 2010b; Greer, 1992). Activity was to be decentralised but control and accountability would be centralised (Carter et al., 1992; Klein, 2013). With developments in IT, the government believed that it could control the periphery and transform itself from a provider of services to a regulator of these services (Day, 1987). Government lacked clarity about whether to centralise or decentralise control (Exworthy et al., 2010b).

5.7.1.6 Tracks of change

It is necessary at this point to introduce another idea on archetype change; i.e. tracks of change. Organisations do not always follow the same change trajectory (Greenwood & Hinings, 1988; Greenwood & Hinings, 1993; Kikulis, Slack, & Hinings, 1995) but can have one of the following different trajectories:

- A successful reorientation, which is a quick simultaneous and parallel change in all three components of the archetype;
- An unresolved excursion, which is a decoupling from an archetype without a complete recoupling to a different archetype;
- An aborted discursion, which is a decoupling from an archetype with movement towards another archetype and then a return to the original archetype; and
- Inertia, which is an instance of no change.

A professional archetype is more inclined towards stability than change (Mintzberg, 1978, 1983). In healthcare radical change in the delivery model is complicated by a number of factors (Denis, Lamothe, & Langley, 2001; Lee, Weiner, Harrison, & Belden, 2013) including the wickedness of healthcare issues (Austrailian Publis Service Commission, 2007; Conklin, 2006b; Raisio, 2009; Rittel & Webber, 1973; Vartiainen, 2005), the hospital as a complex adaptive system (Anderson, 1999; Barach & Johnson, 2006; Ferlie & Dopson, 2005; Kickert, Klijn, & Koppenjan, 1997; McKelvey, 1999; Shiell et al., 2008) and the distributed professional skills and leaderships in healthcare organisations (Godfrey et al., 2003; Nelson et al., 2003; Nelson et al., 2002). In healthcare organisations an imperative exists to build consensus at different levels rather than relying on charismatic leaders (Buchanan, Addicott, Fitzgerald, Ferlie, & Baeza, 2007; Dickinson et al., 2013b). Successful reorientation is more the exception rather than the rule (Ferlie, 2002; Greenwood & Hinings, 1993; Kitchener, 1998). Change driven from the top, in healthcare environments, is difficult (McNulty & Ferlie, 2004; Waring & Currie, 2009) because professional values are difficult to change (Crilly & Le Grand, 2004; Kirkpatrick & Ackroyd, 2003a). The Cabinet committee process that excluded doctors from making an input into the formulation and assessments resulted from a failure to acknowledge wickedness, complexity, multiplicity of logics and expectations so that despite the upheavals over three decades of managerial healthcare policy the professional bureaucracy is still operative (Crilly & Le Grand, 2004; Currie & Suhomlinova, 2006; Dickinson et al., 2013b).

5.7.1.7 A change in archetype: from a district general hospital to a market-oriented hospital

This section reflects on the processes that led to the change from the traditional publicly owned and operated district general hospital to the quasi-market trust (Kitchener, 1998), the NPM hospital (Fitzgerald & Ferlie, 2000a) or perhaps the post-bureaucratic hospital (Hoggett, 1996). It is important to keep in mind the focus of this study, which is the explication of the main

concern and its continual resolution by the participants of the study. Hence, the attention of this study is directed at institutional complexity (Goodrick & Reay, 2011; Greenwood et al., 2011), the agency of the participants (Delmestri, 2006; Emirbayer & Mische, 1998; Friedland & Alford, 1991a; Hwang & Colyvas, 2011; Powell & Colyvas, 2013) and the observed practices and behaviours (Smets & Jarzabkowski, 2013a; Smets, Morris, & Greenwood, 2011) of the inhabitants (Hallett & Ventresca, 2006; Hughes, 1971) at the coalface of institutionalism (Barley, 2008) as the carriers of the logics (DiMaggio, 1988; Friedland & Alford, 1991a; Jepperson, 1991; Zilber, 2002).

The Conservative government introduced a White Paper, Working for Patients (Department of Health, 1989) that was enacted in 1990. As with the Griffiths Report (Griffiths, 1983, 1992), the medical profession did not participate in drafting the document. A cabinet committee, rather than a royal commission of all stakeholders, prepared the document. This is strange, given the wickedness of the social organisation of healthcare (Raisio, 2009; Rittel & Webber, 1973; Vartiainen, 2005) and the complexity of the hospital as an organisation (Holland, 1999; Strauss et al., 1963; Waldrop, 1994). The first thing to note was the introduction of a quasi-market in the NHS. The government legislated the separation of the delivery of healthcare services from the purchasing of services (Le Grand, 2009a; Propper et al., 1998; Walsh, 1995; Weber & Khademian, 2008). Healthcare authorities would focus on a purchasing function on behalf of geographic populations while providers would engage in competition to win contracts from purchasers. The White Paper, Working for Patients could be considered a tame solution to a wicked problem (Vartiainen, 2005; Weber & Khademian, 2008; Weick & Roberts, 1993). Wicked problems require the adoption of patiently constructed collaborative processes where ambiguity, complexity and uncertainty are accepted as part of the processes of trying to define the problems and crafting solutions. Moreover, the complexity of the spatio-temporal rhythm of the hospital means that the NPM management model was hardly appropriate.

Structure

Planning by health authorities based on the needs of geographic populations was replaced by resource allocations as determined by a quasi-market, financial incentives and competition (Farrell & Morris, 2003; Le Grand, 2009a; Pollock, 1992, 2005). Fragmentation replaced integration, albeit bureaucratic. In considering the move to quasi-market competition, management-based control systems and metrics-based performance-management systems (Exworthy, 2010a; Farrell & Morris, 2003; Greener, 2003), wickedness and complex adaptive system features were arguably ignored. Years later attempts would be made again to fix the fragmentation as patients, especially elderly, frail patients with multiple medical ailments, fell through the cracks (Ham, Imison, Goodwin, Dixon, & South, 2011c; Ham, Smith, & Eastmure, 2011d; Lewis, Rosen, Goodwin, & Dixon, 2010).

NHS hospitals became independent NHS hospital trusts with Boards of Directors that would assume responsibility for the operational management of the hospital. The regional and district health authorities – as representatives of the Secretary of State with a legal duty to provide a

comprehensive and free NHS – would no longer retain operational responsibility for the delivery of healthcare. The managed hospital was a departure from the professional bureaucracy (Ashburner et al., 1996; Exworthy et al., 2010b; Kitchener, 1998; Kitchener & Whipp, 1998; Mintzberg, 1979). Professional power and autonomy (Ackroyd et al., 2007b; Harrison & Ahmad, 2000a; Waring & Currie, 2009) receded. The first assumption was that competition would lead to increased efficiency (Propper et al., 1998; Söderlund, Csaba, Gray, Milne, & Raferty, 1997). Secondly, GPs would hold funds for purchasing some services from providers on behalf of their patients (Crisp, 2005; McNulty & Ferlie, 2004). Working for Patients introduced financial incentives into the NHS (Kay, 2002; Pollock, 2005). The medical profession exploded in anger that the founding political consensus of the NHS was at risk (Mulligan, 1998; Pollock, 2005). Others argued that not much had changed (Klein, 2013; Mulligan, 1998). Some said that new business model had changed the dynamics of the NHS (Mays, Mulligan, & Goodwin, 2000; Pollock, 2005).

Working for Patients also changed the relationship between hospital consultants and the hospitals. Previously the Regional Health Authority employed doctors. Now they became employees of the hospital, with employment contracts that were managed by the management of the hospital. Private practice was to be limited by the management; i.e. doctors would have to commit themselves to work for the hospital in a more structured manner. Moreover, hospital management could employ all hospital staff on locally agreed terms and conditions. National bargaining agreements between the state and representative medical professional organisations could be adjusted at a local level. Clinical excellence awards (extra income for going the extra mile in developing clinical services) would have management input for the first time. Lastly, doctors had to take part in medical audits in which their clinical practices would be reviewed (Klein, 2013; Mooney, 2009). Medical audits linked the clinical decisions with the effectiveness and efficiency of their resource implications. The hospital had to deliver value for money (Dunleavy, Margetts, Bastow, & Tinkler, 2006; Hood, 1991; Pallot, 1998). That meant that, for the first time in the history of the NHS, managers had managerial oversight over consultant outputs (McKee & Healy, 2002). Doctors have always been of the most expensive members of staff.

Decision-making systems

The NHS hospital Trust has a statutory duty to balance its books. At the same time to create pressure to use assets productively a 6% capital charge was introduced on the value of buildings, land and equipment and a 3% efficiency savings target was introduced (Pollock & Gaffney, 1998). These were new charges on the “revenues” of the hospitals. The NHS hospital moved from input controls and cost containment (Dunleavy et al., 2006; Hood, 1991; Pallot, 1998), such as numbers of beds and nurses, to output controls, such as numbers of patients treated and operations performed. Hospitals were to operate like private businesses. The focus on efficiency, contracts and competition meant that decision-making systems had to be put in place. So investments were made in IT systems. Management staff was hired so that the hospital could be efficient and competitive. Key numbers were to be tracked. The management of

budgets and costs assumed greater significance. The relationship between the hospital and the health authorities had changed from being based on trust to being based on contracts between providers and purchasers (Pollock, 2005). The aim of the contracts was to introduce transparency into the agreements between purchasers and providers regarding the specifications of services to be delivered. The administration of the contracts resulted in increased administration costs (Paton, 1995; Söderlund et al., 1997). Moreover, hospitals were disaggregated into clinical directorates that were managerially inspired collections of clinical services under the leadership of a senior consultant who was assisted by a general manager and often a senior nurse. The medical profession was against the introduction of competition but was less hostile on the matter of clinical directorates (Klein, 2013). Hospital doctors had to participate in clinical audits (Hitchen, 2008; Mooney, 2009). Clinical audits strengthened the control of managers and linked clinical activities and financial management imperatives (Pollock, 2005).

The structure changed significantly. Decision-making systems were improved. However, the Boards were not in a position to make significant strategic decisions because the service mix and "prices" for services were centrally controlled although theoretically the market should determine the service mix (Exworthy et al., 2010b; Exworthy & Greener, 2008). Providers had to deliver services according to NHS standards. Should a hospital fail to meet its financial and service obligations, the Secretary of State could intervene in its operational affairs. The Board of Directors could be replaced. Doctors were not clamouring to become clinical directors. These were positions that were of a part-time nature and the primary source of identity for doctors had always been clinical (Ashforth & Johnson, 2001; McGivern et al., 2015; Spyridonidis, Hendy, & Barlow, 2014).

Control in the hospital was, however, not through managerial hierarchies. Its functioning as a complex adaptive system (Holland, 1999; Waldrop, 1994) and therefore its self-organisation, non-linearity and emergence suggest that strong management might not be particularly effective. Some scholars proposed that the hospital remained a professional bureaucracy (Currie & Suhomlinova, 2006; Dickinson et al., 2013b; Ferlie, 1999). Professional leadership still played a substantial role in leading clinical services and remained dispersed across a number of individuals in the hospital (Crilly & Le Grand, 2004; Godfrey et al., 2003; Nelson et al., 2003; Nelson et al., 2002). The administrator, who became a general manager and later a CEO of the independent NHS Trust, still had to deal with a clinical frontline that retained control over their work. The managerial NHS Trust reduced its costs and increased its throughputs (Mulligan, 1998; Söderlund et al., 1997). Its wards became busier and noisier (McKee & Healy, 2002). The spatio-temporal rhythm of the district general hospital had been replaced by the frenzy of the quasi-market trust. Professional bureaucratic decision-making systems had changed to a sedimented hybrid decision-making system that was a mixture of centralisation and decentralisation, professionalism, bureaucracy, markets and later networks (Cooper et al., 1996; Exworthy et al., 2010b; Exworthy et al., 1999; Kirkpatrick, 1999).

Interpretive scheme

A change in the interpretive scheme is fundamental to an archetype approach to radical institutional change. The question is: given the significant structural changes and the less fundamental changes in the decision-making systems, has there indeed been a change in the interpretive scheme? Already, it should be clear that a radical change may not have taken place because this would involve simultaneous and parallel change in the structures, decision-making systems and the interpretive scheme. It would be amiss to argue that the interpretive scheme did not change, given that the structure and the decision-making systems radically changed. Doctors were less hostile to clinical directorates than they were to the Griffiths general managers. The evidence on this matter is mixed. Communication between primary care GPs and hospital consultants improved because of GP fundholding (Glennester, Matsaganis, Owens, & Hancock, 1994; Smith et al., 2005). Competition, instead of improving patient outcomes, resulted in poorer outcomes (Cooper & Le Grand, 2007; Pollock, 2005; Propper et al., 1998). Professional reservations were reinforced. The lack of fundamental change was said to be due to the market-oriented incentives being too weak and the constraints too strong (Ham, 1999; Le Grand, Mays, & Mulligan, 1998a). Waiting lists of fundholding GPs came down at a faster rate than those of the health authorities (Dusheiko, Gravelle, & Jacobs, 2004), which suggested that commissioning was potentially useful. However, non-market relationships were hard to change (Allen, 2002; Checkland et al., 2011). Healthcare services are not readily bought and sold as commodities; hence, competition and contracts are difficult to frame and administer, which complicates changes in the interpretive scheme (Ferlie et al., 1996b; Shaw, Smith, Porter, Rosen, & Mays, 2013). Despite talk of decentralisation away from the Department of Health, central bureaucratic control remained very strong (Braithwaite, Westbrook, & Iedema, 2005; Exworthy et al., 2010b; Exworthy et al., 1999; Kirkpatrick, 1999). The hostility towards general management was not repeated with the introduction of clinical directors (Braithwaite et al., 2005; Fitzgerald & Dufour, 1998; Klein, 2013).

The unevenness in the scope and rates of change in structures, systems and interpretive schemes raises questions about a key hypothesis of archetype coherence in the longer term (Greenwood & Hinings, 1988; Greenwood & Hinings, 1993). The longevity of a hybrid archetype and an unresolved excursion with the quasi-market hospital trust (Kitchener, 1998; Kitchener & Whipp, 1998) or the NPM archetype hospital (Ferlie, 1999) call into question the soundness of the "tracks of change" argument as well. In the context of institutional complexity (Greenwood et al., 2011) and a practice-based approach to institutional complexity (Smets & Jarzabkowski, 2013a) – discussed later in this section – the ambiguities, paradoxes and contradictions in large-scale change become clearer as enduring and socially constructed.

Since no quick, parallel and simultaneous change took place in the structure, systems and interpretive scheme in the change from a district general hospital to a quasi-market or NPM hospital trust, it is questionable whether radical archetype change had indeed taken place. Over time, the patterns of value commitments and interests of the two major players in healthcare remained fundamentally at odds despite the external pressures in the field that precipitated the

crisis. The government had the monopoly of power as funder and rule-maker but it lacked capacity for action and its agents (i.e. managers) did not have the power to move the healthcare organisations irretrievably in a managerial direction. The structures changed significantly, the decision-making systems were more constrained and the interpretive scheme hardly moved. From a wicked problem perspective, it is unclear whether the fragmentation between purchasers and providers and the competition between providers necessarily was a good move. Moreover, the reinforcement of the vertical walls silos between providers and agencies involved with healthcare, transport, education and social welfare can hardly be said to have helped. It is also not obvious how strong CEOs could impose their executive will on the distributed, collective clinical leadership in an acute hospital.

The introduction of quasi-markets was an incomplete shift from the public sector bureaucracy (Exworthy et al., 2010b). What were the role of institutional complexity (Goodrick & Reay, 2011; Greenwood et al., 2011) and the agency of the participants (Delmestri, 2006; Emirbayer & Mische, 1998; Friedland & Alford, 1991a; Hwang & Colyvas, 2011; Powell & Colyvas, 2013) in this shift? How do the observed practices and behaviours (Smets & Jarzabkowski, 2013a; Smets et al., 2011) of the inhabitants (Hallett & Ventresca, 2006; Hughes, 1971) clarify the dynamics of this change? What has been happening at the coalface of institutionalism (Barley, 2008), who are the carriers of the sedimented logics (Delmestri, 2006; DiMaggio, 1988; Jepperson, 1991; Zilber, 2002). The messiness, complexities and paradoxes are further clarified in Section 5.10, where the literature is integrated into the GT established in Chapter 4.

5.7.1.8 Networks

After the Conservative government left office in 1997, the New Labour government took office with a "third way" of organising healthcare delivery; i.e. neither hierarchy nor markets. The internal market was dismissed as wasteful but a key element of this market was retained; i.e. the purchaser-provider split. Healthcare providers had to collaborate. Complex, non-elective conditions require integrated service delivery. These healthcare services include as treatments for frail, old people with multiple chronic conditions; stroke services; and paediatric heart surgery. Clinical networks of providers from the social, primary, secondary and tertiary care services were expected to coordinate care for these groups of patients (Edwards, 2002; Goodwin, Curry, Naylor, Ross, & Duldig, 2010; Goodwin et al., 2004; Ham, Dixon, & Chantler, 2011b; Ham et al., 2011c; Ham et al., 2011d). Networks put the patient at the centre of the service design, improve access to care, transcend professional boundaries and share best practice. Collaboration would promote efficiency, effectiveness and quality of care (Edwards, 2002; Hamilton et al., 2005). Managed care networks took account of the cross-cutting nature (Sullivan & Skelcher, 2002b) of healthcare. However, the ambivalence in policy appears to have escaped government, which insisted on retaining a purchaser-provider split, competition between providers, and performance management of individual providers while at the same time expecting them to collaborate.

Between 1999 and 2009, the new government strengthened the regulatory framework as another means to improve quality. Initially, until 2000, there was a subtle shift away from competition as a route towards efficiency and quality to collaboration and tighter regulation to achieve the same ends. The government established the Commission for Health Improvement (CHI), later replaced by the Healthcare Commission and more recently the Care Quality Commission. Scandals in medical practice created a moment for government to remove the implied responsibility for quality assurance from the clinical professionals and to meet pre-existing political objectives of controlling the clinical frontline (Dixon-Woods et al., 2011; Kennedy, 2001; Smith, 1998). The NICE (renamed the National Institute for Health and Clinical Excellence in 2005) was set up to formulate clinical guidelines and protocols of best practice based on the available evidence (Ferlie & McGivern, 2013; Timmermans & Berg, 2003; Timmermans & Kolker, 2004). Quality assurance was being codified. National service frameworks were drafted to promote consistency of service delivery across organisational boundaries. These were evidence-based professional consensus guidelines of what was considered good clinical practice for particular conditions or groups of patients. These central institutions aimed to promote consistently high clinical quality, irrespective of geographical location.

Decentralisation was proclaimed loudly. It was probably more the continuation of centralised decentralisation (Exworthy et al., 2010b; Klein, 2001a). Once again the state lacked the capacity for action (Hinings, 2008) as it lacked a clear vision of what a network archetype would look like, how it would fit within the residual quasi-bureaucracy, quasi-market archetypes (Allen, 2002; Exworthy et al., 1999; Kirkpatrick, 1999). There was also not a clear plan to manage the migration from an already deeply sedimented archetype (Brown et al., 1996). Managed care networks have been described as sedimented archetypes (Addicott & Ferlie, 2006). Once again the contradictions have implications for institutional complexity (Goodrick & Reay, 2011; Greenwood et al., 2011). How does agency of the participants (Delmestri, 2006; Emirbayer & Mische, 1998; Friedland & Alford, 1991a; Hwang & Colyvas, 2011; Powell & Colyvas, 2013) unfold? What do the observed practices and behaviours (Smets & Jarzabkowski, 2013a; Smets et al., 2011) of the inhabitants (Hallett & Ventresca, 2006; Hughes, 1971) suggest about the compromises and choices being made? What pictures do we see at the coalface of institutionalism (Barley, 2008)? What is happening with the hospital doctors, amongst other staffs, who are also carriers of the logics (DiMaggio, 1988; Jepperson, 1991; Zilber, 2002)?

The meanings and purpose of the managed care networks have not been clear; i.e. were they to manage the linkages between organisations or were they responsible for service delivery (Addicott & Ferlie, 2006; Addicott et al., 2006; Agranoff & McGuire, 2001; Wistow & Dickinson, 2012)? The managed care networks did not have budgetary responsibility as that still resided with the commissioners of services. Provider organisations had individual service delivery and quality targets to meet. Clinicians – without any operational authority – managed the care network board which in turn managed the networks while the organisations that employed them had to deliver the services and meet targets (Addicott, 2008). The networks had to

structure services according to national service framework and NICE guidelines so they had very little room for discretion. The managed care networks had unclear responsibilities with limited or no authority (Exworthy et al., 2010b; Fitzgerald, Mark, McKee, Addicott, & Ferlie, 2007; Wistow, Dickinson, Cunningham, Morris, & Braithwaite, 2012). The autonomy of individual frontline clinicians was constrained while an administrative and knowledge elite protected the collective autonomy of the profession (Domagalski, 2007; Freidson, 1988) or themselves. It could also be seen as indirect steering from the centre (Ferlie & McGivern, 2013; Miller & Rose, 2008). The networks had limited strategic decision-making capacity with a healthcare policy-focus on structural configuration and performance management (Addicott, 2008; Exworthy et al., 2010b). This often meant that expertise had to be centralised in secondary and tertiary centres with smaller district general hospitals doing routine treatments (Fitzgerald et al., 2007). Amidst all the change so much appears to remain the same.

What happened to the interpretive scheme? Was the new value system more collegial, horizontal and professional than a system that underpinning command and control in a hierarchy or competition by markets? The managed care networks assumed operational responsibility for managing the linkages between organisations that remained accountable for meeting targets and delivering services according to national service frameworks, clinical guidelines and protocols. In a system where efficiency, effectiveness and outcomes are set in a strong and centrally controlled metric-based performance-management system (Exworthy, 2010a; Farrell & Morris, 1999; Power, 1999) of targets to reduce waiting times (Bevan & Hood, 2006; Propper et al., 2008), it is hard to see the operational effect of the official rhetoric of collaboration and care networks while the guiding principle for resource allocation remained quasi-bureaucratic and quasi-market (Exworthy et al., 2010b; Fergusson, 2000).

The collaboration-competition paradox appeared to be unproblematic to the policymakers. Yet, the operational reality at the coalface it could hardly be more different. An elite emerged that captured some of the managerial jurisdiction (Abbott, 1988) of the managed care networks. The medical once again, restratified (Freidson, 1988). The academic clinicians at teaching hospitals recaptured central roles in the managed care networks and their power reverted to what it had been at the time of the establishment of the NHS (Pollock, 2005). Traditional bureaucratic norms still applied to a networked NHS hospital (Addicott & Ferlie, 2006; Addicott et al., 2006; Exworthy et al., 2010b). The NHS continued to function as a professional bureaucracy (Currie & Suhomlinova, 2006; Dickinson et al., 2013b).

The interpretive scheme of managed care networks was an amalgamation of managerial, professional and bureaucratic beliefs, values and material practices. However, one does not appear to get a tangible sense of how hospital consultants adapt to, avoid, manipulate and compromise (Lawrence, 2008; Oliver, 1991) with the new managerialist structuring of service delivery. How did they find their ways within the complex balance between strategic direction and operational control (Currie et al., 2009; Farrell & Morris, 2003; Freidson, 1985; Waring & Currie, 2009)?

The next, and last, archetype is that of foundation trusts, which are discussed in the next section.

5.7.1.9 Foundation trusts

After a few years of joined-up government (Bogdanor, 2005; Sullivan & Skelcher, 2002a) and managed care networks (Guthrie et al., 2010; Le Grand, 2003), in 1999, the Labour government announced another changed policy direction. The new policy was a return to market-based competition, management-based control systems and metrics-based performance-management systems (Farrell & Morris, 2003; Harrison & Ahmad, 2000b). It would eventually be based on patient choice, money following the patient (payment by results) and a diversity of healthcare providers. The Health and Social Care Act (2003) was the instrument that created a new hospital structure: the Foundation Trust. This was set up as a public benefit corporation in 2004. The policy has been dismissed as privatisation below board level (Pollock, 2005; Unit, 2003). High-performing NHS trusts could gain greater autonomy as foundation trusts (Allen et al., 2010; Day & Klein, 2005) that could be used to drive further improvements (Exworthy, 2010a).

Structure

The NHS Foundation Trust is not accountable to the Secretary of State or the NHS bureaucracy (Francis, 2013; Unit, 2003). An independent regulator, Monitor, reports to Parliament on behalf of foundation trusts. All high-performing NHS Trust hospitals are eligible for the right to a licence to operate as foundation trusts. Monitor primarily assumes responsibility for the financial integrity of the Foundation Trust. The government intended that all NHS trusts should become foundation trusts by 2008 (House of Commons Health Committee, 2008). That target was extended to 2013/14 (Department of Health, 2010) and the policy objective still seems unattainable as many foundation trusts and NHS hospital trusts have severe financial and quality of care issues (Francis, 2013; O'Dowd, 2013; Pollock & Price, 2013b). Even foundation trusts have been running into all sorts of financial and operational problems.

Decision-making systems

Since the Foundation Trust remains within the NHS, it has to operate according to NHS standards and is subject to the NHS quality-of-care inspectorate bodies. Foundation trusts are not required to balance their books and can borrow funds up to prudential limits set by Monitor. A Board of Directors is answerable to Monitor and assumes operational responsibility for the Foundation Trust. A Board of Governors represents all the stakeholders, including the staff, and the local community is a means to promote local accountability and citizen involvement in the running of the hospital (Allen et al., 2011b; Klein, 2013). The relationships between the two structures are not always clear (Audit Commission, 2008; Day & Klein, 2005). However, matters appear to be improving (Allen et al., 2011b; Exworthy et al., 2010b). Like NHS hospital trusts, foundation trusts have contractual relationships with commissioners and other service providers. A standard fee-for-service delivered, Payment-by-Results, was introduced. The money would follow the patient. It would be aimed at promoting entrepreneurialism and

efficiency among providers. The private sector could also compete with, or deliver services on contract to, the Foundation Trust. This has been criticised as a way to contain costs through cherry-picking uncomplicated patients and medical procedures. Thus, potentially undermining the principles of equity, access, comprehensiveness and universality (Pollock, 2005). A system of contracts, pricing and competition opens the door to privatisation (Unit, 2003).

Foundation trusts' greater financial and operating freedoms are supposed to make them more responsive and innovative (Audit Commission, 2008). Foundation trusts added new wards and theatres (Allen et al., 2011b) but they could have done more, as indicated by the large retained surpluses in their bank accounts and their unwillingness to depart from nationally agreed conditions of employment for their staff, including clinicians (Audit Commission, 2008). Despite their freedom from operational management by the Department of Health, they are still subject to the NHS outcomes framework and national targets (Allen et al., 2011b; Exworthy et al., 2010b). The Foundation Trust can go into joint venture agreements with other providers – including the private sector – to provide or buy-in services. This would expand capacity and be an avenue for innovation. However, it could also be seen as a backdoor to privatisation (Pollock, 2005; Unit, 2003). A critical reading of the purchasing authorities is that they have not been effective in their role of moving services away from high-cost acute hospitals to cheaper alternatives in the community (Audit Commission, 2008; Robinson et al., 2011; Smith, Curry, Mays , & Dixon, 2010). Since the Foundation Trust has remained part of the NHS, changes in the service mix have to be agreed with Monitor and the commissioning authorities. So decision-making is an overlapping maze among the Department of Health, the Care Quality Commission, the Board of Directors, the Board of Governors and Monitor.

In terms of the interpretive scheme, the targets and performance-management terror regime (Bevan & Hood, 2006; Exworthy et al., 2010b; Greener, 2003; Propper et al., 2008) had proved to be insufficient to reduce the waiting lists and concerns with quality. Supplier competition was reinstated as a key operating principle to meet the expectations of the state, the public and the patients (Hawkins, 2011; Stevens, 2004). The senior management had become more rational (Mannion et al., 2009) while the hospital remained a professional organisation (Currie & Suhomlinova, 2006; Dickinson et al., 2013b; Kitchener, 1999a; MacDonald, 2006). The reticence to take full advantage of the freedoms to borrow money to develop services and employ staff in terms of locally agreed terms and conditions (House of Commons Health Committee, 2008) shows that it is difficult to change professional values (Crilly & Le Grand, 2004). The embeddedness of the hospital within a local healthcare economy constrains the impact of attempts at organisational change (Exworthy et al., 2010b; Smith et al., 2010). Non-market relations between commissioners and providers were still robust despite the structural and decision-making systems changes (Porter, Mays, Shaw, Rosen, & Smith, 2013).

5.7.1.10 Summary of the archetype approach to institutional theory in NHS change

This review of an archetype approach to institutional theory shows how difficult it has been to implement market-based reform within a professional context (Crilly & Le Grand, 2004;

Dickinson, Shaw, Glasby, & Smith, 2013c). Moreover, it allowed one to see how institutional complexity (Greenwood et al., 2011) and the constellation of logics (Goodrick & Reay, 2011) are socially constructed and dynamic. The underlying wickedness and complexity bedevilled the attainment of healthcare policy objectives (Allen, 2013; Dickinson, Glasby, Nicholds, & Sullivan, 2013a). It is important to take explicit account of history to appreciate the contingency, situatedness and flux of the hospital as an organisation (Bjerregaard & Jonasson, 2014).

However, much of the literature on organisational change in the NHS has dealt with structural changes (Addicott & Ferlie, 2006; Addicott et al., 2006; Ashburner et al., 1996; Exworthy et al., 2010b; Kitchener, 1998) at organisational level and not much is really known about how individuals deal with these changes on a mundane, routine, everyday basis (Barley, 2008; Pache & Santos, 2013a; Smets & Jarzabkowski, 2013a; Smets et al., 2012). The rest of the literature review examines the hospital as a professional organisation that houses multiple logics under its roof (Battilana & Dorado, 2010; Kraatz & Block, 2013; Pache & Santos, 2010), including hierarchy, markets, networks, bureaucratisation, commercialism, professionalism and public service (Dickinson et al., 2013c; Exworthy et al., 1999; Kirkpatrick, 1999). These can lead to contradictory demands being made on the hospital (Pache & Santos, 2010; Thornton & Ocasio, 1999, 2013; Zilber, 2002). These logics and demands are not incompatible by definition (Besharov & Smith, 2013; Friedland & Alford, 1991b; Reay & Hinings, 2009) but their relative incompatibility is a function of the actual practice context (Jarzabkowski & Spee, 2009b; Smets & Jarzabkowski, 2013a). This part of the literature review visits the practice context; i.e. the coalface of institutionalism (Barley, 2008), where the inhabitants of institutions (Hallett & Ventresca, 2006; Scully & Segal, 2002) enact behaviours, and material practices and symbolic systems of meaning are manifestations and instantiations of institutional logics (Thornton & Ocasio, 1999, 2013; Zilber, 2008). This section of the literature review draws a theoretical line from micro-institutional processes to macro-institutional processes.

5.8 INSTITUTIONAL COMPLEXITY

Institutional logics have been described as "socially constructed, historical patterns of material practices, assumptions, values and rules" (Thornton & Ocasio, 1999) that shape the beliefs and behaviours of actors. Institutional logics are thus the rules of the game and frame the worldviews and behaviours of actors within given contexts. The acute hospital, like many other organisations, has come to embed multiple conflicting logics under one roof (Battilana & Dorado, 2010; Kraatz & Block, 2013; Pache & Santos, 2013b). These comprise a hierarchical bureaucracy, a quasi-market and a quasi-network (Cooper et al., 1996; Exworthy et al., 2010b; Exworthy & Greener, 2008; Exworthy et al., 1999; Kirkpatrick, 1999). Each of structural configurations has different implications for the ways in which the hospital goes about organising the delivery of service and criteria for success or failure.

One could also say that a hospital combines multiple logics in novel ways (Battilana & Dorado, 2010; Thornton et al., 2012). Alternatively, it can be considered as a place that manages to blend different logics that are relatively compatible (Haveman & Rao, 1997). Much of the work in

institutional theory on responses to institutional complexity has been largely structural and at an organisational level (Greenwood et al., 2011; Pache & Santos, 2010; Smets & Jarzabkowski, 2013a). An organisation has to engage in a type of institutional bricolage where it adopts either parts of different logics to construct a new overarching hybrid logic or complete sub-units of given logics and constructs a new logic. Organisations can engage in strategic decoupling – manipulating templates from competing logics (Battilana, Sengul, Pache, & Model, 2014; Pache & Santos, 2013b). Other practices include the importance of an overarching, integrated organisational identity in dealing with multiple, competing logics (Battilana & Dorado, 2010; Kodeih & Greenwood, 2014; Kraatz & Block, 2013). For example a study of four French business schools (Kodeih & Greenwood, 2014) examined how they had to cope with the increasing internationalisation of business education while retaining their distinctive traditional French orientation. In another study, a natural food organisation manages the competing logics associated with idealism and social welfare on the one hand and pragmatism and commercialism on the other (Ashforth & Reingen, 2014).

Multiple institutional logics also raise questions about an underlying assumption of a singular organisational identity in organisation studies (MacLean & Webber, 2014). However, as mentioned above, organisations are sites that often embed multiple logics (Friedland & Alford, 1991b; Haveman & Rao, 1997; Kraatz & Block, 2013; Meyer & Rowan, 1977). Therefore, one could say that organisations are arenas for the contestation of multiple logics (Greenwood et al., 2011; Pache & Santos, 2013a; Thornton et al., 2012; Zilber, 2002). Much of the attention given to organisation studies has assumed that one logic will prevail, especially in the short term (Pache & Santos, 2010), and that the organisation could make strategic and tactical adaptations (Kraatz & Block, 2013; Oliver, 1991; Pache & Santos, 2013b). However, how do organisations, and the people within those organisations, respond in contexts where multiple logics are permanently part of the operations (Besharov & Smith, 2013; Greenwood et al., 2011; Reay & Hinings, 2009; Zilber, 2011)?

This GT study does not address how the organisation responds but rather how individuals respond to these competing logics on a routine, everyday basis. In doing this, it fills a gap in the literature on institutional theory (Battilana & Dorado, 2010; Pache & Santos, 2013a; Smets & Jarzabkowski, 2013a; Smets et al., 2012). Earlier in the literature review, it was shown how the government policies, as macro-institutional logics, frame the hospital as an organisation that houses multiple, sedimented logics under one roof (Goodrick & Reay, 2011; Greenwood et al., 2011). The next question is: how do these logics – in turn – shape, constrain and stimulate the agency of the participants (Foucault, 1977; Hughes, 1971; Knights & Willmott, 1989)? What is the nature of the mutual implication of the hospital as a structure and the agency of the hospital consultants (Berger & Luckmann, 1967; Blumer, 1971; Giddens, 1984; Hughes, 1971)? From the perspective of institutional entrepreneurship (DiMaggio, 1988; Maguire, Hardy, & Lawrence, 2004) and institutional work (Lawrence et al., 2013; Lawrence & Suddaby, 2006), what is the nature of the individual agency (Battilana & D'Aunno, 2009a; Emirbayer & Mische, 1998; Hwang & Colyvas, 2011; Powell & Colyvas, 2013) that is employed as the participants engage with

institutional complexity on an everyday, routine basis? Does "purposive" in institutional work that is aimed at creating, maintaining and disrupting institutions (Lawrence et al., 2013; Lawrence & Suddaby, 2006) mean having a clear vision that one single-mindedly pursues. Or, is agency more situated, dynamic, improvised and emergent (Smets & Jarzabkowski, 2013a; Smets et al., 2012)? How does the structure shape and stimulate agency (Hwang & Colyvas, 2011; Yu, 2013) with the day-to-day agency iteratively creating and shaping structure (Hwang & Colyvas, 2014; Powell & Colyvas, 2013)?

On the one hand, a closed loop exists between structure and agency. On the other hand, agency underpins the practical, routine, everyday actions of the participants (Smets & Jarzabkowski, 2013a) as carriers of institutional logics (Delmestri, 2006; DiMaggio, 1988; Jepperson, 1991; Zilber, 2002). These routine, observed behaviours are, in turn, instantiations of agency. So a second closed loop is formed between agency and observed practice. What are the micro-foundations of institutionalism? How does institutionalisation take place in the absence of the drama (March, 1981) associated with institutional entrepreneurship and institutional work (Suddaby, Lawrence, & Leca, 2009) but is grounded in everyday practice (Jarzabkowski et al., 2013b; Smets & Jarzabkowski, 2013a; Smets et al., 2012).

As was mentioned earlier, healthcare organisation is a wicked issue and a hospital, as a place where healthcare is delivered, is a complex place. Performance management has become a central feature of the managerial public service (Exworthy, 2010a; Farrell & Morris, 2003; Pollitt & Bouckaert 2011). Yet wickedness and complex adaptive systems appear not to moderate the certainties of the centrally controlled performance-management system (Bevan & Hood, 2006; Smith, 2002b; Talbot, 2009). Many of the services, such as mental health, elderly patients with multiple chronic comorbidities and children with complex chronic conditions, diabetes care, cancer services, stroke services and paediatric heart surgery, are not readily transformed into products that can be competitively bought and sold as commodities (Allen, 2013; Ashburner et al., 1996; Porter et al., 2013; Walsh, 1995). There are areas where the nature of the service is in conflict with a competitive ethos and service improvement is more important than the choice of provider (Lewis et al., 2010). Also the need for service integration (Curry & Ham, 2010; Dixon, Mays, & Jones, 2012; Hawkins, 2011) conflicts with the ways in which providers are reimbursed for costs and performance is measured. Examples of these tensions are found in the provision of stroke services, paediatric heart surgery, knee surgery, hip replacements and treatment of cataracts. For some services, a robust regulatory framework of standards, periodic inspections, performance data and patient choice are important drivers. For other services, target standards, procurement rules, training staff for quality outcomes and increased funding are more important (Dixon et al., 2012).

Wickedness (Austrailian Publis Service Commission, 2007; Raisio, 2009; Vartiainen, 2005), institutional complexity (Greenwood et al., 2011) and the constellation of logics (Goodrick & Reay, 2011) have different impacts on the different subsystems in the hospital (Godfrey et al., 2003; Nelson et al., 2003; Nelson et al., 2002). These structural features differentially affect the different types of services that they deliver (Dixon et al., 2012; Hawkins, 2011; Lewis et al.,

2010) and the people inside the organisation who carry logics (DiMaggio, 1988; Jepperson, 1991; Zilber, 2002). The complexities, tensions and congruence between the processes of macro-institutionalisation and micro-institutionalisation (Gray, Purdy, & Ansari, 2015; Smets et al., 2012) are resolved by the inhabitants of the institutions (Hallett & Ventresca, 2006; Hughes, 1971; Scully & Segal, 2002) as they go about their everyday, routine workplace activities at the coalface (S. R. Barley, 2008). The clinical frontline is where the logics are translated into techniques, technologies and procedures and people deal with these, not logics in the abstract. An absence of drama (March, 1981) conceals the difficulties that the frontline staff members have to juggle as they deliver healthcare services to patients.

So, what does it mean to be a hospital consultant in a managerial hospital; i.e. an inhabitant of a hybrid institution who operates at the clinical coalface? Numerous calls have been made for accounts of how professionals get by on a day-to-day basis in managerial organisational contexts (Correia, 2013; Noordegraaf, 2011; Numerato et al., 2012; Thomas & Davies, 2005; Tonkens, Broer, van Sambeek, & van Hassel, 2013). There has been a shortage of studies that look at actors as carriers of logics (Jarzabkowski, 2009; Smets et al., 2012; Zilber, 2002) within an institutionally complex environment (Greenwood et al., 2011) made up of a constellation of logics (Goodrick & Reay, 2011).

The plural institutional demands (Battilana & Dorado, 2010; Fligstein, 1997; Friedland & Alford, 1991a; Jay, 2013; Pache & Santos, 2010; Zilber, 2002) are not mutually exclusive and contradictory. These logics can be both complementary and contradictory (Besharov & Smith, 2013; Friedland & Alford, 1991a). People, on the clinical frontline, work out the relationships between logics in their day-to-day practices (Jarzabkowski et al., 2013b; Thornton & Ocasio, 2013; Thornton et al., 2012). Institutional logics provide criteria for what are considered appropriate and the means to achieve them. Logics shape, constrain and stimulate the possibilities for agency by organisations and individuals (DiMaggio & Powell, 1983; Foucault, 1977; Meyer & Rowan, 1977, 1983; Reed & Anthony, 2005). This idea concurs with interactional sociology (Hughes, 1971), phenomenology (Berger & Luckmann, 1967), structuration theory (Giddens, 1984) and the negotiated order (Strauss et al., 1963).

People inhabit institutions, logics and structures (Hallett & Ventresca, 2006; Strauss, 1996) and through their routine, everyday work discover problems, pose questions and develop answers inter-subjectively, thus creating structures and logics. Are the inhabitants of institutions "cultural dopes" (Garfunkel, 1984; Hirsch & Lounsbury, 1997a) who robotically and unthinkingly act out their over-socialised roles, or are they hyper-muscular agents who are able to act more rationally than all the other embedded agents around them (Powell & Colyvas, 2013; Suddaby et al., 2009)? The question is: how do people understand and experience the contradictions, overlaps and tensions in their institutional environment (Greenwood et al., 2011)? It has been conceptualised (Carvalho, 2012; Numerato et al., 2012; Waring & Bishop, 2013) as binary social formations (Gleeson & Knights, 2006). Managerial hegemony prevails as proletarianisation (McKinlay & Arches, 1985; McKinlay & Stoeckle, 1988), McDonaldisation (Ritzer, 1996; Ritzer & Walcak, 1988) and deprofessionalisation (Haug, 1973, 1988), on the one

hand, and as restratification, where hospital doctors exercise some forms of agency (Freidson, 1988), on the other hand. How that agency is exercised is a question that requires a nuanced understanding (Delmestri, 2006; Powell & Colyvas, 2013; Smets & Jarzabkowski, 2013a). Some researchers have argued that professionals reject the managerial project and remain committed to their own professional identities and priorities (Ackroyd et al., 2007b; Clarke & Newman, 2006; Dent, 2003; Kirkpatrick & Ackroyd, 2003a; Kitchener, 1998; MacDonald, 2006). Some studies on professionalism have emphasised that since organisations are primary sites for professional activity (Cooper & Robson, 2006; Faulconbridge & Muzio, 2008) the lines between managerialism and professionalism have been blurred (Correia, 2013a; Noordegraaf, 2007a, 2011; Noordegraaf & Steijn, 2014a). The managerial hospital has indeed resulted in the weakening of the power, authority and status of hospital consultants (Deem et al., 2007; Dent, 2003; Farrell & Morris, 2003) but not all the professionals are equally committed to the managerial norms (Crilly & Le Grand, 2004; Currie & Suhomlinova, 2006; Dickinson et al., 2013b; Farrell & Morris, 2003; Porter et al., 2013). Therefore, it is important to ask: how do the people who inhabit the institutions (Hallett & Ventresca, 2006) and who carry the logics in their heads and hearts (Delmestri, 2006; DiMaggio, 1988; Jepperson, 1991; Zilber, 2002) enact their agency at a local level on an everyday, routine basis? This is a black box in institutional theory (Jarzabkowski, 2009; McPherson & Sauder, 2013; Smets & Jarzabkowski, 2013a; Smets et al., 2012; Zilber, 2002).

5.9 CONCEPTUAL MODEL: STRUCTURE, AGENCY AND PRACTICE/OBSERVED BEHAVIOURS

Exploration of the dimensions of agency (Emirbayer & Mische, 1998) is a useful way to approach the relationship between agency and observed everyday behaviours (Battilana & D'Aunno, 2009a; Battilana & D'aunno, 2009; Delmestri, 2006; Hwang & Colyvas, 2011, 2014; Powell & Colyvas, 2013; Smets & Jarzabkowski, 2013a).

Before examining the relationship between agency and observed practices, it may be useful to step back to recall the relationship between structure and agency. This is because the conceptual model that is being proposed is a loop where social structures shape agency and the latter iteratively creates the former (Berger & Luckmann, 1967; Blumer, 1971; Giddens, 1984; Hughes, 1971; Strauss et al., 1963). Thus, the mutual implication of structure and agency brings to the fore the situatedness, historicity, contingency and flux of both structures and agency.

The next section develops a deeper understanding of agency and then sketches a conceptual closed loop from agency to modes of observed practice (Smets & Jarzabkowski, 2013a). One can visualise a conceptual model that is made up of three circles: structure on the left, agency in the middle and observed practice on the right. There are two closed loops: one between structure and agency to the left and another between agency and practice to the right (Smets & Jarzabkowski, 2013a).

5.9.1.1 Dimensions of agency

Institutions, social structures and logics shape, constrain and stimulate action, whereas iterative actions create social structures (Berger & Luckmann, 1967; Blumer, 1971; Emirbayer & Mische, 1998; Giddens, 1984; Hughes, 1971). Institutional complexity (Goodrick & Reay, 2011; Greenwood et al., 2011; Pache & Santos, 2010) could manifest as competing demands from external stakeholders (Battilana & Dorado, 2010; Meyer & Rowan, 1977; Oliver, 1991). It could also be revealed in competing priorities or identities within organisations (Kraatz & Block, 2013; Zilber, 2002). Competing priorities might be triggers for sense-making (Weber & Glynn, 2006) or agency (Emirbayer & Mische, 1998; Friedland & Alford, 1991a) by which the incoherent is framed into meaningful patterns (Ancona, 2012; Weick, 1995) that are enacted as situated practices (Jarzabkowski et al., 2013b; Weick, Sutcliffe, & Obstfeld, 2005). Meaning is not only an individual accomplishment but is also negotiated in social interaction (Berger & Luckmann, 1967; Blumer, 1971; Weber & Glynn, 2006). Understandings of, and responses to, constellations of logics are clarified, framed, negotiated, affirmed, legitimised and delegitimised inter-subjectively.

A three-dimensional view of agency (Emirbayer & Mische, 1998) consists of projective agency, iterative agency and practical-evaluative agency. It places human agency within a temporal-relational framework. Human agency is conceptualised as a process of social engagement that is informed by the past, oriented towards the future and engaged in the present as a bridge between the demands of the moment as informed by the past and the future. In this view, agency is a dynamic response to the demands of a given situation at a given time. It is possible for an agent to have multiple concurrent temporal agentic orientations, although one orientation may be dominant.

Projective agency involves the changing of existing institutional arrangements. This refers to the actors' reflecting on the status quo and potential new institutional arrangements, given existing and emerging interests, needs and priorities. It takes effort to overcome existing institutional constraints and to contemplate alternative institutional arrangements. The latter are not always clear goals that actors pursue rationally. On the contrary, they are choices made from emergent, shifting and fluid possibilities, given dynamic human motivations, interests, priorities and social commitments. Projective agency is socially interactive (Emirbayer & Mische, 1998). It is rooted in conflicts, negotiations and agreements as actors frame dilemmas as they ask questions and seek answers at the junctures between the adequacy of maintaining existing institutional arrangements, just getting by with the day-to-day demands, or reflecting on whether alternative institutional arrangements may be required. This is an area of study that has received significant attention, especially under the guise of institutional entrepreneurship and the paradox of embedded agency (DiMaggio, 1988, 1991; Fligstein, 1997; Leca, Battilana, & Boxenbaum, 2006; Maguire et al., 2004).

Iterative agency involves maintaining existing institutional arrangements that are taken-for-granted (DiMaggio & Powell, 1991; Jepperson, 1991; Zucker, 1977). With routine actions,

dilemmas are discovered, framed and resolved iteratively and institutions are maintained. Hence, despite the apparent objectivity and givenness of social structures, iterative agency opens a view to the contingency, flux and historicity of social structures (Berger & Luckmann, 1967; Blumer, 1971; Emirbayer & Mische, 1998; Giddens, 1984; Hughes, 1971). The phenomenological, ethnomethodological, social interactionist and social constructionist underpinnings of shared beliefs and expectations inform understandings of the dynamics of the neo-institutional perspective (DiMaggio & Powell, 1991; Meyer & Rowan, 1983; Tolbert & Zucker, 1983). However, this does not necessarily mean that iterative agency is the mindless act of a "cultural dope" (Garfunkel, 1984; Hirsch & Lounsbury, 1997b). It requires an active comparison of the existing institutional arrangements with the other institutional options that are routinely reconciled at the coalface (Barley, 2008; Smets & Jarzabkowski, 2013a; Smets et al., 2012). This is particularly so when actors are viewed as carriers of logics (Delmestri, 2006; DiMaggio, 1988; Jepperson, 1991; Zilber, 2002).

Practical-evaluative agency involves assessments and actions that are involved in getting through the immediate day-to-day work. The present is not always an untroubled space as it can be filled with uncertainties, ambiguities and paradoxes (Emirbayer & Mische, 1998). Logics do not just apply themselves but have to be interpreted and applied (Friedland & Alford, 1991a). Hence, the gap between the prescriptions for action and their enactment is filled by understanding, sense-making, situation-based judgement or practical evaluative agency. Often contexts where the rules for conduct are not always clear call for situated improvisations (Smets et al., 2012). Practical-evaluative agency is relatively neglected in institutional studies (Besharov & Smith, 2013; Lawrence, 2008). Yet, it is an area that could illuminate our understandings of how people get by in complex and unambiguous situations. It includes temporal improvisations in which people can advance their own interests by avoiding, resisting, subverting and contending the logics of the prevailing order (Emirbayer & Mische, 1998; Lawrence, 2008; Scott, 1985, 1990).

A dynamic, fluid and complex understanding of agency facilitates an appreciation of how agents are able to negotiate their roles within the wickedness of the social organisation of healthcare delivery. Agents are able to negotiate their places within the hospital as a complex adaptive system, find spaces between and within the constellation of logics and develop a routine resistance profile within a non-hegemonic exercise of managerial attempts to reshape their clinical autonomy and self-governance.

The reciprocal implication of structure and agency (Berger & Luckmann, 1967; Blumer, 1971; Giddens, 1984; Hughes, 1971; Strauss et al., 1963) is enhanced by the contingency, fluidity and historicity of relational-temporal structures that are supportive of particular agentic orientations (Emirbayer & Mische, 1998). The relationship between structure and agency is therefore not one of either stable opposition or mutual constitution but rather of flux and unpredictability with situational improvisation (Bjerregaard & Jonasson, 2014; Smets et al., 2012) between the agentic orientations to maximise the opportunities for choice and impact (Emirbayer & Mische, 1998).

5.10 INSTITUTIONAL WORK

This multi-dimensional understanding of agency opens the way for examining institutional work (Lawrence et al., 2013; Lawrence & Suddaby, 2006; Suddaby et al., 2009). The latter, is a significant institutionalist approach to the study of organisations (Lawrence et al., 2013; Zilber, 2013). "Institutional work" refers to the determined, deliberate and intentional daily activities of actors that are aimed at maintaining, disrupting and creating new institutions. Actors are considered competent and reflexive individuals, who, despite their institutional embeddedness, are able to affect the institutionalisation process. This understanding affirms the ideas noted earlier about the mutual implication and constitution of structure and agency, with the added adjustment of the fluidity of structure and the multi-dimensionality of agency thrown into the conceptual mix. The dynamics and contingency of context, time and audience (Zilber, 2008) complicate the determination of the intentions of purposive actors as accounted for in institutional work. One can legitimately infer intentions from actions (Blakemore & Decety, 2001; Lawrence & Suddaby, 2006; Press, Heyes, & Kilner, 2011). The coping behaviours (i.e. problem-focused and emotion-focused) are manifestations of an appraisal process that frames the intentions of an actor (Lazarus & Folkman, 1984, 1987). One could also argue that dimensions of agency (Emirbayer & Mische, 1998) underpin modes of practice and that the modes of practice are therefore an instantiation of dimensions of agency (Jarzabkowski et al., 2013b; Smets & Jarzabkowski, 2013a). This is the right-hand loop of the conceptual model proposed earlier in this study. A practice perspective draws attention to happenings at the coalface of institutionalism (Barley, 2008), to the inhabitants of institutions (Hallett & Ventresca, 2006); i.e. the people and what they do on a routine basis, and to the shared understandings that underpin their interactions because meaning is created, shaped, negotiated and modified in social interaction (Berger & Luckmann, 1967; Blumer, 1971; Hughes, 1971). Those negotiations (i.e. social interactions) do not take place in a vacuum. They take place in structural contexts that shape, constrain and stimulate them. Hence, we are back to the two closed loops in the conceptual model (Smets & Jarzabkowski, 2013a). Social interaction crafts meanings but also iteratively creates, affirms and modifies structures. A given practice by itself may not be significant but patterns of practices reveal shared meanings and interpretations (Gray et al., 2015; Lounsbury & Crumley, 2007). Institutional logics provide frames of reference as well as social identities and vocabularies of motive for actors in a field (Meyer, Egger-Peitler, Höllerer, & Hammerschmid, 2014; Thornton et al., 2012).

This literature review confirms a link between institutional logics, frames of reference, understanding, social identity, and dimensions of agency, intentionality and action in the field. Everyday action instantiates or represents agency (Sillince, Jarzabkowski, & Shaw, 2012; Smets & Jarzabkowski, 2013a), which, in turn, iteratively creates structure. Institutional complexity (Greenwood et al., 2008; Greenwood et al., 2011) and the constellation of logics (Goodrick & Reay, 2011) make demands on organisational and individual actors and shape their understandings and behaviours. These demands are not – by definition – contradictory or complementary (Friedland & Alford, 1991a; Greenwood et al., 2011) but people interactively

negotiate and recast the meanings of these logics and in this way they reframe institutional complexity (Suddaby, Elsbach, Greenwood, Meyer, & Zilber, 2010; Yu, 2013).

In constructing a link between institutional logics, structure, agency and practice, one is able to work backwards from the coalface of institutionalism (Barley, 2008). One looks to the inhabitants of institutions (Hallett & Ventresca, 2006; Hwang & Colyvas, 2011) as they carry logics (Delmestri, 2006; DiMaggio, 1988; Zilber, 2002). One closely examines how they engage in routine everyday practice (Jarzabkowski et al., 2013b; Smets & Jarzabkowski, 2013a). Their observed everyday actions instantiate their reflexive, multi-dimensional and dynamic agency (Emirbayer & Mische, 1998; Friedland & Alford, 1991a; Lounsbury & Crumley, 2007; Zilber, 2002). This creates a link between routine, everyday material enactments and constellations of institutional logics (Smets & Jarzabkowski, 2013a; Thornton et al., 2012). Institutional complexity is framed as a problem (Jarzabkowski et al., 2009a; Jarzabkowski et al., 2013b) not to be resolved but one that remains a permanent feature of the institutional field (Goodrick & Reay, 2011; Greenwood et al., 2011; Zilber, 2011). Thus, institutional complexity is managed (Battilana & Dorado, 2010; Kraatz & Block, 2013; Pache & Santos, 2010) routinely (Greenwood et al., 2011; March, 1981). It is possible for competing demands to be both central and incompatible (Besharov & Smith, 2013) yet equally inalienable (Greenwood et al., 2011; Reay & Hinings, 2009). The actors at the coalface do not have the option of choosing the logics that are in play. They have to deal with all of them at the same time. Also, they are themselves implicated because they do not occupy a privileged space outside the paradoxes.

This understanding opens the way for a dynamic, everyday appreciation of the relationships between institutional logics, complexity, wickedness, professionalism, routine resistance, the acute NHS hospital and the hospital consultants. A practice perspective suggests that hospital consultants construct and reframe the relationships between a plurality of institutional logics within their day-to-day work (Jarzabkowski et al., 2013b; Smets & Jarzabkowski, 2013a; Smets et al., 2012). To understand what it means to be a hospital consultant in a managerial acute NHS hospital, it helps to recall how a national healthcare policy ignores the wickedness of healthcare organisation (Raisio, 2009; Vartiainen, 2005) and seeks to transform a complex adaptive system (Holland, 1999; Waldrop, 1994). National healthcare policy attempted to transform the public sector district general hospital, which was part of a bureaucracy, into a quasi-market hospital trust (Ferlie et al., 1996b; Hood, 1991) and later into a quasi-network of trusts (Bevir & Rhodes, 2010; Newman, 2001; Newman & Clarke, 2009; Rhodes, 1997). This resulted in a policy environment with residual traditional bureaucratic, quasi-market and quasi-network features (Addicott, 2008; Exworthy & Halford, 1999; Kirkpatrick, 1999). Multiple prescriptions for actions added up to a constellation of logics (Goodrick & Reay, 2011). Between these logics are varying degrees of incompatibility and interdependence (Friedland & Alford, 1991b; Kraatz & Block, 2013), thus leading to institutional complexity (Greenwood et al., 2011). This may sound like a mouthful but in the real world, it is likely to be worse.

The institutionally complex policy and professional environment aims to control the behaviours of the clinical frontline through enhanced vertical accountability and performance-management

systems (Exworthy et al., 2010b; Harrison & Ahmad, 2000a). Clinical practice is standardised with evidence-based clinical guidelines and protocols (Greenhalgh et al., 2014; McDonald & Harrison, 2004; Mickan, Burls, & Glasziou, 2011; Miller & Rose, 2008; Spyridonidis & Calnan, 2011; Timmermans & Berg, 2010). Collaboration is reshaped by an increased commercial orientation (Dickinson et al., 2013c; Dixon et al., 2012; Timmermans & Oh, 2010; Waring & Bishop, 2013). Inside the hospital a spatio-temporally complex adaptive system is in place Clinical professionals act as street-level bureaucrats (Lipsky, 2010), enacting the meanings of policy as they provide healthcare services to patients. The complex constellation of policies has created technologies of control that sometimes work in contradictory ways. One policy instrument could stimulate agency in one direction whilst another constrains agency in an opposite direction. Structures are therefore not given, which leaves room for multi-dimensional agentic orientations to be activated, depending on the priorities, interests and motivations of embedded actors. The latter might choose to maintain existing institutions, create new ones or merely just get by with the day-to-day demands. Within a given situation it is possible for an actor to have multiple agentic orientations, although one orientation may dominate. Agency underpins the behaviours of actors. From routine resistance we have seen that there is more to behaviours than meets the eye. A closer examination of motivations of actors explicates their behaviours that instantiate their agency, which, in turn, iteratively creates institutions. Deprofessionalisation, proletarianisation, McDonaldisation and restratification may just not adequately account for the nuances and subtleties of professional agency within the context of institutional complexity, wickedness, complex adaptive systems and routine resistance. As the structures have been chopped, changed and sedimented so the agency of hospital consultants has modified, hence the concept of a *danse macabre* (Degeling et al., 2003).

5.11 SUMMARY

The literature review has compared the concepts in the GT with their use in other bodies of literature. The literature was used, as data for constant comparison with the GT, *Rolling with the Punches*, make up an integrated set of propositions of what it means *to be a doctor* in a managerial hospital.

The main concern for the actors in this GT is managerialism in the hospital. Key features of the managerial hospital are market-based competition, management-based control systems and metrics-based performance-management systems (Farrell & Morris, 2003; Harrison & Ahmad, 2000a), and standardisation of clinical practice (Timmermans & Berg, 2003, 2010). However, the hospital is a complex place, institutionally (Goodrick & Reay, 2011; Greenwood et al., 2011), systemically (Nelson et al., 2002; Shiell et al., 2008; Waldrop, 1994) and spatio-temporally (Allen, 2000; Zerubavel, 1979). It is difficult to see how strong management (Hammer & Champy, 2001) could impose its will on the organisation. The management of the hospital itself is but the evolution of a number of tame solutions (Austrailian Publis Service Commission, 2007; Conklin, 2006a; King, 1993; Roberts, 2000) to the wicked problems associated with healthcare delivery organisation (Phelan et al., 2010; Raisio, 2009; Thoits, 2010; Umberson &

Montez, 2010; Vartiainen, 2005). Why do people come to the hospital? Why are the doors always open? Why are the lights always on? Why is someone always there to receive whomsoever walks through the door? Why does the NHS hospital treat that person irrespective of an ability to pay? What are the health, social and moral imperatives that are operating in this scenario?

Rolling with the Punches emerged as a pattern of behaviour through which the hospital consultants deal with their main concern. It frames their ways of being doctors in an acute managerial hospital. It conceptually frames their ways of being medical professionals within a hybrid organisational (Battilana & Dorado, 2010; Besharov & Smith, 2013; Pache & Santos, 2010) context (Brock et al., 2014; Muzio et al., 2011; Muzio & Kirkpatrick, 2011; Noordegraaf, 2007a, 2013).

Rolling with the Punches involves four modes of observed behaviours: *Stabilising Temporarily, Resisting, Limiting the Impact* and Living with/*Adjusting to*. The actual mode of observed behaviours depends on a *Weighing-up* process (Cox & Ferguson, 1991; Lazarus & Folkman, 1984) that is used to make sense (Ancona, 2012; Frankl, 1984; Weick, 1995; Weick et al., 2005) of the dilemmas and puzzles posed in, and by, the managerial hospital. The constellation of logics (Goodrick & Reay, 2011) does not impose itself but has to be interpreted (Friedland & Alford, 1991b) before it is enacted. The actual mode of behaviour is dynamic and complex as it is a function of the needs, priorities and personal narratives of the actors. *Rolling with the Punches* does not represent a complete account of what actors do within the context but is an important pattern of behaviour in which they engage. It accounts for a significant amount of variation in their behaviours. A classic GT transcends time, place and people (Glaser, 1978, 1998) and it could be a pattern of behaviour in which people resolve similar main concerns in routine, everyday, non-dramatic ways (March, 1981; Prasad & Prasad, 1998; Scott, 1985; Smets & Jarzabkowski, 2013a; Smets et al., 2012). Thus, further research could test whether the theory fits other substantive areas, such as professionals in universities, social care, education, utilities and city management. These studies would indicate whether the theory stands its ground or whether new concepts could emerge to modify the GT in this study to ensure that it continues to meet the criteria for a GT; i.e. fit, work, relevance and modifiability (Glaser, 1998). It also does not take a stand on what constitutes good or bad behaviours as it is but provides a conceptual account of how people resolve their main concern.

The next chapter integrates the GT described in Chapter 4 into the literature reviewed in this chapter.

CHAPTER 6 INTEGRATING THE GROUNDED THEORY INTO THE LITERATURE

6.1 INTRODUCTION

From the literature review, it is clear that the managerial hospital did not emerge in the 1980s for the first time. The aim of governments to hold the clinical frontline accountable for the resource implications of its clinical decisions is as old as the NHS itself (Klein, 2013). Ministers had to account to Parliament for the way tax funds were spent on the NHS and the Treasury always wanted to know whether money was well spent. So for a long time input controls were implemented. The Financial Management Initiative, the regional health authorities, the Hospital Advisory Service and the Health Service Commissioner, The Cogwheel Report and Hospital Activity Analysis were attempts to link the tax-funded NHS budget with value for money (Gray et al., 1991; Klein, 2013) but things have changed in the last three decades. The balance of power has shifted away from the doctors.

The 1980s was different from the earlier decades of the NHS because of the congruence of a number of factors. These included a need for transparent accountability, a more critical view of expertise and the data-management possibilities that emerged with the IT revolution. The 1980s was the beginning of a process of the transformation of a Weberian public sector bureaucratic iron cage into a Foucauldian gaze (Deem et al., 2007; Ferlie & McGivern, 2013). A key operational change in the NHS started with the Griffiths general managers, who replaced the administrators (Griffiths, 1983, 1992). General managers were placed on performance-related contracts (Klein, 2013; Pollock, 2005). The health service was fragmented as long-term care, dentistry and optical services were spun off from the NHS service. Similarly, hospitals were required to focus on their core "business"; thus, catering, cleaning, parking and shops were outsourced (Exworthy et al., 2010b; Pollock, 2005; Pollock & Whitty, 1990). Management control shifted from a focus on inputs to a greater emphasis on outputs. Managerialism took on a more robust content and posture with the NPM (Clarke & Newman, 2006; Hood, 1991; Pollitt, 1993). Providers were required to compete for contracts. Performance was managed according to clearly defined metrics. Control was systematised with general managers in charge (Farrell & Morris, 2003; Harrison & Ahmad, 2000b; Le Grand, Roberts, & Bartlett, 1998b). Professional and organisational accountability was made more transparent (Donaldson, 2001; Power, 1999). Clinical practice became standardised through evidence-based clinical practice (McDonald & Harrison, 2004; Timmermans & Berg, 2003). Medical professionals lost control over their work. These were not abstract concepts because the NPM. At a practical level it meant that books had to balance at year-end. Contracts and budgets had to be managed. It often meant that on the clinical frontline nursing posts were frozen, wards and theatres closed and demands on the remaining resources intensified in pursuit of efficiency.

In the 1990s the performance-management system was refined with targets (Bevan & Hood, 2006; Propper et al., 2008), a quality agenda that included national service frameworks, clinical guidelines and protocols (Ferlie & McGivern, 2013; Timmermans & Berg, 2003), and regulatory bodies such as the Audit Commission, the Care Quality Commission and Monitor (Audit Commission, 2008; Francis, 2013; House of Commons Health Committee, 2014; Roderick & Pollock, 2014). So rather than bureaucratic command and control, the welfare state was fragmented. The state steered from a distance with sophisticated technologies of control (Ferlie & McGivern, 2013; Miller & Rose, 2008).

The rationalising, standardising, commodifying, observing, verifying, inspecting and performing managerial hospital challenged the core of the professionalism of the hospital consultants. The sociological impact of the managerial hospital on the consultants' professionalism has been conceptualised as a binary of either managerial hegemony with deprofessionalisation (Haug, 1973, 1988), the McDonaldisation (Ritzer, 1996; Ritzer & Walcak, 1988) and the proletarianisation of doctors (McKinlay & Arches, 1985)- on the one hand- or restratification (Freidson, 1985, 2001) – on the other hand. Haug suggested that IT developments would result in the disappearance of professionalism whereas Freidson was not persuaded that the profession was losing its status because of something that was being done to it. On the contrary, he challenged the idea of a homogenous medical profession. He argued that doctors would routinely resist encroachment (Scott, 1965) and they would respond to changes with a knowledge and administrative elite that sought to exercise control of the rank-and-file in a process of restratification. The key would be how that resistance to encroachment would manifest itself.

The literature on professionalism provides little empirical evidence that the imposition of a managerial order in hospitals has necessarily resulted in either deprofessionalisation or proletarianisation (Numerato et al., 2012; Thomas & Hewitt, 2011; Waring & Bishop, 2013). Crude accounts of embedded agents either as cultural dopes or heroic agents have been subjected to criticism (Delmestri, 2006; Hwang & Colyvas, 2011; Powell & Colyvas, 2013; Yu, 2013). Empirical studies have provided evidence of increasing stratification in the medical profession (Cheraghi-Sohi & Calnan, 2013; McDonald, Checkland, Harrison, & Coleman, 2009; Waring, 2014) but even this may be a simplification. Professions have adopted more varied positions from which they resist (Doolin, 2002; Levay & Waks, 2009) or strategically adopt managerial technologies (Courpasson, 2000; Levay & Waks, 2009). They view managerialism either as technically and professionally neutral (Kurunmäki, 2004) or they seek to protect themselves with a decoupling strategy (Levay & Waks, 2009; Waring & Currie, 2009). Calls have been made to explicate the relationship between institutions and micro-level identities because the relationship between the two is considered to be intimate (Lawrence & Suddaby, 2006; Thornton et al., 2012).

Rolling with the Punches integrates the multiple and diverse bodies of literature on the wickedness of the social organisation of healthcare delivery, the difficulties of imposing private sector management practices on the hospital as a complex adaptive system, the sociology of

medical professionalism, Foucauldian power and resistance, and the routine accomplishment of reframing of institutional complexity. Moreover, *Rolling with the Punches* provides a mechanism of that shows how participants routinely recast relations between logics. Their everyday behaviours instantiate of their agency and, in turn, iteratively create the institutions (Smets & Jarzabkowski, 2013a). It responds to the need for empirical studies that explain how relations between logics are resolved on a routine basis and how meaning is constructed (Zilber, 2013).

Rolling with the Punches is a pattern of behaviour that shows what it means to be a doctor in a managerial acute hospital. In so doing, it shows how participants address their main concern, which is managerialism. Managerialism comprises market-based competitive relationships between providers, patient choice, money following the patient, management-controlled organisational structures and decision-making systems. It also involves metrics-based performance-management systems with transparent and auditable quality control systems, and standardisation of clinical practice. The managerial hospital is aimed at ensuring that resources are efficiently allocated, effectively used and the quality of services is systematically assured. *Rolling with the Punches* emerged as a pattern of behaviour through which participants endeavoured to resolve their main concern.

The managerial hospital is a crucible for a constellation of logics (Goodrick & Reay, 2011). It is institutionally complex (Greenwood et al., 2011). "Institutional logics" refers to the belief systems and associated practices that predominate in an organisational field (Scott et al., 2000). Logics provide the rationale for appropriate organisational practices within given institutional settings, at given moments in history (Greenwood et al., 2010). Institutional logics have also been described as the socially constructed, historical patterns of material practices, assumptions, values and beliefs by which people organise their time and space (Thornton & Ocasio, 1999; Thornton et al., 2012). Institutional logics introduce a vocabulary for discussing the symbolic and practical, i.e. cultural dimensions of institutions. Bureaucratic hierarchy, markets, networks, professionalism, measurement, transparency value-for-money, professional autonomy and clinical-performance management are not neutral, technical instruments. On the contrary, they reflect particular beliefs, values and interests, as they are prescriptions for, and criteria for the evaluation of, action.

The professional bureaucracy (Mintzberg, 1978, 1983) has remained largely intact (Dickinson et al., 2013b). However, it coexists with various reincarnations of a managerial logic (Currie & Suhomlinova, 2006; Denis, Davies, Ferlie, Fitzgerald, & McManus, 2011; Reay & Hinings, 2009; Scott et al., 2000; Van den Broek, Boselie, & Paauwe, 2013). Multiple logics can coexist in organisations (Battilana & Dorado, 2010; Kraatz & Block, 2013; Pache & Santos, 2010). In a review of empirical studies (Greenwood et al., 2011), an operating assumption was that of incompatibility between logics. Yet, it need not necessarily be the case (Battilana & Dorado, 2010; Besharov & Smith, 2013; Goodrick & Reay, 2011).

The literature review showed that organisations are significant sites for institutional complexity (Greenwood et al., 2011; Pache & Santos, 2013b). Much of what is known about responses to

institutional complexity is structural (Greenwood et al., 2011). These include, the importance of an integrated organisational identity (Kraatz & Block, 2013), the juggling between the conflicting prescriptions for appropriate behaviour that flow from the exploitation and exploration logics (Andriopoulos & Lewis, 2009), tensions between social and financial goals (Ashforth & Reingen, 2014; Haigh & Hoffman, 2014; Pache & Santos, 2010) and in case of the internationalisation of management education the retention of a distinctive national identity in business schools (Kodeih & Greenwood, 2014).

But gaps exist in our understanding of a level below structural responses by organisations. Institutional entrepreneurship (Battilana & D'Aunno, 2009a; Battilana & D'aunno, 2009; DiMaggio, 1988; Garud, Hardy, & Maguire, 2007; Maguire et al., 2004) has been an attempt to give an account of the role of actors (Thornton et al., 2012). However, it has been hampered by criticism about its handling of the paradox of embedded agency (Leca et al., 2006; Seo & Creed, 2002). Scholarship within institutional logics (Thornton & Ocasio, 2013; Thornton et al., 2012) and institutional work (Lawrence et al., 2013; Lawrence & Suddaby, 2006; Suddaby et al., 2009) have seen significant attempts to explain purposive effort at an individual level (Zilber, 2013) in managing organisational hybridity (Jarzabkowski et al., 2009; Smets & Jarzabkowski, 2013). Little attention has been given to what individuals actually do to resolve institutional complexity on a routine, everyday basis (Blomgren & Waks, 2015; Lok, 2010; McPherson & Sauder, 2013; Zilber, 2013). Not enough is known about the role of local, embedded social actors and their engagement with, and reactions to, institutional pressures at the frontline (Barley, 2008; Hallett & Ventresca, 2006; Lok, 2010).

Norms are cognitively intransparent and even more so when they are plural. Interpretation and agency are needed when prescriptions and norms are in conflict. Meanings have to be determined as logics do not impose themselves (Friedland & Alford, 1991a). Actors have to determine the story, make sense, unravel the dilemmas, structure the unknown or decide what is to be done (Weick, 1995; Weick & Roberts, 1993). Sense-making enables actors to act when the world that they know has changed in significant ways (Weick et al., 2005). People often make sense by acting in the situation despite the absence of a clear roadmap (Klein, 1999), especially in dealing with wicked problems in complex adaptive systems. Objectives are modified as one goes along and learns more about what is at stake. This has been called adaptive sense-making (Weick et al., 2005) or adaptive decision-making (Klein, 2011). It suggests a preparedness to act despite not knowing completely while trying to understand the impact of one's action on the system at a local level and at the same time trying to achieve one's goals. One works at the lack of clarity and makes adjustments along the way. The sense-making process is also reflected in the appraisal processes of the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984, 1987). People make judgements on the basis of their own sense of self, interests, priorities as well as the beliefs and interpretations of significant others. Meaning making and sense making are social interactional processes (Blumer, 1971; Hallett & Ventresca, 2006; Hughes, 1971; Weick, 1995; Weick et al., 2005), in which institutional understandings are emergent, in flux and historicised as they are negotiated and legitimated.

Institutional entrepreneurship (Battilana et al., 2009; Garud et al., 2007) assumes a projective agentic orientation (Emirbayer & Mische, 1998). One gets a sense, in institutional entrepreneurship literature, that visions of alternative institutional alignments are apparently fully formed (Smets & Jarzabkowski, 2013a) and embedded agents consciously and strategically set out to reshape social institutions accordingly (Suddaby et al., 2009). On the other hand, institutional work takes a more modest perspective of the role of the actor within the institutional process. It focuses on the effort that the actor exerts while either coping – getting by - within an existing set of institutional arrangements, working at maintaining or changing these institutional settings. With its focus on effort, there is space to consider incomplete, emergent visions and also failed attempts and unintended consequences (Lounsbury, 2008; Suddaby et al., 2009). This closer scrutiny, of where and how the social actor is embedded in the institutional process, has resulted in calls for an understanding of agency that is more nuanced than what could be called the "cultural dope" or "hyper-muscular" (Battilana et al., 2009; Garfunkel, 1984; Suddaby et al., 2009).

This study responds to the view (Battilana & D'Aunno, 2009a; Delmestri, 2006; Emirbayer & Mische, 1998; Hwang & Colyvas, 2011; Powell & Colyvas, 2013) that intentionality is multi-dimensional, empirically grounded, dynamic, emergent and complex whilst underpinning varying modes of practice. This research also shows that at the coalface of institutionalisation (Barley, 2008), the inhabitants of institutions (Hallett & Ventresca, 2006) reframe relations within the constellation of institutional logics (Goodrick & Reay, 2011). The process unfolds in non-dramatic (March, 1981) everyday, routine yet complex ways (Smets & Jarzabkowski, 2013a; Smets et al., 2012). There is very little, if any, conjectured grand accounts of institutional complexity (Greenwood et al., 2011). The orientation of this study takes the argument away from the abstractions of deprofessionalisation, proletarianisation and restratification. As a literature review that is delimited by a classic grounded theory it starts with what the participants are doing and then finds conceptual accounts for what is happening. This is the magic of GT and it concurs with practice theory accounts of the world.

Having metaphorically rummaged through Foucault's toolbox, I found a note that reads exercise of power is weakest where it becomes technologies, procedures and capillaries (Foucault, 1977, 1988). For instance, when managerial structures are created to exercise an indirect steering role (Miller & Rose, 2008; Rhodes, 1997), commissioners do not always have the capabilities to exercise their restructuring and controlling roles (Exworthy et al., 2010b; House of Commons Health Committee, 2008). A space for engagement emerges for the clinical frontline. Competition between providers has not always improved outcomes for patients despite the rhetoric (Propper et al., 1998; Propper et al., 2008). A discursive space comes into view. The *Patient Choice* agenda (Rosen, Florin, & Hutt, 2007) comes into conflict with the gatekeeping role of GPs and the mediating role of the latter has ensured that non-market relationships with hospital consultants have remained strong (Allen, 2002). Those who are alert, to the contradictions, can transform a fissure into a canyon. It has been argued that the incentives for change have been too weak and the constraints too strong (Le Grand et al., 1998a). The turf

battles between independent agencies have led to role confusion and sometimes catastrophic oversight failures at supposedly high-performing hospitals (Francis, 2013; House of Commons Health Committee, 2008). Even when hospitals are given greater operational freedoms with respect to borrowing money for capital investment, developing new services and determining the terms and conditions for the employment of all staff, those freedoms are not fully exercised (Audit Commission, 2008; Exworthy & Greener, 2008; House of Commons Health Committee, 2008). Despite the investment by the neo-liberal state in structural and decision-making systems changes, gaps exist for the hospital doctors to be recalcitrant and hold – sometimes tenuously – the line for medical autonomy and collegiality.

It is important to repeat that people, as carriers of logics (Delmestri, 2006; Jepperson, 1991; Zilber, 2002), interpret and make sense (Friedland & Alford, 1991a; Weick et al., 2005) of the institutional complexity (Greenwood et al., 2011) and enact their interactional recasting of the multiple logics and wickedness (Jarzabkowski, 2009; Smets & Jarzabkowski, 2013a). The inhabitants of institutions (Hallett & Ventresca, 2006; Scully & Segal, 2002) engage in a dynamic process of sense making and meaning-making (Ancona, 2012; Lazarus & Folkman, 1984; Weick, 1995; Weick et al., 2005). A similar picture emerges from literature on stress and coping behaviours, which states that the behaviours are consequent on an appraisal process. This literature is important because coping with institutional complexity can be stressful. If actors hold the view that they are able to change a situation, they are likely to engage in problem-solving behaviours where they address causes of stress by, for example, seeking information and weighing up the pros and cons of some action. If they feel that they do not really have any control then they may adopt emotion-focused behaviours, which involve managing their reactions to the issues that cause them to be stressed; e.g. keeping busy, talking to others to get things off their chest, avoidance, detachment and preparing for things to get worse (Endler & Parker, 1994; Lazarus & Folkman, 1984, 1987; Moos & Holahan, 2003; Roger, Jarvis, & Najarian, 1993). This reflects a multi-dimensional agency (Battilana & D'aunno, 2009; Emirbayer & Mische, 1998; Friedland & Alford, 1991a). The dimensions of agency are empirically intertwined but are conceptually disaggregated to understand how complexity (institutional and systemic) and wickedness interact to frame relationships between logics practically. That understanding underpins behaviours that might show conformity with or acting in ways that avoid, compromise with, defy and manipulate (Oliver, 1991) in routine ways (Fleming & Spicer, 2008; Knights & McCabe, 2000; Prasad & Prasad, 1998; Scott, 1985, 1990).

The consultants' iterative, routine agency frames and reconstructs the relationships between logics (Besharov & Smith, 2013; Smets & Jarzabkowski, 2013a; Smets et al., 2012) that underpin their routine practices. In everyday behaviours institutional complexity is resolved and managed. The behaviours and practices reflect understandings of what is at stake and the possibilities of acting within the institutional context. The sense making, understanding, agency, patterns and observed behaviours constitute being a doctor in the acute NHS hospital. *Rolling with the Punches* is an integrated set of hypotheses that accounts for much of the variation in the

ways in which their main concern is resolved. The different components of *Rolling with the Punches* follow below.

6.2 ROLLING WITH THE PUNCHES

Below is a repeat in the table that appears at the end of Chapter 4. At the end of Chapter 6 some of the concepts and ideas from the literature review will be included to develop the components of the grounded theory that are summarised in Table 6.1.

Table 6.1: The components of the grounded theory: Rolling with the Punches

THE GROUNDED THEORY: ROLLING WITH THE PUNCHES	
	OBSERVED PATTERNS OF BEHAVIOURS
	STABILISING TEMPORARILY
	RESISTING
	• Quibbling
	• Subverting
WEIGHING UP	
• Making sense	**LIMITING THE IMPACT**
• Deciding what to do	• Lying low
• Mode-shifting triggers	• Faking it
	LIVING WITH/ADJUSTING TO CHANGE
	• Going with the flow
	• Complying substantially
	• Complying fully
	• Waiting it out

6.2.1 Weighing up

This is the core process that individual, embedded actors use as they routinely go about making sense of, and resolving, institutional complexity. *Weighing up* is need when the world becomes unintelligible to us in some ways (Ancona, 2012) and requires adaptive responses since the

usual repertoire of responses has become inadequate (Heifetz, Linsky, & Grashow, 2009). Individual, embedded actors in the acute NHS hospital environment seek to solve this dilemma by constructing conceptual maps of the conflicting institutional prescriptions that are found in the managerial hospital. These hypothetical depictions structure and order the tensions and points of congruence (Besharov & Smith, 2013) allowing for the emergence of plausible understandings that may enable them to act (Weick, 1995; Weick et al., 2005) within the constellation of logics (Goodrick & Reay, 2011). They have to balance their assessment of the demands of the managerial hospital for bureaucratisation, standardisation and commercialisation (Waring & Bishop, 2013) and their salient identity as doctors (Ashforth & Johnson, 2001). Even the latter is but a plurality of selves identity (Burke & Tully, 1977; Doolin, 2001; Spyridonidis et al., 2014). *Weighing up* is a means of coming up with reasonable understandings. These are tested inter-subjectively and are refined in real-world situations. Adjustments are made as one goes along. It is a process of muddling along, finding answers to questions and managing by discovery (Klein, 1999). *Weighing up* takes explicit account of the actors' personal and professional needs, beliefs and values and the demands posed by the managerial hospital. Actors are able to act despite uncertainty, complexity and ambiguity.

Weighing up is a two-stage process of assessment. In the first phase, the hospital consultants consider how their professional identity and clinical autonomy are challenged by vertical accountability procedures, transparent accountability measures and work intensification driven by demands for efficiency, documentation to underpin contracts, commodification, recording and auditing. The second phase involves doing something about the assessment, in phase one. Medical professionalism as a process of institutionalisation aims to bring order, structure and meaning to an important area of healthcare delivery. It is indeed a set of structures and practices that are based on rationalised myths and symbols that express the expectations of the wider society (Meyer & Rowan, 1977). The transformation in the social organisation of the hospital has introduced new myths and symbols that do not necessarily eliminate a previous set. Thus, one has a process of sedimentation of myths and symbols (Brock, 2006; Cooper et al., 1996). There emerges the rub. Medical professionalism is being reframed. Market-based competition, management-based control systems and metrics-based performance-management systems (Exworthy et al., 2010b; Farrell & Morris, 2003; Flynn, 1999; Greener, 2003) leave their marks on clinicians. *Weighing up* is a complex process of juggling the demands from multiple frames of reference, including professionalism within organisations. The assessment process underpins the mode of professional practice and observed behaviours.

The question is whether – for the hospital consultants – the meanings of the myths and symbols have radically changed and how those interpretations are framed. Medical professionalism is not only about treating a patient but also about the meanings associated with that process that early accounts of neo-institutionalism had apparently assumed could be taken-for-granted (DiMaggio & Powell, 1991; Tolbert & Zucker, 1983). In the managerial hospital, to the management the patient has become a customer. The hospital has to compete with other hospitals - public, private and NGO - for customers. Customers have rights. How do doctors see

the change in the language and meanings associated with their engagement with the patient? Doctors have duties to patients. In fact, this meaning-making process is more agentic (Emirbayer & Mische, 1998; Jarzabkowski, 2005; Weick, 1995; Weick et al., 2005) than taken-for-granted. It places greater emphasis on the cognitive work needed to overcome the causal influence of structures than previously assumed by neo-institutionalists (DiMaggio, 1988; Greenwood & Hinings, 1996). This is because it requires the constant comparison of multiple logics and the crafting of an option from a constellation of logics (Goodrick & Reay, 2011) and justifying that choice to oneself and to significant others (Suddaby & Greenwood, 2005). It is also an interactional process, which means that actors have to take account of the views, goals, needs and interests of relevant referent audiences (Berger & Luckmann, 1967; Blumer, 1971; Giddens, 1984; Hughes, 1971).

The *weighing-up* process can be viewed as a reflection of the appraisal processes in the *Transactional Model of Coping and Stress* (Lazarus & Folkman, 1984, 1987), in which actors do not respond to a stressor itself. They interpret what it means to them in terms of their beliefs, values, interests and priorities. With the secondary appraisal, they determine what they could do to address the cause of the stress. The meaning-making process is a gateway to a response to three calls. Firstly, it responds to the need for a more nuanced understanding of agency (Delmestri, 2006; Hwang & Colyvas, 2011, 2014; Powell & Colyvas, 2013; Smets & Jarzabkowski, 2013a). Secondly, it offers a reply to appeals for better understandings of how doctors take decisions (Correia, 2013a), given that the GT (as described in Chapter 4) indicated that doctors are disinclined to make ill-judged or rash decisions. Thirdly, it provides an insight into key elements of how the paradox of professional autonomy (Thomas & Davies, 2005) is juggled on a routine basis.

Meaning-making is emergent and serendipitous (Smets et al., 2012) yet intentional (Dorado, 2005; Klein, 1999, 2011). This incongruous process consequently provides a more subtle understanding of intentionality and purpose than suggested in institutional work (Lawrence & Suddaby, 2006; Suddaby et al., 2009). It illuminates meaning-making developments at the coalface (Barley, 2008) of institutionalism. Understandings are inter-subjectively generated by inhabitants of institutions (Hallett & Ventresca, 2006; Scully & Segal, 2002) as they seek practical ways to resolve the wickedness of the social organisation of healthcare (Raisio, 2009; Vartiainen, 2005). The process of meaning-making is bedevilled by the complex adaptive system of the hospital and its institutional complexity (Greenwood et al., 2011). Meaning-making as a social process draws on phenomenology (Berger & Luckmann, 1967), interpretive sociology (Hughes, 1971), symbolic interactionist sociology (Blumer, 1971) and structuration theory (Giddens, 1984). That said meaning making is embedded in power relations that privilege some actors and exclude or neglect others (Album & Westin, 2008; Meyer & Höllerer, 2010; Rosoff & Leone, 1991). Power has not been adequately addressed in institutional theory (Lawrence, 2008; Munir, 2015). Similarly, in the hospital, the clinical prestige hierarchy privileges some meanings over others.

Doctors try to accomplish two things on an on-going basis: getting through the workload and sustaining a sense of meaning in their work (Gleeson & Knights, 2006). From the previous paragraphs, it is clear that meaning is negotiated in social interaction. Hence, the meanings of the multiple logics and the inter-relationships between logics are not given but are constructed as contradictory, complementary, comparable and strange within the routine, everyday practices of embedded actors (Smets & Jarzabkowski, 2013a; Smets et al., 2012). Hospital doctors are – amongst other major players – intra-organisational carriers of mental models of the competing logics in the field (Thornton et al., 2012). The managerial hospital is a hybrid organisation because it houses multiple logics under its roof (Battilana & Dorado, 2010; Greenwood et al., 2011; Pache & Santos, 2010). A national health policy hybrid (Ferlie & McGivern, 2013) created a sedimented quasi-hierarchy, quasi-market and a quasi-network (Exworthy et al., 1999; Sullivan & Skelcher, 2002a) so that one has the worst of both worlds; i.e. public services with neither markets nor bureaucracy (Kirkpatrick, 1999). Doctors interpret organisational issues through the lenses of the multiple logics that they carry and enact (Besharov & Smith, 2013; Delmestri, 2006; Jepperson, 1991; Thornton et al., 2012; Zilber, 2002; Zilber, 2011). Meaning-making, although it is interactional, is always a personal response to the questions posed by life (Frankl, 1984, 1997). The doctors ask what these logics mean for their own sense of self (Ashforth & Johnson, 2001; Burke & Tully, 1977; Spyridonidis & Calnan, 2011; Spyridonidis et al., 2014), what they are supposed to do for the patient, how they should go about it, the implications for the relative distribution of power in the hospital and their economic well-being. Sense making and weighing up are processes that are central to the micro-foundations of the institutionalisation processes (DiMaggio & Powell, 1991; Lok, 2010; Smets & Jarzabkowski, 2013a; Smets et al., 2012).

"Performance management means sweating the assets. Doctors are the more expensive assets. That means more should be done with less. So our sessions are over-booked and there is always pressure to add another patient or two to our lists." *(Surgeon)*

"Managers watch targets and dashboards. Doctors treat patients." (A & E consultant)

"Doctors are not inclined to take ill-considered decisions. As individuals, we have too much invested in the system, especially our pensions. Therefore, we try to make the best under the circumstances. You roll with the punches and keep a knuckle-duster in case you need a knockout punch." (Surgeon nearing retirement)

Doctors are constantly weighing up and appraising. They have workload figures that they have to meet in order for the hospital to meet mandatory targets. Moreover, they have to judge how to meet their professional commitments to patients, as they no longer exclusively control the resources of the hospital. Then there are a number of other basic issues to consider. These include the inalienable wickedness (Conklin, 2006a; Raisio, 2009; Rittel & Webber, 1973; Vartiainen, 2005) of the social organisation of healthcare delivery (Timmermans & Oh, 2010). Technology has resulted in changes in clinical practice. Patients have greater expectations. Technology has changed the doctor-patient relationship. Scandals had undermined the prestige

of the medical profession. Fiscal pressures have resulted in demands for greater effectiveness and efficiency. More people are coming through the front door of the hospital because community and primary healthcare services are failing. In addition, they have to contend with issues such as patients blocking beds because they are not ill enough to be in an acute hospital but cannot be discharged because home-care arrangements are not in place. What is the meaning of doing the best for the patient in the room, while having to follow standard guidelines and protocols? This is an on-going process.

So one might look at a hospital and not find doctors on a picket line having dropped their stethoscopes and banging bedpans on the sidewalk. However, institutional complexity is unravelled on the clinical frontline. The process of institutionalisation of the meanings of the acute hospital, the framing of the patient and illness, and the role of the doctor are deeply contested processes that are constantly being destabilised by the social transformation of the delivery model for healthcare. Every situation has the potential to be meaningful. One finds meaning by doing something that matters, experiencing something important or bearing difficulties with courage. The absence of meaning leads to alienation (Frankl, 1984). This study is about how embedded individuals find themselves within multiple, and sometimes, contradictory logics (Goodrick & Reay, 2011; Greenwood et al., 2011). The physician identity may be more salient in that the actor will primarily remain a doctor – despite incidental and strategic hybridity (McGivern et al., 2015). Other identities are likely to be nested (Ashforth & Johnson, 2001; Ashforth & Mael, 1989; Spyridonidis et al., 2014). Their identity work is an on-going project within the process of weighing up, so they go about framing their personal stakes in maintaining and reproducing fluid and plural selves (Carroll & Levy, 2010). Institutional entrepreneurship (Battilana et al., 2009; DiMaggio, 1988; Maguire et al., 2004), institutional logics (Thornton & Ocasio, 1999, 2013) and institutional work (Lawrence et al., 2013; Lawrence & Suddaby, 2006; Suddaby et al., 2009) have been different accounts of the role of actors in institutionalism. However, as discussed above, there have been calls for more nuanced accounts of agency (Delmestri, 2006; Hwang & Colyvas, 2011, 2014; Smets & Jarzabkowski, 2013a; Suddaby et al., 2009; Yu, 2013). *Weighing up* is a multi-dimensional and dynamic part of the response to those calls.

The multi-dimensional view of agency (Emirbayer & Mische, 1998) is a starting point from which to begin a process of understanding how a situated and dynamic agency functions as an element in the weighing-up process. The causal implications of logics and structures do not just happen, nor are they simply imposed. The mutual implication of structure and agency (Berger & Luckmann, 1967; Blumer, 1971; Hughes, 1971) is adjusted with a greater view of the on-going contingency of structure (Bjerregaard & Jonasson, 2014). This leaves room for cognitive roles for actors to determine, negotiate, clarify, frame and change meanings associated with particular structures or combinations of these structures (Ancona, 2012; Weick, 1995; Weick et al., 2005). The isomorphic turn of neo-institutionalism (DiMaggio & Powell, 1983; Greenwood & Hinings, 1993; Tolbert & Zucker, 1983) focused on the taken-for-grantedness of institutional logics from the institutional field to the extent that the actor may be a cultural dope (Garfunkel,

1984). The range of behaviours of hospital doctors suggests that they are more agentic than mindless followers of cultural scripts (Blomgren & Waks, 2015; Levay & Waks, 2009; Morrow, Burford, Redfern, Briel, & Illing, 2012; Numerato et al., 2012; Waring, 2014).

Meaning making, sense making and weighing up take a closer look at the cognitive processes that inform behaviours. Even the reproduction of existing institutional arrangements within an institutionally complex environment (Battilana & Dorado, 2010; Greenwood et al., 2011; Pache & Santos, 2010) requires active agency. The embedded actor has to take account of the shaping, constraining and stimulating provided by multiple logics and make bounded choices even if that means choosing what is already in place (Besharov & Smith, 2013). Hence *iterative agency* (Emirbayer & Mische, 1998) is not equivalent to passivity. Active agency responds to questions posed (Frankl, 1997) within the workplace. *Projective agency* (Emirbayer & Mische, 1998) involves an assessment of existing institutional arrangements against possible alternatives and the choice of supporting new and emerging institutional arrangements. This has been the focus of institutional entrepreneurship scholarship (Battilana, Leca, & Boxenbaum, 2009b; DiMaggio, 1988; Dorado, 2005; Garud et al., 2007; Greenwood & Suddaby, 2006; Jennings, Greenwood, Lounsbury, & Suddaby, 2013; Leca, Battilana, & Boxenbaum, 2008). *Practical evaluative agency* (Emirbayer & Mische, 1998), the assessments and actions associated with getting by and doing routine work, has been relatively neglected in institutional theory scholarship (Besharov & Smith, 2013; Lawrence, 2008). Individuals are carriers of logics within organisations (DiMaggio, 1988; Jepperson, 1991; Zilber, 2002; Zilber, 2011) and their contested, shared, contingent, fluid and historicised understandings and subjective interpretations become objectified or institutionalised (Berger & Luckmann, 1967). The routine interpretations and actions of embedded actors manifest the systems of logic within institutional fields (Thornton et al., 2012). This study is about these micro-foundations of institutionalisation (Smets & Jarzabkowski, 2013a; Smets et al., 2012; Thornton et al., 2012).

Routine resistance and public and private transcripts (Ackroyd et al., 2007b; Prasad & Prasad, 1998, 2000; Scott, 1985, 1990) invite one to look beyond public encounters to clarify what situations might mean. They also call for a critical look at the privilege afforded to managerial control and hegemony (Jermier et al., 1994) and the rediscovery of the recalcitrant worker (Ackroyd & Thompson, 2003b). The *Transactional Model of Coping and Stress* (Lazarus & Folkman, 1984, 1987) presents suggestions for how the process unfolds. It proposes that people seek to match the demands of a situation with the resources at their disposal with two linked appraisal processes. In the *primary appraisal* stage, they try to determine what a particular change may mean for them with respect to their values, beliefs, goals and interests. A particular event may be considered potentially harmful if it is associated with earlier loss. It can be considered a challenge if the possibility exists that the demands can be met with available resources. It can be considered a threat if demands potentially exceed resources. The *secondary appraisal* process determines what can be done and is influenced by the primary appraisal process (Cox & Ferguson, 1991). Depending on available resources, there are feedback loops to the primary appraisal process. The coping behaviours are either problem-focused coping or

emotion-focused coping. The former behaviours are attempts to solve the issue at hand. These could include seeking more information, developing new skills and seeking social support. Problem-focused coping behaviours have better stress outcomes than emotion-focused coping (Lazarus & Folkman, 1984; Moos & Holahan, 2003). Emotion-focused coping behaviours are adopted when the situation is beyond the control of the participants.

To a large degree, the managerial hospital is a creation of the government of the day because it pays the bills. The responses and behaviours of the social, creative and intellectual capital of the hospital; i.e. the frontline clinicians, especially the doctors (Walshe & Smith, 2011), place limits on the emergence and evolution of the managerial hospital.

A complex institutional field (Goodrick & Reay, 2011; Greenwood et al., 2011) makes contradictory demands on the managerial hospital (Battilana & Dorado, 2010; Pache & Santos, 2010; Zilber, 2002). Such an institutional environment does not offer complete and specific solutions that the participants can follow strategically (Smets & Jarzabkowski, 2013a). Their agency and behaviours are experimental solutions as they seek to reframe relations between institutional logics. The modes of agency that they employ (Emirbayer & Mische, 1998) underpin the observable behaviours of the participants and the observable behaviours are instantiations of the modes of agency. The modes of agency are analytically separated but empirically entangled in any concrete situation of action (Emirbayer & Mische, 1998; Smets & Jarzabkowski, 2013a). The observable behaviours have institutional work consequences (Lawrence et al., 2013; Lawrence & Suddaby, 2006; Suddaby et al., 2009); i.e. maintaining, creating and disrupting institutions.

The weighing-up process is the connective link between the constellation of logics (Goodrick & Reay, 2011) and institutional complexity (Greenwood et al., 2011) - that arise in the institutional field (Gray et al., 2015; Hinings & Malhotra, 2008), the associated competing external demands (Battilana & Dorado, 2010; Fligstein, 1997; Pache & Santos, 2010; Zilber, 2002) - and institutional work (Lawrence & Suddaby, 2006) practices of embedded actors. The work practices are enacted as the four modes of observed behaviours in *Rolling with the Punches*: *Stabilising Temporarily, Resisting, Limiting the Impact and Living with. Weighing up* is a meaning-making process (Weick et al., 2005) in which embedded actors evaluate the paradoxes of the managerial hospital against their own sense of self, their values, priorities and beliefs. They can try *stabilising temporarily, resisting, limiting the impact* or *living with* the contradictions and tensions. This perhaps explains why the acute hospital has largely remained a professional bureaucracy (Currie & Suhomlinova, 2006; Dickinson et al., 2013b; Sullivan & Skelcher, 2002a) since professional values do not change easily (Crilly & Le Grand, 2004; Kirkpatrick & Ackroyd, 2003a; McNulty & Ferlie, 2004). *Weighing up* goes on all the time (Lazarus & Folkman, 1984, 1987).

6.2.2 Stabilising Temporarily

Newly qualified consultants adopt this pattern of behaviour for a period of more than 12 months – if not a few years – to become established in their new positions (Brown, Shaw, & Graham, 2013; Morrow et al., 2012; Morrow et al., 2009) as they strive to become clinically independent within their new roles. It has become increasingly difficult for specialist registrars who have completed their training to secure permanent posts (Gordon & Newbery, 2013), so getting the first job is crucial. Hospitals are under pressure to deliver a service around the clock but financial pressures lead them to offer locum/contract posts rather than substantive/permanent posts.

Working as a newly qualified duty consultant in a hospital where one has not trained or worked before can be stressful. The protocols and location of equipment and the quality of the junior doctor teams are just a few of the variables that could spell disaster even before the new consultant has seen a patient. Induction and mentoring programmes that are specifically geared for consultants are needed, yet rare (Dean, 2003; MacLeod, 2007; Roberts, Moore, & Coles, 2002) or may be inappropriately conceived (Harrison et al., 2014).

The transition from specialist registrar to consultant is big, given the added management responsibilities for which registrars are not well trained (Beckett, Hulbert, & Brown, 2006; McKinstry, Macnicol, Elliot, & Macpherson, 2005; Morrow et al., 2009). Studies in which newly qualified consultants were interviewed showed that they had a higher opinion of their clinical training compared to the lowest rating given to their preparedness to manage resources and the delivery system (Higgins, Gallen, & Whiteman, 2005; Morrow et al., 2012). Consultants felt clinically well trained for their roles but significantly less so with respect to management, service delivery organisation, patient complaints, job planning, chairing meetings and supporting colleagues (Brown et al., 2013; Shaw, Stenson, Fenton, Morrow, & Brown, 2012).

A new consultant faces acute pressures in a market-based competitive hospital, under management-based control systems with metrics-based performance systems (Farrell & Morris, 2003). A study by Brown et al. (2013) found that while workload figures cannot suffer and one must be seen to be clinically competent by one's peers, the new consultant struggles to prioritise, delegate and deal with conflicts. The same study found that new consultants have difficulties with controlling those who act in the name of "my consultant". Having trained in a hospital helps with knowing protocols and procedures but it poses identity problems. How should new consultants deal with senior consultants with whom they had trained, the junior medical team, the ward team, the directorate management team, job planning, appraisal and service development (Stanaway et al., 2011).

Two of the competing forces in the managerial hospital: managerialism and professionalism pull this consultant in different directions. The newly qualified consultant has to find the extra hours to get through the work lists in a clinical session. The acute hospital is in market-based competition with other providers, the clinical autonomy of the consultant is constrained by management-based control systems and value added is measured in a metrics-based

performance-management system (Carter et al., 1992; Farrell & Morris, 2003; Greener, 2003). This may mean working extra hours in a day and over weekends. This doctor is caught in the vortex of the wickedness of healthcare organisation (Raisio, 2009; Vartiainen, 2005) and the relative insularity of working in a subsystem of a complex adaptive system (Godfrey et al., 2003; Holland, 1999; Nelson et al., 2003; Nelson et al., 2002; Waldrop, 1994). At the same time the complex adaptive system itself is a hybrid organisation (Battilana & Dorado, 2010; Noordegraaf, 2013; Pache & Santos, 2010; Reay & Hinings, 2009; Scott et al., 2000) for which performance has been raised to a supreme value (Gabriel, 2008). Medical professionalism is being expanded beyond the delivery of quality care to the individual patient to being efficient with the use of scarce resources. Medical professionalism has been undergoing change (Christmas & Millward, 2011; Evetts, 2003; Rosen & Dewar, 2004). The efficiency logic places this doctor under severe time pressures and causes anguish (Iversen, Rushforth, & Forrest, 2009) as the doctor has to learn resource management on the job, while at the same time being the scarce expert resource to be managed. The purpose of the performance-management system is self-management. Newly qualified hospital consultants struggle with the management roles associated with being the duty consultant(Higgins et al., 2005).

New doctors tend to prioritise a better work-life balance more than their predecessors did (Dacre, 2008; Mayor, 2009; McKinstry, 2008; Thomas, 2014). They often choose to work flexibly and to live in areas where they are close to family and friends. This is especially true especially if they are in dual-income relationships. An increasing number of women are choosing to work part-time or flexibly, even taking time out to start families. Hospitals are moving towards extended seven-day weeks while the new doctors are moving towards a better work-life balance. The managerial hospital and the new consultant appear to travel in opposite directions. However, these consultants know only the managerial hospital. They themselves do not have a memory of a hospital where consultants were in charge.

The observed practices show that newly qualified consultants tend to try to get through the work, develop their ability to work under pressure, become clinically competent and create a support network for themselves. Their efforts and intentionality are not aimed at changing institutional arrangements so *projective agency* (Emirbayer & Mische, 1998), institutional entrepreneurship (Battilana et al., 2009b; DiMaggio, 1988) and institutional work that is geared towards creating new institutions (Lawrence & Suddaby, 2006; Suddaby et al., 2009) do not feature at all in this phase of the career of the consultants.

The consultant primarily employs *practical-evaluative agency* to get through the day-to-day work and to develop a good professional reputation. Their primary mode of agency tends to reproduce the existing institutional arrangements; thus, *iterative agency* is also evident. However, *the practical-evaluative* and *iterative dimensions of agency* that the newly qualified consultant employs are not just passively taken-for-granted. On the contrary, their modes of agency require constant effort to compare viable alternative assumptions, beliefs and material practices (Thornton & Ocasio, 1999; Thornton et al., 2012) and make choices. It is certainly not the case of being a cultural dope (Garfunkel, 1984). *Practical-evaluative agency* – with *iterative*

agency consequences – underpins observable behaviours that, in turn, have the institutional work implications of maintaining institutions. However, the aim of this newly appointed consultant is not necessarily a purposeful maintaining of existing institutional arrangements. Just wanting to get by, which is the intention, has unintended institutional work consequences. This subtlety appears to be lacking in institutional work theory (Lawrence et al., 2013; Suddaby et al., 2009). The participants legitimate what they are doing and discursively dismiss (Mumby, 2005; Suddaby & Greenwood, 2005) almost everything else as relatively unimportant (Smets & Jarzabkowski, 2013a; Suddaby & Greenwood, 2005). Sometimes they may actively dismiss alternative practices or, at other times, they are just too tired to bother.

Living up to the expectations of the primary, salient identity as a hospital consultant (Ashforth & Johnson, 2001; Burke & Tully, 1977) is the main objective of the newly qualified consultant. That accomplishment comes with its own interpretive scheme (Greenwood & Hinings, 1996; Ranson et al., 1980b), template (DiMaggio & Powell, 1991) and institutional logics (Thornton & Ocasio, 1999, 2013). The relative independence of the clinical departments provides new consultants with sufficient room to focus on the tasks at hand. They are able to seek local solutions to the day-to-day complexities that they face. However, the interdependence with other clinical and service departments has the potential to, and often does, disrupt their attempts at splendid isolation (Godfrey et al., 2003; Holland, 1999; Nelson et al., 2003; Nelson et al., 2002; Waldrop, 1994). Their idea of medical professionalism is to get through the work, do the best for their patients and earn the trust and respect of their colleagues. They often have public transcripts that do not openly challenge the managerial hospital but they are likely to have very deep hidden transcripts (Prasad & Prasad, 1998, 2000; Scott, 1985, 1990).

Thus, *stabilising temporarily* is a way of being in which the mode of agency (Emirbayer & Mische, 1998) is primarily practical-evaluative as the focus of the newly appointed consultant is mainly to get through their work. This mode of agency has iterative agency consequences because institutional maintenance is an unintended outcome. The observed practices are primarily those that practical-evaluative agency underpins. One can therefore take a look from the coalface of institutionalism (Barley, 2008) at how this group of inhabitants of the institutions (Hallett & Ventresca, 2006; Scully & Segal, 2002) casts and reframes a Byzantine institutional environment in its routine, everyday practice. Practical-evaluative agency dominates whilst iterative agency consequences may be unplanned. Both modes of agency require effort because the participant has to compare individual and primary referent group priorities constantly within a fluid, contingent and intricate institutional environment. The observed practices are instantiations of the dominant practical-evaluative agency and unintended iterative agency. The modes of agency loop backwards to the institutional field, which results in a coalface iterative micro reframing of relationships between field-level structures, logics and demands. Structures are therefore contingent and unstable (Bjerregaard & Jonasson, 2014; Emirbayer & Mische, 1998) with non-hegemonic power to shape behaviour (Anderson, 2008; Foucault, 1979; Mumby, 2005; Prasad & Prasad, 1998; Scott, 1985, 1990).

Since structures do not impose themselves (Friedland & Alford, 1991a) but have to be interpreted, room is left for sense-making and meaning-making (Ancona, 2012; Frankl, 1997; Lazarus & Folkman, 1984; Weick, 1995; Weick et al., 2005). Meaning-making is expressed as a multi-dimensional agency (Battilana & D'Aunno, 2009a; Emirbayer & Mische, 1998) whose different modes interact dynamically in two directions. Firstly, the modes of agency underpin observed behaviours, which manifest specific instances of institutional work (Smets & Jarzabkowski, 2013a). These behaviours represent intended and accidental framings of relations between structures or logics, thus in effect resulting in maintaining, disrupting or creating new institutions. *Stabilising temporarily* is characterised by mainly practical-evaluative agency, with iterative agency consequences, thus resulting principally in both effortful *and* unintended institutional maintenance. So the observed institution-maintaining behaviours instantiate the dynamic interaction between a dominant practical-evaluative agency and a subordinate iterative agency. Secondly, dynamic interaction between the modes of agency iteratively frames – for this group of consultants – the relations between the institutional logics as practically incompatible and feeds back the coalface instantiations of those relations.

This is perhaps one of the reasons for the acute hospital remaining primarily a professional bureaucracy (Currie & Suhomlinova, 2006; Dickinson et al., 2013b) despite the significant investments in structural and decision-making systems changes. However, since the carriers of the logics inside the hospital (Delmestri, 2006; DiMaggio, 1988; Jepperson, 1991; Zilber, 2002) have salient and nested identities (Ashforth & Johnson, 2001; Burke & Tully, 1977; Spyridonidis & Calnan, 2011; Spyridonidis et al., 2014) that vary, the modes of agency, their interactions and the observed practices are unlikely to be uniform, although the preponderance will be as outlined in this section on *stabilising temporarily*. It should be noted that a generational element might be involved, because this group of consultants has trained - and is practising - in the managerial healthcare system. It could be that in future, the institutional arrangements that are maintained are not the professional bureaucracy.

6.2.3 Resisting

This is a coalface institutionalisation (Barley, 2008), in which the inhabitants of institutions (Hallett & Ventresca, 2006; Scully & Segal, 2002) try to keep managerialism and professionalism apart.

In the *resisting* mode, hospital consultants seek discursively to dismiss (Anderson, 2008; Mumby, 2005; Suddaby & Greenwood, 2005) the managerial logic. They prioritise a professional logic and identity (Ashforth & Johnson, 2001; Burke & Tully, 1977; Spyridonidis & Calnan, 2011; Spyridonidis et al., 2014). Moreover, they exercise primarily practical-evaluative and iterative dimensions of agency (Emirbayer & Mische, 1998). In this way they are getting through the day-to-day work. These are the underpinnings of their observed behaviours which are aimed at maintaining existing institutional arrangements (Lawrence & Suddaby, 2006; Suddaby et al., 2009). Professional values are difficult to dislodge (Crilly & Le Grand, 2004; Currie & Suhomlinova, 2006) so they prioritise their duty to the patient, clinical autonomy, collegiality

and traditional medical professionalism. *Resisting* reflects the accusations of "professional recalcitrance" in the face of a managerial reconfiguration of service delivery (Ackroyd et al., 2007b; Dent, 2003; Farrell & Morris, 2003). However, *resisting* is a contingent and dynamic process. The *Resisting* mode of behaviour is made up of two strategies: *subverting* and *quibbling*. The differences are significant but they are a matter of degree. Few doctors actually operate in this space, which probably constitutes about 5% of the consultant body.

The systemic power (Lawrence, 2008) exerted by the market-based competitive hospital, with its managerial-based control systems and metrics-based performance-management system (Farrell & Morris, 2003; Flynn, 1999), is pervasive. Power is not necessarily hegemonic, and generates its own resistance (Foucault, 1979, 1988). The managerial hospital – as a hybrid, contested space of multiple logics (Battilana & Dorado, 2010; Pache & Santos, 2010; Zilber, 2002) – leaves room for resistance. Resistance behaviours exist within those spaces between the capillaries of technologies of control (Foucault, Burchell, Gordon, & Miller, 1991; Miller & Rose, 2008) associated with the competing logics.

These actors perform their daily work in established ways that keep the professional and managerial logics separate. It is an active, not a mindless or effortless, process (Emirbayer & Mische, 1998; Smets & Jarzabkowski, 2013a). Resisters deliberately engage the managerial logic and discursively justify their own behaviours.

The doctors who adopt a resistance pattern of behaviour find themselves on the resistance end of the resistance-compliance continuum. They access the professional logic to engage reflexively in self-creation and resistance (Spicer & Böhm, 2007). What drives them is their sense of self, their salient physician identity (Ashforth & Johnson, 2001; Burke & Tully, 1977; Spyridonidis et al., 2014). They deeply reflect on how best to serve their patients and be of service to their colleagues. Moreover, they are disturbed by the extent to which the managerial project is trying to transform them into docile subjects (Ferlie et al., 2012; Kondo, 1990).

6.2.3.1 Subverting

Subversion involves taking a particular practice or symbol and reframing it, in this way undermining the original intention of its use. In the novel *The Wrapped Woman* by Boolell, Supaya, the protagonist, rejects the sari as a symbol of the oppression of women and transforms it into a tool for the creative construction of her strength, dignity and identity (Barrios, 1996). In political thought, subversion is often advised when conditions do not favour a direct assault (Gramsci & Forgacs, 2000).

In the subversive mode of behaviour, agency is mainly practical-evaluative (Emirbayer & Mische, 1998) because, whilst an actor may have issues with the social organisation of the delivery of healthcare, they still have a primary on-going duty to patients and getting through the day-to-day work. Doctors arrive at the hospital to help patients and assist their colleagues. Iterative agency also features prominently since the aim of the participant is to keep managerialism and professionalism apart. Being subversive deals with how they go about doing

their work. The resistance practices are often discursive and depend on the meanings, which are highly dependent on the context in which actions take place (Anderson, 2008; Mumby, 2005; Suddaby & Greenwood, 2005). Thus, the primary dimension of agency is practical-evaluative with almost an equal iterative agency. Projective agency does not feature in this pattern of behaviour.

Subversives take a managerial technology and decouple it (Hirsch & Bermiss, 2009; Levay & Waks, 2009; Meyer & Rowan, 1977; Oliver, 1991) from the intentions to extend the managerial gaze and control. They either formally comply without changes in clinical practice or use the technology to entrench clinical autonomy further. Taking the clinical audit as an example, the clinical audit evolved from being voluntary (during and after the 1960s) to mandatory (after 1989) and then became part of the bigger clinical governance (after 1999) project (Klein, 2013; Scally & Donaldson, 1998). Clinical audit aims at making clinical practice transparent and at improving the quality of care (Mooney, 2009). It also links clinical practice and resource utilisation (Pollock, 2005). This provides an opening for discursive de-legitimisation. Given the lack of funding, an absence of a national strategy and the multiple groups involved in clinical audits, there is sufficient room for decoupling (Hitchen, 2008). However, to the subversive consultant, the audit as a component of the risk-governance system in addition to making clinical practice transparent has the added effect of mediating and shaping the doctor-patient encounter (Hillman et al., 2013). The patient is fragmented into an agglomeration of risks. The patient, as a person, is lost in the process.

As was argued in archetype theory (see Section 5.7.1), structures are meaningful (Greenwood & Hinings, 1993; Ranson et al., 1980b) and are not neutral processes. Clinical governance frames the encounter with the patient as a bundle of risks that have to be mitigated, recorded, verified and tracked. The subversive consultant takes a dissenting view and argues that the audit should be a means of peer review – to improve clinical practice – rather than an extension of the Panoptic gaze of management (Ferlie et al., 2012; Miller & Rose, 2008). One can see the point that the managerial logic works despite the activities of the subversive consultant. It might be dismissed as decaf resistance (Contu, 2008) because it leaves power relations unchanged (Dey & Teasdale, 2015). That, however, would be a misreading of what was found in this literature review about power relations and routine resistance. The subversive consultant would take clinical governance as a discourse aimed at creating an environment where safe, consistently high quality care is delivered to patients and would argue that a safe environment for patients starts with the safety of, and respect for, the staff who deliver care. One cannot expect staffs that are driven to the edges of exhaustion to deliver safe, high-quality care. The subversive is always on the lookout for gaps to exploit. The performance-management systems result in work intensification that can undermine the ability of staff to deliver good quality care. The subversive highlights the dark sides of the performance- and risk-management systems (Brown & Calnan, 2010; Hillman et al., 2013). Subversives are not averse to using the system against itself and putting a clinical spoke in the managerial wheel. They bring to the fore the safety of

patients when managers apply pressure to cut costs (Pollock, 2005). So the subversive uses the spaces created by the competing logics.

*"I have complained about the lack of bedside or mobile suction units in our wards for some time. Only some wards e.g. the intensive treatment unit, the high dependency unit and another ward have these mobile suction units. I had recorded them as audits on numerous occasions and it probably went into a filing cabinet. However, I am personally and professionally responsible for the patient, not the manager. So when I got fed up with a lack of response I used the clinical governance system against the bean counters. I graded the matter as a one. That meant that it had to be escalated and management went ape sh*t. They could not ignore it any longer and there is a record that will feed into other records. It was bad for the manager but this is a problem everywhere in the hospital. The managers control the budget and we are responsible for patient care. One must not overdo it and be sure to cover your back." (Consultant)*

In the managerial hospital, almost everything that does not directly deal with patients is seen as a cost to be reduced or cut and is subject to forensic scrutiny. Doctors hold DCC sessions that involve contact with patients and other SPA sessions. The latter include things like teaching, research, continuing professional development and service development. The efficiency imperative requires that SPAs be reduced and more time spent on DCC. The subversive argues these activities are part of their requirements for appraisals and professional revalidation (periodic relicensing). They also argue that the quality of care delivered by doctors requires that they have time to reflect and discuss with colleagues.

Not many doctors choose to be subversives. Many consultants choose to have deep public and hidden transcripts (Prasad & Prasad, 1998; Scott, 1985, 1990) because the NHS is a monopoly employer and the fear of retaliation is tangible (Dyer, 2013, 2014; Francis, 2015). From a labour process theory perspective, organised, formal and collective resistance by hospital consultants is almost unthinkable (Spicer & Böhm, 2007; Thomas & Davies, 2005). Hospital doctors who use whistleblowing as a subversive tactic can have tremendous difficulties, which include being marginalised, investigated on spurious charges, placed on indefinite leave and even reported for professional misconduct (Dyer, 2015; Francis, 2015). In a time when performance is publicised the delivery of service is a spectacle, with image and reputation becoming ever more important (Gabriel, 2008). The subversives therefore have to find alternative ways of leaking information into the public domain. Often websites like www.doctors.net become fora for bringing matters to the attention of a wider audience. This is the type of activity that can be carried out from the shadows yet can be devastating to the managerial project.

In an environment with an aggressive policy of performance management, targets and severe sanctions or the infliction of terror (Bevan & Hood, 2006; Propper et al., 1998), the subversive engages in discursive resistance (Anderson, 2008; Mumby, 2005; Suddaby & Greenwood, 2005). They will mock the management focus on the achievement of mandatory targets while missing the point of healthcare; i.e. health outcomes for patients. The participants juggle the requirements to complete their work lists, meeting the needs of the patient in the room and

consulting their own professional values to find ways of doing the right thing. Even resistance behaviour is about finding the right balance between the multiple variables that include the workload, the needs of the patient and the professional values. The right decision is taken on balance. Subversive practices therefore are effortful accomplishments (Giddens, 1984; Smets & Jarzabkowski, 2013a). The physician identity is salient in that the actor will primarily be a doctor. In incidental and strategic hybridity (McGivern et al., 2015), nested identities (Ashforth & Johnson, 2001; Ashforth & Mael, 1989; Spyridonidis et al., 2014) – do not feature frequently. Their identity work is not complicated by on-going projects of maintaining and reproducing fluid and plural selves (Carroll & Levy, 2010).

When clinical guidelines – as technologies of systemic power – become too burdensome, subversives dismiss these as "cookbook medicine" (Timmermans & Berg, 2003, 2010) or as assembly-line medicine (Brownlie & Howson, 2006) or the McDonaldisation of medicine (Ritzer, 1996). These are rhetorical barbs quietly traded in the struggle about the meanings of the patient, treatment, outcomes and identity. It must be remembered that this is a small – but astute – segment of the body of consultants.

Subversives rarely show their hand in public; i.e. the hidden transcript does not readily go public. The June 2012 strike over pensions by NHS hospital doctors reflects the second time in four decades that doctors took industrial action, which shows the infrequency of open conflict between the powerful and the weak (Scott, 2008a). The main weapon of subversive doctors is to operate in the shadows. There is always ambiguity and sufficient room to retreat, hide away, live and fight another day. Subversives more often than not do indeed have an exit strategy.

6.2.3.2 Quibbling

In an article on bioethics that discusses the use of surrogacy, where the body of a woman is used to carry the baby for another family, several questions are asked. Is this practice exploitative because one is renting space or could it become less exploitative in the event of informed consent? What if the person who wishes to employ a surrogate is wealthy and the surrogate mother is from a poor family? What are the ethical issues associated with exploitation when transnational surrogacy is involved? On the other hand, does the relationship between the surrogate "mother" and the genetic "material" matter? The arguments about exploitation and informed consent can be said to narrow semantic quibbling rather than dealing with the bigger and more fundamental issue of human relationships between the surrogate person and the embryo (Rothman, 2014). The negative, hair-splitting gamesmanship associated with quibbling has also been featured in an article on disputes that involve the use of a trademark between a trademark proprietor and a collective with a geographical indicator (Gangjee, 2007). Who has the right to use the signifier in a given jurisdiction? This has been a semantic squabble for decades.

As shown in the two examples above, quibbling involves behaviours that include raising hair-splitting criticisms and using a magnifying glass to identify issues that others might routinely

overlook. In the managerial hospital, quibbling involves a conscious and tortuous comparison of an existing practice with a proposed change that is to be resisted. The goal is to slow down the managerial bureaucratic and competitive pressures at the extremities or capillaries (Foucault, 1979). The extremity is where power is at its weakest (Ezzamel & Willmott, 1998; Kondo, 1990). This is not narcissistic self-indulgence but has a normative component; i.e. it is a pattern of behaviour rooted in a professional bureaucracy. An individual act of quibbling by a solitary hospital consultant may not be the single grain of sand in the wheel bearing that causes the system to grind to a halt. However, the cumulative effects are sufficient to slow things down. A grand plan is not always visible.

"*I might not be able to stop these procedures, protocols and form-filling. But I can – and do – take the time to follow the procedures that will make things happen or not happen. As long as I frame the issues in terms of patient safety and the quality of the service then the managers cannot easily take action against me." (Consultant)*

Wickedness associated with the social organisation of healthcare delivery (Raisio, 2009; Vartiainen, 2005) gives rise to institutional complexity (Goodrick & Reay, 2011; Greenwood et al., 2011). Byzantine demands are made on a hybrid organisation (Battilana & Dorado, 2010; Kraatz & Block, 2013; Pache & Santos, 2010). These demands are not necessarily incompatible (Besharov & Smith, 2013; Friedland & Alford, 1991b). They can coexist (Battilana & Dorado, 2010; Goodrick & Reay, 2011; Zilber, 2002). But this requires sense making (Ancona, 2012; Lazarus & Folkman, 1987; Weick, 1995; Weick et al., 2005) and agency (Berger & Luckmann, 1967; Blumer, 1971; Hughes, 1971; Strauss et al., 1963). The professional identity component of the sense-making process (Frankl, 1984, 1997) involves a salient physician identity. The actor will primarily remain a doctor. The salient identity is substantially uncomplicated by incidental and strategic hybridity (McGivern et al., 2015) or The maintenance and reproduction of fluid and plural selves (Carroll & Levy, 2010) are not key concerns. The main professional project is holding the line of the salient traditional hospital consultant identity.

The agency is a combination of practical-evaluative and iterative dimensions (Battilana & D'Aunno, 2009a; Emirbayer & Mische, 1998). The observable practices (Smets & Jarzabkowski, 2013a; Smets et al., 2012) are the same as the subversive in being opposed to market-based competition, management-based control systems and metrics-based performance-management systems (Farrell & Morris, 2003; Greener, 2003; Noordegraaf & Abma, 2003). Both aim maintaining existing practices. The difference is that, whereas the subversive seeks to strike decisive blows, the quibbler seeks to kill with a thousand cuts. The quibbler does not readily decisively agree or disagree. On the contrary, this is a person who works within the realms of that which is possible and does that which cannot be unambiguously identified as open dissent. The public transcript (Scott, 1985, 1990) still operates according to the expectations of the management. However, the hidden transcript is activated in the corridors, canteens and outside during smoke-breaks. These are sites that are beyond the immediate gaze of management. This is where the quibbler builds support at least to slow down or review decisions that have been sufficiently discredited in meetings.

The features of wickedness and complex adaptive systems mean that final decisions require patience and building consensus horizontally (Godfrey et al., 2003; McNulty & Ferlie, 2004; Nelson et al., 2003; Nelson et al., 2002). Quibblers create and discursively exploit the gaps that such consensus building requires. Quibblers are often good at for building alliances to influence organisational processes (Demil & Bensédrine, 2005; Suddaby & Greenwood, 2005). So it should be clear that not much of the institutional template is taken-for-granted or given (DiMaggio & Powell, 1991; Greenwood & Hinings, 1993). Institutional arrangements are effortful and on-going accomplishments (Giddens, 1984; Smets & Jarzabkowski, 2013a). Weighing up, sense making and meaning making, the appraisal processes, are on-going. They require continual assessing and determining what managerial procedures, techniques and technologies might mean. At the same time one has to be exploring for ways of engaging in routine resistance that operates within the tolerance limits of managerial power. As long as dissent is not public and unambiguous, it can indeed be accommodated by the patterns of domination (Prasad & Prasad, 1998, 2000; Scott, 1985, 1990). The quibbler aims to slow down the managerial project to a snail's pace because managers are under pressure to deliver tangible outcomes within limited time frames (Klein, 2013; Pollock, 2005).

"A consultant has a job for life, whilst managers come and go." (Consultant)

Doctors are aware that resistance is a lonely affair that often ends badly for the doctor who breaches the tolerance limits. Resistance requires a keen awareness of the managerial red lines and staying within the boundaries. Quibblers use the pressures of the multiple – often conflicting, unending and ever-changing – national priorities of managers to put spokes in the wheels. Managers are under pressure to meet all sorts of targets, some contradictory, and delays can derail or stall their careers. Quibblers build alliances with people who share their dissatisfaction with the managerial hospital and seek to influence the organisational processes in a plethora of small ways (Demil & Bensédrine, 2005; Suddaby & Greenwood, 2005). They use the contradictions and spaces in the multiple logics to engage in legitimacy politics (Kraatz & Block, 2013), justify their behaviour and solidify their support networks (Courpasson, Dany, & Clegg, 2012; Pina e Cunha, Clegg, Rego, & Story, 2013; Suddaby & Greenwood, 2005).

Resisting behaviours involve mainly practical-evaluative agency because all doctors have work lists that have to be completed. This already is indicative of a reconfiguration of their professional autonomy. Managers and their staff compile the work lists. It also illustrates the real-world constraints that doctors face. Clinical guidelines and protocols further frame how they do their work. Managerial logics, as systemic power (Lawrence, 2008), shape and constrain their agency (Evetts, 2003; Noordegraaf, 2007a). Power generates resistance (Foucault, 1988), albeit of a routine kind (Prasad & Prasad, 1998; Suddaby & Greenwood, 2005). Their iterative agency combines with practical evaluative agency aiming to keep the managerial and professional logics separate. Public and hidden transcripts (Scott, 1985, 1990) suggest that the observed behaviours, although very similar, may be underpinned by different dynamically interacting, empirically intertwined but analytically separate modes of agency (Battilana & D'Aunno, 2009a; Emirbayer & Mische, 1998; Smets & Jarzabkowski, 2013a). Resisters get

through the day-to-day work whilst intentionally and unintentionally working at maintaining existing institutional arrangements and disrupting the emergence of new ones (Lawrence & Suddaby, 2006).

Neither the subversive nor the quibbler have grand visions for the social organisation of healthcare delivery (Waring & Bishop, 2013) to be strategically pursued. Their observed behaviours are similar but the subversive acts decisively while the quibbler aims to drain the life out of management. It is worth noting that creating, maintaining and disrupting institutions are not actions taken by separate actors. The same actors can at one time be creating whilst, at another time they could be maintaining or disrupting institutions (Hirsch & Bermiss, 2009; Jarzabkowski et al., 2009a) Thus, one develops a sense of the subtlety, reflexivity and skills of embedded actors and the contingency of institutions during coalface framings of relations between institutional logics. The differences in the modes of practice are subtle but they serve the same purpose; i.e. resisting. The gerund "resisting" allows for the emergence of a sense of an on-going activity, some of which is successful while some fail the aim of maintaining existing institutional arrangements.

6.2.4 Limiting the Impact

Limiting the impact as a strategy has been used in literature. Two examples illustrate *limiting the impact* concisely. In the first example, light pollution contributes to environmental degradation when compared to natural starlight and moonlight. Unnecessary upward light emission and residual light distribution have significant effects on wildlife, human health and stellar visibility. Effective practices have been identified that *limit the impact* of direct upward light distribution and over-lighting (Falchi, Cinzano, Elvidge, Keith, & Haim, 2011). The second example concerns resistance to antibiotics, which is a nightmare, especially in facilities where people are ill or frail. Steps can be taken to *limit the impact* of antibiotic resistance in nursing homes (Drinka, 2010). So *limiting the impact* suggests that one accepts the fact of a phenomenon and does whatever one can to minimise the effect it could have.

"We can make positive suggestions and complain as much as we want but the managers still do what they want. But we will still suggest and complain." (Consultant)

This is an instance of the hospital consultants using their social position (DiMaggio, 1988; Garud et al., 2007) within the hospital to reduce the influence of market-based competition, management-based control, and decision-making systems and metrics-based performance-management systems (Farrell & Morris, 2003; Sheaff et al., 2003; Talbot, 2009) on their medical professionalism. *Resisting* behaviours attempt to subvert or delay managerial initiatives. *Limiting the impact* behaviour is adopted when *resisting* is not an option or, when it has failed to achieve its objectives.

Limiting the impact behaviours are legitimacy actions (Kraatz & Block, 2013) to hinder shifts in the balance of power and adverse impacts on personal commitment structures (Binder, 2007; Hallett & Ventresca, 2006). The imposition of managerial logics (Ackroyd et al., 2007b; Oldham,

2013; Smith, Walshe, & Hunter, 2001b) has not eliminated medical professional logics (Numerato et al., 2012; Waring & Currie, 2009). Healthcare services are not easily transformed into commodities (Ferlie et al., 1996b; Walsh, 1995). Managerial, bureaucratic and professional logics still coexist within the NHS hospital (Crilly & Le Grand, 2004; Exworthy et al., 1999; Sullivan & Skelcher, 2002a) as a result of multiple attempts to deal with the wickedness of the social organisation of healthcare delivery (Ferlie & Dopson, 2005; Raisio, 2009; Vartiainen, 2005). Institutional complexity (Greenwood et al., 2011) and the constellation of logics (Goodrick & Reay, 2011) are inalienable features of the healthcare system. They cannot be wished away by any of the stakeholders.

Some people do not choose resistance as an option at all. They might choose *limiting the impact* behaviours. There is sufficient room for manoeuvring and *limiting the impact* behaviours in the wickedness of healthcare delivery organisation, the acute hospital as a complex adaptive system and the way that doctor-patient contact is structured. Professionals within organisations are able to adapt to organisational life (Deem et al., 2007; Evetts, 2003; Noordegraaf, 2007a; Reed, 1996; Suddaby et al., 2009). They are elite workers rather than cultural dopes (Garfunkel, 1984; Lawrence & Suddaby, 2006; Thomas & Davies, 2005). *Limiting the impact* behaviours is an account from the real world of a group of professionals within a managerially transformed organisation. It is a narrative that engages the call (Lawrence, 2008) for more empirical studies that show how actors enact the compromising, avoiding and acquiescing contingent and strategic responses to institutional pressures (Oliver, 1991). Seeking ways to insulate themselves are but some of the complex, pragmatic and routine resistance ways (Knights & McCabe, 2000; Prasad & Prasad, 1998, 2000; Thomas & Davies, 2005) in which hospital doctors intentionally and unintentionally maintain and disrupt institutions (Lawrence & Suddaby, 2006; Suddaby et al., 2009). Their efforts are directed at getting by with their increasingly over-committed work lists despite the lack of drama or noise (March, 1981; Smets et al., 2012). The capital charges imposed on hospitals, as well as the statutory duty to balance their books, mean that managers are under pressure to reduce costs and deliver more services with diminishing resources (Dunnigan & Pollock, 1998; Pollock, Shaoul, & Vickers, 2002). Clinical guidelines and protocols reduce discretion on the clinical frontline (McDonald & Harrison, 2004; Timmermans & Berg, 2003).

The meanings of professionalism and duty to the patient are crafted in the midst of these dilemmas (Ancona, 2012; Frankl, 1997; Lazarus & Folkman, 1984; Weick et al., 2005). The intentionality that follows from the sense-making process is reflected in the modes of agency (Smets & Jarzabkowski, 2013a). The dimensions of agency that underpin the *limiting the impact* observed behaviours combine the practical-evaluative and iterative dimensions (Battilana & D'Aunno, 2009a; Emirbayer & Mische, 1998), with the iterative dimension dominating. This means that *limiting the impact* behaviours are situated at the resistance end of the resistance-compliance spectrum. In enacting both their practical-evaluative and iterative dimensions of agency, they do not have a fully formed vision of the institutional arrangements that they strategically pursue. On the contrary, their observed behaviours are experimental, contingent,

fluid and situated improvisations (Smets et al., 2012) that allow them to accomplish their daily work while *resisting* managerial transformations of their work. The mundane, yet purposeful actions of professionals are consistent with the institutional work theory of deliberately creating, maintaining and disrupting institutions. These actions also reflect routine resistance behaviours (Scott, 1985, 1990). *Limiting the impact* behaviours is one of the many complex ways in which professional people exercise mundane, episodic power in the workplace (R. Thomas & Davies, 2005; Lawrence, 2008). It shows that even people for whom power may have slipped a little are likely to find routine ways to protect their interests (Knights & McCabe, 2000; Prasad & Prasad, 1998).

Limiting the impact behaviours involves two strategies: *lying low* and *faking it*.

6.2.4.1 Lying low

GT allows one to take concepts from outside the boundaries of specialist bodies of literature (Glaser, 1978), with the grounded theorist likely to have something new to say about these concepts. *Lying low* is a concept that is used in foreign policy and cell biology. Adopting *lying low* behaviours does not mean not doing anything. China, for example, adopts a *lying low* position in its foreign policy orientation (Chen & Wang, 2011). China may stay below the radar but it does pursue its national interests quite robustly. In an example from cell biology, muscle satellite cells, which play an important role in skeletal muscle regeneration when after injury they become activated (Montarras, L'Honoré, & Buckingham, 2013), lie low until needed.

As mentioned above, *Limiting the impact*, as a pattern of behaviours, has two dimensions or strategies: *lying low* and *faking it*. The first is a buying time strategy and the second is a more opportunistic strategy. *Lying low* behaviours are contingent on the non-hegemony of systemic power (Gramsci & Forgacs, 2000; Lawrence, 2008). *Lying low* involves behaviours that include playing one's cards close to one's chest, lurking in the shadows, staying below the radar and doing just enough not to be noticed as being either for, or against anything. A person who adopts this strategy may adopt some of the managerial discourse and practices to keep the management happy enough and then make sure that they meet as little of the management requirements as possible, to remain credible with their colleagues. This is an example of *inverse decoupling* (Levay & Waks, 2009; Power, 1999). The actors reconstruct the institutional order in which they are embedded by a practical-evaluative agency that underpins observed behaviours aimed at largely completing their work lists so that the hospital reaches its performance targets. However, their iterative agency underpins observed behaviours that manifest intentions formally to comply with the managerial hospital while actual work is informed by a professional value system (Crilly & Le Grand, 2004).

Lying low behaviours can be seen as instantiations of a "negotiated order" (Strauss et al., 1963) as jurisdictions and roles are contested at micro-levels and continually resolved with contingent, fluid and local coalface (Barley, 2008) solutions by the inhabitants of the institutions (Hallett & Ventresca, 2006; Scully & Segal, 2002). Thus, their intentionality reflects in a dynamic

combination of practical-evaluative and iterative agency that is aimed at both getting by on a day-to-day basis and, at the same time, constraining the advance of managerialism by decoupling behaviours. This reflects the dynamic multi-dimensionality of agency (Emirbayer & Mische, 1998) and the subtlety – and sometimes contradictions– in the nature of effort and purpose involved in institutional work (Lawrence & Suddaby, 2006; Suddaby et al., 2009). It shows the low-key ways in which relations between institutional logics are negotiated on the clinical frontline, thus altering the ways in which actors experience institutional complexity (Greenwood et al., 2011).

Lying low can be a buying time tactic while not losing ground, as the actor may be unsure of which way to go. *Limiting the impact* behaviour can be instantiated by hybrid clinical-management roles (Waring & Currie, 2009). In this study *limiting the impact* was found to be more of an avoidance behaviour (Endler & Parker, 1994; Lazarus & Folkman, 1984) but it can be a case of collaborating with or accommodating power because the boundaries between compliance and resistance are not obvious (Knights & Vurdubakis, 1994; Scott, 1985). *Lying low,* as a pattern of behaviours, aims at maintaining credibility with colleagues, patients and managers. It takes hard work to keep all the balls in the air. However, in order to not draw attention from management, this participant will dabble in a bit of projective agency (Emirbayer & Mische, 1998) while not doing too much since this would risk credibility with colleagues. One could consider this as projective agency that is aimed at defending professional logics. Projective agency therefore may not involve the pursuit of fully formed visions as suggested in institutional entrepreneurship (Battilana et al., 2009b; Smets & Jarzabkowski, 2013a). *Lying low* could therefore be considered an instance of tempered radicalism (Myerson, 2001) as actors try to find a space between resistance and conformity, already having decided that resistance is not really an option but not yet having decided to adopt conformity as a way forward. It can sometimes be *ham in the sandwich* behaviour.

Lying low involves a salient physician identity, in that the actor remains primarily a doctor while dipping their toes into the ponds of incidental and strategic hybridity (McGivern et al., 2015). These identities are deeply nested (Ashforth & Johnson, 2001; Ashforth & Mael, 1989; Spyridonidis et al., 2014) because the participant still operates in the zone of resistance. Their identity work is an on-going accomplishment of maintaining and reproducing fluid and plural selves (Carroll & Levy, 2010) so that the balance between salience and nestedness is maintained.

With *limiting the impact* behaviour, the projective agency is primarily defensive. The associated modes of practices that this underpins begin to recast incompatible logics as relatively compatible (Reay & Hinings, 2009; Scott et al., 2000; Smets & Jarzabkowski, 2013a). Hybrid practices are incubating in the shadows.

6.2.4.2 Faking it

Faking it is the second dimension of *limiting the impact* behaviours. It can be seen as an opportunistic positioning strategy because, rather than buying time to decide which way to go, those who are faking it are just waiting for the right moment to play their hand. Meaning-making, although it is interactional (Berger & Luckmann, 1967; Blumer, 1971; Hughes, 1971), means that the individual still assumes responsibility for the process (Frankl, 1997; Lazarus & Folkman, 1984). The individual is the one who is faking it.

Lest some take a moral stance against *faking it* behaviours of hospital consultants, it may perhaps help to recall that faking it could be an essential social lubricant that makes the world an easier place in which to live (Miller, 2012). *Faking it*, according to Miller, is about routine impression management; i.e. the conning, scamming, praising, bluffing and manoeuvring in which actors engage rather routinely. Impression management goes on all the time, from the faking of orgasms to artists miming at live shows or at presidential inaugurations, expressions of joy at the arrival of much disliked guests and sorrow at their departure, happiness in a colleague's getting a promotion that one desired for oneself, people wearing fake brands (Gino, Norton, & Ariely, 2010) and applicants doctoring their CVs (Donovan, Dwight, & Schneider, 2013). *Faking it* behaviours allow actors to respond to immediate demands while working at positioning themselves for emerging situations. These behaviours deal with the secret agendas that actors have and the games that they play with multiple selves (Ashforth & Johnson, 2001; Burke & Tully, 1977) that are constructed within contingent, fluid and historicised contexts. A similar influential argument was advanced earlier about life as nothing more than a performance (Goffman, 1990). *Faking it* behaviours can be both exhausting and exhilarating. There is always the possibility of being unmasked. Yet, in being found out, one might even feel better, Miller could add.

Faking it behaviours are underpinned by a complex combination of intentionalities that dynamically interact and are instantiated by a mode of agency that combines practical-evaluative, iterative and projective dimensions. Practical-evaluative appraisals are always present because doctors have to get through their day-to-day work with and for patients. Much of this is likely to be genuine, without *faking it* behaviours. There is, however, a degree of faking about how much work some doctors actually do. The workload figures – within and between departments – appear to bear that out. Much of the *faking it* behaviour reflects the varying combinations of iterative and projective agency that individuals choose to adopt, given their own appraisal processes (Lazarus & Folkman, 1987). However, these combinations of iterative and projective agency are not necessarily associated with the strategic pursuit of given institutional visions. On the contrary, they situationally improvise (Smets et al., 2012) and pursue opportunities in the gaps between the capillaries of power (Foucault, 1988). Living up to the expectations of relevant stakeholders, while framing – and recasting – relations between institutional logics and paradoxes can be hard work and extremely tiring. It involves the delicate balancing of intentions, actions and identities (Miller, 2012).

Faking it is a *decoupling strategy* since formal managerial requests are agreed to but professional practices remain largely sealed off (McGivern & Ferlie, 2007; Meyer & Rowan, 1977; Power, 1999). In the same way that managerial control is not hegemonic, the insulation of professional priorities and practices is not complete but rather a matter of degree. Even those who are *resisting* make a few compromises here and there because the NHS is a monopoly employer. Material and symbolic constraints temper radicalism (Meyerson & Scully, 1995; Myerson, 2001) on either side of the resistance-compliance continuum. The hospital consultant who is *faking it* engages in incidental hybridity (McGivern et al., 2015) to gain legitimacy with important stakeholders but clinical practice remains substantially professionally informed. These participants believe that the professional frame of reference tis technically more efficient (Boxenbaum & Jonsson, 2008a).

The physician identity is the more salient one in that the actor will primarily remain a doctor – with some incidental hybridity and hardly any strategic hybridity (McGivern et al., 2015). Incidental hybridity is nested within the salient physician identity (Ashforth & Johnson, 2001; Ashforth & Mael, 1989; Spyridonidis et al., 2014). Their identity work is an on-going project of maintaining and reproducing fluid and plural selves (Carroll & Levy, 2010). A study by Levay and Waks (2009) found that Swedish clinicians saw merit in quality enhancement programmes but assumed control of the content and the process (Levay & Waks, 2009). In their 2007 study of NHS hospital consultants, McGivern and Ferlie found that although they accepted the implementation of job planning and clinical audits – thus changing their clinical autonomy – NHS hospital consultants did not allow non-clinical managers to assume control of the process (McGivern & Ferlie, 2007). *Faking it* does not involve the active dismissal or subversion of managerial technologies. The same logics – that actors would construct *resisting* behaviours as contradictory or would seek to avoid lying low behaviours because of an interpreted degree of incompatibility – are reconstructed as at least marginally compatible. This concurs with the findings that logics are not necessarily incompatible by definition but that those relationships are framed within the dilemmas and puzzles that actors discover within their practice contexts, the questions that they frame and the answers that they develop (Jarzabkowski et al., 2009a; Smets & Jarzabkowski, 2013a).

The intention is to get through the day-to-day tasks at hand; hence, the mode of agency is also mainly practical-evaluative with iterative dimensions (Emirbayer & Mische, 1998). The latter reinforces existing institutional arrangements. The intentionality differs from that of *lying low* because the actor is waiting to take advantage of emerging opportunities. Faking it is not avoidance but priming for opportunity and it requires a constant surveying of the landscape. Thus, it is an effortful accomplishment (Emirbayer & Mische, 1998). The portfolio of observable practices that *faking it* instantiates is wider than *lying low*, despite being within the *limiting the impact* pattern of behaviour. This perhaps contributes to the explanation of why successful archetype change has not taken place.

Resisting and *limiting the impact* differ in their intentionality – as reflected in the mode of agency (Smets & Jarzabkowski, 2013a) – regarding emerging institutional arrangements and

the observed modes of practice which they instantiate. *Weighing up* is on-going at every stage of *Rolling with the Punches*. With *limiting the impact* behaviours, the participants seek either, to buy time by lying low or to position themselves by *faking it.* Thus taking advantage of the way that the wind is blowing. If these behaviours have failed, or if the person is more inclined to be compliant, then *adjusting to, or living with,* managerialism is an option. For those who choose to *adjust to* a market-based, management-controlled and metrics-based performance-managed hospital, compliance behaviours would instantiate their modes of agency. These, in turn, would routinely and iteratively create and recreate relations between institutional logics, wickedness of healthcare organisation and the complex adaptive system called the hospital.

6.2.5 Adjusting to/Living with

Living with as a pattern of behaviour has been used in literature to refer to having to structure responses around a phenomenon that endures. Living with, or adjusting to behaviours forms a complex pattern of behaviours that indicate varying degrees of adjustment to a given phenomenon. For example *living with HIV* (Cridland, Jones, Caputi, & Magee, 2014; Kalichman, Heckman, Kochman, Sikkema, & Bergholte, 2000), *living with grief* as part of hospice care (Otis-Green, 2014), *chronic illness* (Vassilev et al., 2014) and *heart disease* (Pryor, Page, Patsamanis, & Jolly, 2014). Even where people are living with particular medical conditions, they differ in their adherence to treatment regimes (Thieda, Beard, Richter, & Kane, 2003; Torrey & Zdanowicz, 2001). Compliance is also uneven in the case of states that have to live with international law (Carvalho, 2015) (Tallberg & McCall Smith, 2014).

This pattern of behaviour is situated at the compliance end of the resistance-compliance spectrum. *Adjusting to*, or *living with*, managerialism is a complex pattern of modes of agency and observed practices. It involves four analytically distinct but empirically entangled emotion-focused coping patterns (Cox & Ferguson, 1991; Lazarus & Folkman, 1984); i.e. *going with the flow*, *complying substantially*, *complying fully* and *waiting it out*. The *living with* pattern of behaviours is chosen by actors who do not choose *resisting* or *limiting the impact* behaviours or for whom these options have not proved to be effective. Some accept the managerial hospital as a fact of life and try to make the best of the situation in which they find themselves. Instead of banging on closed doors, some will look for those doors that are ajar or wide open. Some participants view the managerial hospital not as a bottomless pit but rather as a ladder. Others do not really care about what is happening around them as they just come to work, deal with their patients and go home. The four different ways of coping involve significant differences in effort, intentionality and constructions of inter-logic relationships. Each way of carrying out the *living with pattern* is a different agentic response to the dilemmas of being a doctor within the context. The mode of agency chosen – each of which is dynamic and composite – underpins a group of observable practices that in turn instantiate and affirm a co-determination between observable practice and agency. The different agentic modes reflect different framings of the puzzles and paradoxes in the hybrid context.

6.2.5.1 Going with the flow

Going with the flow conveys a sense of trimming one's sails according to the direction of the wind. The strategy suggests being immersed in any activity (Csikszentmihalyi, 1997). *Going with the flow* has a presence in literature. A 2014 study by Altabbaa, Beran and Kaba shows that sometimes physicians adopt this strategy in dealing with dilemmas in medical practice (Altabbaa, Beran, & Kaba, 2014). Another study shows that children choose *going with the flow* when majority and minority views are equally plausible (Schillaci & Kelemen, 2013).

For the participants who adopt *going with the flow* behaviours, the boundaries between managerialism and medical professionalism are blurred (Muzio & Kirkpatrick, 2011; Noordegraaf, 2007a; Noordegraaf & Steijn, 2014b; Waring & Currie, 2009). About 10%-20% of hospital consultants and 4%-5% of the NHS hospital CEOs choose to become clinical managers (Dickinson et al., 2013b; Spurgeon, Clark, & Ham, 2011) and adopt *going with the flow* behaviours. Rather than a *danse macabre* (Davies et al., 2003; Degeling et al., 2003), it is more a case of: "Shall we dance?" (Chelsom, 2004).

Going with the flow requires substantial effort (Emirbayer & Mische, 1998; Giddens, 1984; Smets & Jarzabkowski, 2013a). The actor has to reflect deliberately and continually on the existing and emerging managerial institutional arrangements and make the conscious choice to adopt the managerial perspective, work out how to do this and to what extent this should happen. This choice itself is on a minor complex continuum rather than being a simple binary. Moreover, it has to be discursively justified and legitimised to the self and to other relevant stakeholders (Anderson, 2008; Mumby, 2005; Suddaby & Greenwood, 2005). In the medical profession, credibility in the local sub-system (Morgan & Ogbonna, 2008; Nelson et al., 2002) is important. The selection of assumptions, values, beliefs and material practices (Thornton & Ocasio, 1999, 2013) that are more aligned with market-based competition, management-based control systems and metrics-based performance-management systems (Farrell & Morris, 2003) than those who adopt *resisting* or *limiting the impact* behaviours reflects a shift in intentionality and agency when compared to the latter modes of behaviour. The modes of agency are varying combinations of practical-evaluative, iterative and projective dimensions that are the actors' interpretations of solutions that may be needed within a complex, fluid and hybrid managerial hospital (Cooper et al., 1996; Exworthy et al., 2010b; Exworthy et al., 1999; Sullivan & Skelcher, 2002a).

The managerial hospital itself is in a state of becoming (Bjerregaard & Jonasson, 2014). It therefore is not a fully formed vision in which the inhabitants have to occupy predetermined spaces (Hallett & Ventresca, 2006; Scully & Segal, 2002). On the contrary, it is a contested space where actors respond to immediate demands while discovering emerging dilemmas, framing answers and testing these. *Going with the flow* may involve greater commitment to the reframing of relationships between logics in the direction of compatibility and complementarity. However, these are almost always situated improvisations rather than radical transformations (Smets et al., 2012). That is another reason why the NHS has largely remained a

professional bureaucracy (Dickinson et al., 2013b; Mintzberg, 1979). The primary mode of agency of the inhabitants remains practical-evaluative as they have to get through their daily clinical work and the fact that they develop an emerging vision locally in situated improvised practices has iterative consequences as well. The degree of iterative and projective agency commitment is where these actors differ from those who adopt *resisting* and *limiting the impact* behaviours. The practical-evaluative agency, plus the marginal adjustments that hybridisation involves, edges the hospital in the direction of managerialism in order to retain clinical credibility.

By adopting boundary-spanning roles as clinical leads for particular services, or clinical directors of managerially aggregated groups of services or medical directors as clinical voices at senior-management level, clinical-management hybrids see themselves as two-way windows (Llewellyn, 2001). They mediate the impact of the managerial project in the hospital on their colleagues. Soft bureaucracy (Courpasson, 2000) replaces the hard economic and financial edges of direct non-clinical management. Boundary-blurring roles are located on a continuum from incidental to strategic, willing clinical-managerial hybrids (McGivern et al., 2015). These are particular material framings of relationships between institutional logics (Jarzabkowski, 2009; Smets & Jarzabkowski, 2013a) in the direction of agreement and congruence. Clinical-managerial hybrids assume responsibility for some of the implementation of the processes of vertical accountability, lateral standardisation of clinical practice and commercialisation of the values of the hospital. Many of those who choose *going with the flow* behaviours do so on a temporary or part-time basis and return to full-time clinical positions later. This usually tempers their enthusiasm for radical (Meyerson & Scully, 1995) projective agency. Bridges and boats are often needed at later times, so not burning them is a prudent way to go. This type of framing of intentionality, subtlety of agency and the construction of relations between logics to meet immediate demands in independent and inter-dependent local settings answers some of the questions about how actors at the intersection of multiple institutional fields with distinct sets of expectations make decisions (Blomgren & Waks, 2015; Correia, 2013a; Lok, 2010; McPherson & Sauder, 2013; Nancarrow & Borthwick, 2005; Numerato et al., 2012). Thus, the sociological impact of the managerial hospital (Timmermans & Oh, 2010) is more than the simple binary (Gleeson & Knights, 2006; Numerato et al., 2012; Waring & Bishop, 2013) of deprofessionalisation, proletarianisation and McDonaldisation, on the one hand, and restratification, on the other hand.

Wickedness and systemic and institutional complexity have resulted in a hybrid, fluid and ambiguous service delivery context. Embedded actors have to make sense of, and enact, the meanings for themselves, thus micro-framing the macro-dilemmas. The managerial hospital is a hybrid structure (Battilana & Dorado, 2010; Pache & Santos, 2010) that manifests the multiple logics (Goodrick & Reay, 2011; Greenwood et al., 2011). These logics have varying degrees of compatibility (Besharov & Smith, 2013; Friedland & Alford, 1991b). Such a fluid, plural institution does not hold itself together by itself (Kraatz & Block, 2013). It requires that people who make sense of the institutional context and enact their understandings. Their practices are

either completely or loosely coupled (Townley, 1997) and reframe the relations between logics in their day-to-day organisational activities.

Going with the flow, as clinical-management hybridity, may be an instance not of deprofessionalisation but rather of reprofessionalisation (Waring & Currie, 2009) at the coalface (Barley, 2008). It could be seen as a routine (Prasad & Prasad, 1998; Scott, 1985) and non-dramatic (March, 1981) contest for the expansion of professional jurisdiction (Abbott, 1988; Currie, Lockett, Finn, Martin, & Waring, 2012b; Reay, Golden-Biddle, & Germann, 2006) or enhancing of a professional identity (Spyridonidis & Calnan, 2011; Spyridonidis et al., 2014). This is a local, routine translation of logics by actors who have interests, beliefs and preferences and who strategically respond to attempts at institutional control; i.e. by acquiescing, compromising, avoiding, defying and manipulating (Oliver, 1991).

How embedded actors routinely engage with systemic power is largely still an empirical black box (Lawrence, 2008; Lok, 2010; McPherson & Sauder, 2013; Munir, 2015; Zilber, 2013). The various combinations of agency, intentionality, effort and modes of observed behaviours in *Rolling with the Punches* contribute to decoding the black box. Transcending the boundaries, by engaging in hybridity, is a way of engaging institutional control. The difference that this account adds is the roles of sense-making in opening the black box and framing intentionality and effort that are instantiated in complex combinations of modes of agency that underpin observed practices, thus micro-dynamically framing relations between macro-logics. Clinical hybrids as carriers of multiple logics (Jepperson, 1991; Smets et al., 2012; Zilber, 2002) show how individuals can pursue otherwise divergent expectations.

In pursuing their expectations, hybrid clinical managers reframe relations between logics on the clinical frontline. They work through the dilemmas and paradoxes that emerge within wickedness, systems and institutional complexity as they engage in professional identity bricolage (Gotsi, Andriopoulos, Lewis, & Ingram, 2010; MacLean & Webber, 2015; Wyatt, 2010). This is their crafting of their personal stakes in the managerial hospital. The physician identity is the more salient in that the actor primarily remains a doctor – despite incidental and strategic hybridity (McGivern et al., 2015) – whilst other identities are nested (Ashforth & Johnson, 2001; Ashforth & Mael, 1989; Spyridonidis et al., 2014). Their identity work is an on-going project of maintaining and reproducing fluid and plural selves (Carroll & Levy, 2010). The process reflects the situated improvisations (Smets et al., 2012) and discursive legitimisations (Anderson, 2008; Mumby, 2005; Suddaby & Greenwood, 2005) as they try to accomplish practical work within the ambiguities, complexities and paradoxes at hand (Smets & Jarzabkowski, 2013a).

Hybrid clinical managers engage in the management of professionals and other non-professional staff (Denis et al., 2001; Doolin, 2002; Fitzgerald & Ferlie, 2000b). However, this is often without adequate training or support, thus these managers end up as enthusiastic amateurs (Ham, Clark, Spurgeon, Dickinson, & Armit, 2011a; Spehar, Frich, & Kjekshus, 2012). It can be a disconcerting role to occupy. Their clinical colleagues suspect them of having gone beyond the dark side to the centre stage (Spurgeon et al., 2011). The non-transparency of their

appointments exacerbates clinical suspicions (Unit, 2012). Non-clinical managers treat them with suspicion. Clinical hybrids often end up being stranded in no man's land between the managerial and clinical domains (Degeling et al., 2003; Marnoch, McKee, & Dinnie, 2000). So some clinical managers have little operational control over their colleagues and assume responsibility for budgets that they do not control (Greener, Harrington, Hunter, Mannion, & Powell, 2011; Mumford, 2010; Unit, 2012). Hybrid clinical-management positions appear unenviable posts to occupy but despite their problems there seems to be a link between clinical leadership and improved service delivery (Dickinson et al., 2013b; Goodall, 2011; Veronesi, Kirkpatrick, & Vallascas, 2013b).

Weighing up is an on-going process and takes place in each stage of *Rolling with the Punches*. Actors do not have big plans to promote the managerial hospital and expand the boundaries and content professionalism. Rather, they seek to cope and exploit opportunities within their work situation. Their agency and observed practices (Smets & Jarzabkowski, 2013a) are neither strategic nor unintentional but are instances of situated improvisations (Smets et al., 2012). They respond to immediate demands. As puzzles are identified, solutions are tested as they go along. This is not management by objectives but rather management by discovery (Klein, 1999, 2011). The managerial hospital, as a work in progress (Bjerregaard & Jonasson, 2014; Smets & Jarzabkowski, 2013a), frames shifts in intentionality, effort, agency and observed practices of actors who adopt *going with the flow* behaviours. In this way, their institutional work (Lawrence & Suddaby, 2006; Suddaby et al., 2009) and recasting of relationships between institutional logics emerge as issues and challenges that are encountered rather than the pursuit of grand institutional projects. Instead of being enthusiastic and skilled institutional entrepreneurs (Battilana & D'Aunno, 2009a; DiMaggio, 1988; Garud et al., 2007), they are tempered radicals (Myerson, 2001) who routinely resist (Prasad & Prasad, 1998; Scott, 1985, 1990) both their clinical colleagues and non-clinical managers (McGivern et al., 2015). Their observed behaviours are constructions of relationships between institutional logics and systemic and institutional complexity through hybrid practices. Those practices instantiate the dynamism, complexity, contingency and fluidity of their mode of agency, which is mainly practical-evaluative but has varying combinations of iterative and projective dimensions and consequences. Their agency feeds back to co-determine the institutional structures. The wickedness of the social organisation of healthcare and the complex adaptive systems features of the hospital allow them the spaces to engage in hybrid efforts, intentionalities, modes of agency and observed practices.

6.2.5.2 Complying substantially

The observed behaviours of hospital consultants should not be taken at face value if one considers routine resistance and public and private transcripts (Prasad & Prasad, 1998; Scott, 1985, 1990). Professionals are able to adapt to organisational life (Muzio et al., 2013; Noordegraaf, 2011, 2013). Even compliance may not imply surrendering (Oliver, 1991) or being a cultural dope (Garfunkel, 1984). Decoupling is always a possible response strategy

(Boxenbaum & Jonsson, 2008b; Levay & Waks, 2009; Meyer & Rowan, 1977). A smile can mask a heavy heart (Scott, 1985) as life can get in the way of taking a more principled stand.

"After a while you just give up on dealing with managers. You come to work, do what you have to do and go home. The NHS is the same everywhere the problems are the same." (Consultant)

Those participants who adopt *complying substantially* behaviours have not necessarily adopted self-surveillance practices (Ferlie & McGivern, 2013; Miller & Rose, 2008). They do their best for their patients, are available for their colleagues and beyond that they drag their feet using the weapons of the weak (Scott, 1985, 1990). They do not have a false consciousness and are aware of the contradictions in the managerial hospital. However, they feel that they are not in a position to do much about it. It is a case of "*we are where we are*" (Consultant). Their way of being is that of *"blades of grass in the wind instead of oak trees*" (Consultant). Stoicism and courage (Frankl, 1984) are key elements in their sense-making processes (Frankl, 1997). Often the people who adopt this pattern of behaviour have deep private transcripts (Scott, 1990). They only reveal those parts of their private transcripts that are safe for them to do so. The wickedness of healthcare delivery organisation (Raisio, 2009; Vartiainen, 2005), the acute hospital as a complex adaptive system (Waldrop, 1994), their own professional training and the expectations of patients leave them sufficient room to manoeuvre into *complying substantially*.

The observed practices in this mode of behaviour reflect primarily a practical-evaluative agency (Emirbayer & Mische, 1998). This is not a mindless or effortless case of getting the work done. The day-to-day work itself is being framed within a market-based competitive, managerial-based control and metrics-based performance-managed system (Farrell & Morris, 2003; Harrison & Ahmad, 2000a) and scientifically bureaucratised standardised clinical practice (Knaapen, 2014; McDonald & Harrison, 2004; Timmermans & Berg, 2010). Even *complying substantially* is an effortful accomplishment (Giddens, 1984; Jarzabkowski, 2005; Smets & Jarzabkowski, 2013a). Participants have to choose how they are going to perform their tasks within an increasingly complex institutional environment (Greenwood et al., 2011). In a hybrid institution (Battilana & Dorado, 2010; Pache & Santos, 2010), those who adopt *complying substantively* behaviours have to monitor their own practice reflexively while discursively legitimising their choices (Harmon, Green, & Goodnight, 2015; Lefsrud & Meyer, 2012; Mumby, 2005; Suddaby & Greenwood, 2005). However, they may not be engaging in purposely disrupting (Lawrence & Suddaby, 2006) the emergence of new institutional arrangements. They also do not necessarily have an explicit commitment to maintaining existing institutional visions. But their practical-evaluative agency does have iterative consequences (Smets & Jarzabkowski, 2013a). Their observed behaviours construct, for them, the relations between the institutional co-existing logics of bureaucracy, markets, networks and professionalism. Their less-than-enthusiastic interest in projective agency contributes to the NHS largely remaining a professional bureaucracy (Currie & Suhomlinova, 2006; Dickinson et al., 2013b) although it might be better described as a sedimented structure of multiple organisational forms (Sullivan & Skelcher, 2002a).

The physician identity is salient in that the actor is primarily a doctor with hardly any incidental or strategic hybridity (McGivern et al., 2015) as nested identities (Ashforth & Johnson, 2001; Ashforth & Mael, 1989; Spyridonidis et al., 2014). Their identity work is not an on-going project of maintaining and reproducing fluid and plural selves (Carroll & Levy, 2010) but of just keeping the salient physician identity intact, despite operating at the compliance end of the resistance-compliance continuum.

Complying substantially and *being a blade of grass in the wind* can have dark consequences – an instance of professionally keeping one's head down – as has been pointed out in the Bristol Royal Infirmary Inquiry (Kennedy, 2001), The Shipman Inquiry (Smith, 2002a) and the Mid-Staffordshire Inquiry (Francis, 2013). *Complying substantially* behaviours are about responding to immediate demands, justifying them and going home. The rest "*is not my problem*" (Consultant).

6.2.5.3 Complying fully

Complying substantially involves acquiescence sometimes even *with a heavy heart*. *Complying fully* involves *not having resistance* to the managerial hospital. This group would have adopted the hyper-rational (Germov, 2005) managerial mode of reasoning (Pollitt, 1993, 1998) and internalised the managerial discourse (Levay & Waks, 2009). These participants believe that efficiency and transparent accountability (Power, 1999) should be part of the new medical professionalism (Christmas & Millward, 2011; Moffatt, Martin, & Timmons, 2014; Spyridonidis & Calnan, 2011). Governmentality, self-management and self-surveillance in the neo-liberal state (Flynn, 2002; Miller & Rose, 2008) are integral to their identity and practice. For those who adopt *going with the flow* behaviours, being a physician is their salient identity (Ashforth & Johnson, 2001; Burke & Tully, 1977; Spyridonidis et al., 2014). They sometimes protect and at other times challenge traditional medical professionalism. Their hybridity is incidental (McGivern et al., 2015). However, for those who adopt *complying fully* behaviours, hybridity is the salient part of their identity (Ashforth & Johnson, 2001; Burke & Tully, 1977; Spyridonidis et al., 2014). They resolve institutional complexity by being the change (Creed, DeJordy, & Lok, 2010b). They argue that standardisation (Timmermans & Berg, 2010), despite the reservations (Knaapen, 2013, 2014), accountability (Lapsley & Lonsdale, 2010; Power, 1999) and clinical audits (Mooney, 2009) are important for the integrity of wider professionalism (McGivern et al., 2015). However, this can lead to severe issues of clinical credibility and the need for discursive legitimisation (Mumby, 2005; Suddaby & Greenwood, 2005) and identity reconciliation work (Creed et al., 2010b).

The mode of agency that is adopted by this group of participants is practical-evaluative and projective (Emirbayer & Mische, 1998), with the latter mode dominating as they challenge traditional out-dated medical professionalism (McGivern et al., 2015). Once again, given the wickedness (Raisio, 2009; Rittel & Webber, 1973; Vartiainen, 2005) of healthcare organisation, projective agency with tame solutions to wicked problems (King, 1993; Roberts, 2000) is of limited value. The hospital works within a broader healthcare system with primary and

community care. As noted in the section on wicked problems (Section 5.3), the social and economic causes of ill health should temper decontextualised projective agency. The hospital as a complex adaptive system (Godfrey et al., 2003; McKelvey, 1999; Nelson et al., 2003; Nelson et al., 2002; Shiell et al., 2008; Waldrop, 1994) complicates attempts at unbridled projective agency. The situatedness tempers the radicalism (Meyerson & Scully, 1995) of those who adopt *complying fully* behaviours. The new institutional order has to emerge from solutions to immediate demands at local subsystem levels.

Projective agency is exercised within the possibilities that emerge within commitments to practical-evaluative agency and having to get through routine work. So projective agency is not working with a blank canvass but emerges within the crevices of seeing patients on the lists today and those that have been booked on lists for six or more weeks ahead. Projective agency is constrained. It is not driven by a fully formed vision of alternatives as suggested by institutional entrepreneurship literature (Battilana et al., 2009b) nor by the unqualified *purposive* action as suggested in institutional work (Lawrence & Suddaby, 2006; Suddaby et al., 2009). Projective agency is forward-looking to the extent that it seeks to address day-to-day work in new ways; i.e. standardised, evidence-based clinical practice with transparent accountability (Ferlie & McGivern, 2013; Timmermans & Berg, 2010). Those who adopt *complying fully* behaviours therefore do not necessarily have completed visions of the new institutional order that they are strategically pursuing. On the contrary, they routinely (Prasad & Prasad, 1998; Scott, 1985) engage in repeated future-oriented situated improvisations (Smets & Jarzabkowski, 2013a; Smets et al., 2012), which gradually congeal over time. Thus, the relations between the constellation of logics (Goodrick & Reay, 2011) are reframed in hybrid practices that reflect particular modes of agency.

Those actors that engage in *complying fully* behaviours exert significant effort in choosing new non-traditional ways to practise as professionals. They have to monitor their own practice reflexively and discursively legitimise their choices to relevant stakeholders, especially in their subsystems (Anderson, 2008; Morgan & Ogbonna, 2008; Mumby, 2005; Suddaby & Greenwood, 2005). Hybridity is the salient part of their identity (McGivern et al., 2015). Their agency is a combination of practical-evaluative and projective dimensions, with the latter dominating yet significantly constrained by the wickedness and systemic and institutional complexity. The new institutional arrangements that they pursue are non-linear and emergent. They deliberately cobble together existing practices with parts of newer material practices, values and assumptions associated with different logics (Thornton & Ocasio, 1999, 2013). In this way they frame relations between logics in ways that differ from those who adopt *resisting*, *limiting the impact* and *going with the flow* behaviours.

Their intentionalities, efforts, combinations of dimensions of agency and framings of relations between logics differ. This shows that rather than the assumed incompatibility between institutional logics (Greenwood et al., 2011) the managerial hospital is a context where relations between logics are constructed at the coalface (Barley, 2008) by inhabitants of institutions (Hallett & Ventresca, 2006; Scully & Segal, 2002) who are carriers of logics to varying degrees

(Delmestri, 2006; DiMaggio, 1988; Jepperson, 1991; Zilber, 2002). The existing institutional arrangements that make up the acute NHS hospital are actively being framed and reconstructed by these embedded actors as they respond to immediate demands in ways that range from traditional professional to hybrid, with the radicalism of the latter being tempered by the context.

6.2.5.4 Waiting it out

Waiting it out is a concept that is widely used in the scholarly literature. A study of the geographic distribution of racial and ethnic diversity in higher education reflects on what has happened to diversity; it questions whether it has been silenced, diversified or waited out (Price, 2014). *Waiting it out* is viewed as an opposite of being fully engaged (Auger-Voyer, Montero-Sieburth, & Cabrera Perez, 2014). It can be associated with negative feelings of being frustrated (Ayan, 2015). *Waiting it out* has been associated with people who do not really want to change their situation or are just holding on until retirement (Mallon, 2014). *Waiting it out* can also be a strategy for making sense of a situation and deciding how to handle it (Tiedtke, Donceel, de Rijk, & Dierckx de Casterlé, 2014).

Those hospital consultants who adopt this mode of behaviour constitute about 30% to 40% of the consultant body, with 5% consisting of more experienced consultants. Some of the last-mentioned consultants take up clinical management positions to defend themselves at this late stage of their careers. They are incidental hybrids (McGivern et al., 2015) who can take hybrid positions on a temporary basis to act as buffers in defence of traditional professionalism. Their defence of traditional professionalism requires them to exert effort in reflecting on their own practices and their outcomes against the emergent practices of the managerial order. Hence, their continuation of their traditional professionalism is an effortful accomplishment (Emirbayer & Mische, 1998; Giddens, 1984). They are required to legitimise discursively (Mumby, 2005; Suddaby & Greenwood, 2005) their choices of practices as situated and emergent alternatives are available. Their experience allows them to find ways to decouple (Levay & Waks, 2009; Power, 1999) word and deed. Their agency is mainly practical-evaluative (Emirbayer & Mische, 1998) as they respond to immediate demands. Their practices have iterative consequences and projective agency seems to be absent. They use their positions to defend professional resistance to the risk of blame (Hood, 2011) in managerial technologies such as performance appraisals (McGivern & Ferlie, 2007; Townley, 1997). Their roles concur with those incidental hybrids that are *going with the flow.* The difference is that the latter may be mid-career physicians while those *waiting it out* are often very experienced and close to retirement. This horizon shapes the efforts, intentionalities and the relative balance of the dimensions that make up their modes of agency.

This group constructs the relations between the co-existing logics as contradictory. Thus, the group members shape their efforts, intentionality, agency and observed practices in defence of traditional, historic medical professional ways of delivering healthcare services.

The physician identity is the more salient in that the actor is primarily a doctor. Some of those who are waiting it out may become incidental hybrids and very few become strategic hybrids (McGivern et al., 2015). Thus, their identity is not a complicated case of multiple nested identities (Ashforth & Johnson, 2001; Ashforth & Mael, 1989; Spyridonidis et al., 2014). Their identity work is not really an on-going project of maintaining and reproducing fluid and plural selves (Carroll & Levy, 2010). The salient physician identity dominates and thus they defend traditional physician ways of doing things.

Others adopt *a resigned* and *detached state of mind*. They do not oppose the management focus on meeting the targets and the disregard for the concerns raised by frontline staff. The raising of concerns is seen as a recipe for professional marginalisation and exclusion (BMA, 2013; Francis, 2013, 2015). After a while, raising issues and being knocked down add up to that *state of not caring* about others and the system. Some of those who adopt *waiting it out* behaviours concern themselves with responding to immediate demands that face them, responding in ways that allow them to get the job done as best as they can, discursively justifying (Anderson, 2008; Mumby, 2005; Suddaby & Greenwood, 2005) this to themselves and going home. For these actors, there is hardly any projective agency (Emirbayer & Mische, 1998). Their agency is primarily practical-evaluative, with iterative effects as well. Waiting it out is an example of avoidance coping behaviours (Endler & Parker, 1994). This is another instance of the professional detachment and resignation that have been blamed for some of the worst scandals in the NHS by the Bristol Royal Infirmary Inquiry (Kennedy, 2001), The Shipman Inquiry (Smith, 2002a) and the Mid-Staffordshire Inquiry (Francis, 2013). *Waiting it out* behaviours are not mindless or effortless (Smets & Jarzabkowski, 2013a). It requires constant effort to ignore what is happening around one, the impact of the focus on financial and other operational targets, and poor care of patients. It takes equal effort to close one's eyes, ears and heart while maintaining an existing practice and discursively dismissing broader professional engagement (Mumby, 2005; Suddaby & Greenwood, 2005).

It is perhaps not what the individual clinical staff member does that is the cause of the scandals that let patients down so badly; perhaps, it is the managerial model itself (Iles, 2011; Pollock & Price, 2013a). The ways in which wickedness, complex adaptive systems and institutional complexity are framed, thus shaping the efforts and intentionality, or lack thereof, of those who are waiting it out, can be exhausting and deadly in their consequences. The amount of effort required to maintain a reflexive practice and to legitimise it discursively in the midst of systemic failure of patients and the staffs that serve them can be exhausting. The practical-evaluative agency, with its iterative dimensions and consequences, is not aimed at maintaining grand institutions because sometimes the managerial hospital can indeed be a disaster. The nature of the institutional work is perhaps not purposive action aimed at creating, maintaining and disrupting institutions. It may just be about maintaining an integrated sense of self; i.e. it may be aimed at just personally staying whole. Table 6.2 overleaf integrates some of the key ideas from Chapters 5 and 6 with Table 4.1, which was reproduced as Table 6.1.

Table 6.2: Rolling with the Punches: behaviour patterns, agency, relations between managerialism and professionalism, and institutional work impact

ROLLING WITH THE PUNCHES THEORY

	OBSERVED PATTERNS OF BEHAVIOUR	AGENCY	RELATIONS BETWEEN MANAGERIALISM AND PROFESSIONALISM	INSTITUTIONAL WORK IMPACT
	STABILISING TEMPORARILY	Practical-evaluative (intentional, dominant) Iterative (accidental, subservient)		**Maintaining** existing institutional arrangements
	RESISTING		**Keeping apart**	**Maintaining**
	• Subverting	Practical-evaluative (intentional) Iterative (intentional)	Keeping apart	Maintaining existing Disrupting emerging
	• Quibbling	Iterative (intentional) Practical-evaluative (intentional)	Keeping apart	Maintaining existing Disrupting emerging
WEIGHING UP				
• Making sense	**LIMITING THE IMPACT**			
• Deciding what to do	• Lying low	Practical-evaluative (mainly) Iterative consequences Microscopic projective	Keeping apart Acknowledging congruence	Maintaining existing On the margins
• Mode-shifting triggers	• Faking it	Practical-evaluative (mainly) Iterative consequences Microscopic ++ projective (much more than lying low)	Keeping apart Dabbling in complementarity	Maintaining existing
	ADJUSTING TO CHANGE			
	• Going with the flow	Practical-evaluative (mainly) Iterative consequences Defensive projective	Keeping apart	Maintaining existing Disrupting emerging
	• Complying substantially	Practical-evaluative (mainly) Iterative consequences Limited projective	Keeping apart	Maintaining existing
	• Complying fully	Practical-evaluative (mainly) Significant projective ("being the change")	Reconciling	Disrupting existing Creating new
	• Waiting it out	Practical-evaluative (mainly) Iterative consequences Defensive projective	Keeping apart	Maintaining existing

6.3 SUMMARY

From this chapter, on integrating the literature into the GT, it is clear that the concepts used **weighing up**, **stabilising temporarily**, **resisting** with its dimensions *subverting* and *quibbling*, **limiting the impact** with its dimensions *lying low* and *faking it* and living with/**adjusting to** with its dimensions *going with the flow*, *complying substantially*, *complying fully* and *waiting it out* are not new concepts but have been used to describe behaviours in multiple contexts.

Taking a long view of the evolution of the managerial hospital, the inalienable wickedness in the social organisation of healthcare and the hospital as a complex adaptive system, the managerial hospital, in fact the NHS, is not a stable social structure (Bjerregaard & Jonasson, 2014). It does not reflect fixed, taken-for-granted meanings (Battilana et al., 2009b; Jepperson, 1991) that shape, constrain and frame the motivations, understandings and discourse of actors at a micro-level (DiMaggio & Powell, 1983; Meyer & Rowan, 1977; Scott & Meyer, 1994; Thornton & Ocasio, 2013) in uncomplicated ways. On the contrary, the hospital is part of an NHS that is a hybrid archetype (Cooper et al., 1996; Ferlie, 1999; Kirkpatrick & Ackroyd, 2003a, 2003b; Kitchener, 1998). The NHS manifests multiple structural forms (Exworthy et al., 2010b; Exworthy et al., 1999; Kirkpatrick, 1999; Sullivan & Skelcher, 2002a) and the multitude of institutional logics in the organisational field (Doolin, 2001; Reay & Hinings, 2005, 2009; Scott et al., 2000). Some of these policy prescriptions are contradictory (Ham et al., 2011d) and messy.

The acute hospital attracts the policy attention that it does because of its centrality in the delivery of healthcare and the resources that it absorbs (Appleby et al., 2014; Glouberman & Mintzberg, 2001; Klein, 2013; Mintzberg & Glouberman, 1997). The aim of the managerial hospital is to control the clinical frontline that spends the budget by its clinical activities (Klein, 2013). Given the underlying wickedness of the social organisation of healthcare delivery, the hybridity of healthcare policy, the hospital as a complex adaptive system and the attempts to shape the clinical frontline, the influence on the agency of hospital consultants is not likely to be hegemonic (Foucault, 1979, 1988; Gramsci & Forgacs, 2000). *Rolling with the Punches* is a conceptual account of the ways in which the actors craft their sense of self within the constraints and opportunities represented by the managerial hospital. Rather than having to deal with the problems associated with structure-agency duality and the paradox of embedded agency (Battilana & D'Aunno, 2009a; Garud et al., 2007), this study adopts the perspectives based on the mutual constitution of structure and agency (Berger & Luckmann, 1967; Blumer, 1971; Giddens, 1984; Hughes, 1971). The responses to the constraints and opportunities in the multiple logics of the managerial hospital manifest the limits on the agency of the actors. They also indicate the ways in which their day-to-day lived experiences, of which *Rolling with the Punches* is but one conceptual account, iteratively in social interaction produce and reproduce relations between the logics in the hospital.

Numerous calls have been made for more nuanced accounts of agency (Delmestri, 2006; Lok, 2010; Powell & Colyvas, 2013; Smets & Jarzabkowski, 2013a). Much of what we know about

how institutional complexity is addressed deals with structural and organisation-level responses (Battilana & Dorado, 2010; Besharov & Smith, 2013; Greenwood et al., 2011; Pache & Santos, 2010; Pache & Santos, 2013a). Very little is known about how individual actors navigate, negotiate and frame institutional complexity (Creed et al., 2010b; Greenwood et al., 2011; McPherson & Sauder, 2013; Smets & Jarzabkowski, 2013a). Filling this gap is important in understanding the micro-foundations of hybrid organisations (Pache & Santos, 2013a; Powell & Colyvas, 2013).

Institutional entrepreneurship has attempted to account for embedded agency but has been hampered by criticism of the paradox of embedded agency (Battilana & D'Aunno, 2009a; Suddaby et al., 2009). Institutional logics and institutional work have become major lenses for framing the debates in institutional theory (Zilber, 2013). Institutional logics (Friedland & Alford, 1991b; Thornton & Ocasio, 1999, 2013) have tried to account for the relationship between agency and structure, the historicity, contingency and fluidity of institutions and the complementarity of the material and symbolic elements of institutional phenomena. However, institutional logics too have been mainly studied at organisation level (Thornton & Ocasio, 2013; Thornton et al., 2012; Zilber, 2013). We have only rudimentary understandings of the messiness, contingency and fluidity that occur as individuals juggle between, negotiate, filter, interpret, and frame meanings, understandings, identities and material practices as they enact relationships between logics (Creed et al., 2010b; Lok, 2010; McPherson & Sauder, 2013; Smets & Jarzabkowski, 2013a; Smets et al., 2012).

Institutional work (Lawrence & Suddaby, 2006; Suddaby et al., 2009) refocuses attention from macro-institutionalism to the micro-foundations of institutionalism, with its accounts of the intentional activities of actors in creating, maintaining and disrupting institutions. Institutional work draws our attention to actions not outcomes and that allows for the situated improvisations (Smets et al., 2011), doings and undoings, successes and failures as people routinely go about their day-to-day activities in maintaining, creating and disrupting institutions. Although institutional work refocuses attention on the actions of actors within institutions, problems exist with the nature of intentionality and efforts as stated in the founding formulations of institutional work and the lack of clarity regarding the dimensions of agency (Jarzabkowski et al., 2009a; Smets & Jarzabkowski, 2013a). An implication of "purposive action" suggests that actors have fully formed visions of the grand institutional arrangements that their actions are creating, maintaining or disrupting. That need not be the case (Jarzabkowski & Spee, 2009b; Smets & Jarzabkowski, 2013a).

The GT, as a conceptual account of the ways of being for the hospital consultants as they resolve their main concern, allows one to examine institutional theory at the coalface (Barley, 2008). The hospital doctors, as embedded actors (Battilana & D'Aunno, 2009a), inhabit the abstract institutions (Hallett & Ventresca, 2006; Scully & Segal, 2002) and carry the multiple logics in their field (Delmestri, 2006; DiMaggio, 1988; Jepperson, 1991; Zilber, 2002). They do not stand apart from the logics with their associated symbolic and material elements. *Rolling with the Punches* describes and explains the routine ways in which the participants resolve the

contradictions, dilemmas and paradoxes associated with managerialism, commercialism, professionalism, standardisation, formalisation of practice, transparent accountability, hierarchy, bureaucracy, networks, wickedness and complex adaptive systems. Their collegiality, independence and association with external professional organisations are shaped by their everyday working lives.

This GT gives a theoretical narrative of how *Weighing up* frames meaning for the actors and how that shapes their intentionality and efforts. These intentionalities and efforts are their decisions about how the dilemmas, paradoxes, contradictions, tensions and congruencies are to be negotiated, worked and reworked. It should be noted that those intentions are directed at the accomplishment of immediate everyday work and not at the realisation of grand institutional visions. Intentionality and effort therefore relate to how day-to-day work is to be performed (Smets & Jarzabkowski, 2013a; Smets et al., 2012). The hospital consultants do not have the power of veto over the acute hospital as a crucible for the multiple logics (Goodrick & Reay, 2011; Greenwood et al., 2011) and organisational forms (Exworthy et al., 2010b; Exworthy et al., 1999; Kirkpatrick, 1999; Sullivan & Skelcher, 2002a). However, they are able to engage the microphysics of power and craft their professionalism within the capillarity (Foucault, 1979; Prasad & Prasad, 1998; Scott, 1985, 1990) of these institutional contradictions and overlaps (Besharov & Smith, 2013; Friedland & Alford, 1991b).

Their ways of resolving their main concern serve only to ameliorate the effects of managerialism. Each of the observed modes of behaviour: *Stabilising Temporarily, Resisting, Limiting the Impact and Living with/Adjusting to*, with their dimensions, represents different effortful accomplishments (Emirbayer & Mische, 1998; Giddens, 1984), intentionalities, orientations, and their associated discursive justifications (Mumby, 2005; Suddaby & Greenwood, 2005). Each mode of behaviour requires the actor to monitor her own practice reflexively against competing claims to preferred practices and to justify those choices on an on-going basis. Thus, this account of intentionality and effort is subtler than those normally given in institutional work (Lawrence & Suddaby, 2006; Suddaby et al., 2009). The absence of a fully formed vision of an alternative institutional order does not necessarily imply unintentionality or lack of effort.

Weighing up frames the intentionality that, in turn, is manifested in the mode of agency (Emirbayer & Mische, 1998; Lawrence & Suddaby, 2006; Suddaby et al., 2009). The mode of agency is a combination of different dimensions: projective agency that is aimed at creating new institutions, iterative agency that is geared towards maintaining existing institutional arrangements and practical-evaluative agency that addresses immediate demands. Although these dimensions are analytically disaggregated, they are empirically hard to separate. Each of the observed modes of behaviour; i.e. *Stabilising Temporarily, Resisting, Limiting the Impact* and *Living with/Adjusting to* represents a different and dynamic combination of the three dimensions of agency. Practical-evaluative agency was common to all of the modes of observed behaviours because doctors have to meet immediate demands. The different modes of observed behaviours are the results of the different degrees to which the iterative and projective

dimensions combined with practical-evaluative agency. Their practical-evaluative agency has significant iterative consequences because they do not completely know in advance what institutional visions they are pursuing. It is a case of management by discovery rather than management by objectives (Klein, 1999, 2011). Iterative agency does not suggest that the agency is that of a cultural dope (Garfunkel, 1984; Hirsch & Lounsbury, 1997b; Powell & Colyvas, 2013). Very few hospital clinical-manager consultants; i.e. incidental and strategic hybrids (McGivern et al., 2015), deliberately adopt unbridled projective agency. Those actors who are *Complying Substantially* would do so but also drag their feet (Prasad & Prasad, 1998; Scott, 1985, 1990). The accounts of structure, agency and observed behaviours explain why very little appears to change (Crilly & Le Grand, 2004) in the institutional arrangements of the NHS and why it largely remains a professional bureaucracy (Currie & Suhomlinova, 2006; Dickinson et al., 2013b).

The portfolios of observed practices (Creed et al., 2010b; Jarzabkowski, 2009; Jarzabkowski, Smets, Bednarek, Burke, & Spee, 2013; McPherson & Sauder, 2013; Smets & Jarzabkowski, 2013a) associated with each of the modes of behaviour represent the material framing of wickedness, social adaptive systems and institutional complexity by embedded actors as they respond to immediate demands, thus reflecting their intentionality, efforts and agency. These demands can be addressed in established or emerging ways. The overwhelming impact of their material and symbolic responses to managerialism is the maintenance of the professional bureaucracy and disruption of the evolution of the hyper-rational, standardised and commodified managerial hospital.

The responses of the hospital consultants are definitely more complex than the binary account (Gleeson & Knights, 2006; Numerato et al., 2012; Waring & Bishop, 2013) of, on the one hand, proletarianisation (McKinlay & Arches, 1985), deprofessionalisation (Haug, 1973, 1988) and McDonaldisation (Ritzer, 1996; Ritzer & Walcak, 1988) and, on the other hand, restratification (Freidson, 1985). Hospital doctors do show that they have the skills and reflexivity to protect their interests as professionals within an organisational context (Brock et al., 2014; Correia, 2013a; Currie et al., 2012b; Gleeson & Knights, 2006; Moffatt et al., 2014; Muzio & Kirkpatrick, 2011; Noordegraaf, 2007a, 2013; Numerato et al., 2012; Spyridonidis & Calnan, 2011; Suddaby & Viale, 2011). Participants have shown that they are substantially able to delay the evolution of the managerial hospital at the points where it is at its weakest; i.e. where it is translated into policies, procedures and techniques.

The absence of drama (March, 1981) does not mean that there is not a struggle is taking place. Patients come into the hospital because the doors are always open, the lights are always on and there is almost always someone there to treat them. Behind that picture is a battle about the meaning of healthcare delivery, the meaning of and duty to the patient, the role of the hospital and the clinical professionals in that process. Hospital consultants with *Rolling with the Punches* define their ways of being a doctor in very situated, contingent and fluid ways. Their professionalism is framed in practical, routine and everyday activities that work and rework the

relations between the logics that make up the hospital. In carrying out these routine activities, they instantiate their agency that, in turn, iteratively creates the hospital.

Rolling with the Punches is a complex integrated set of propositions of how hospital consultants address their main concern; i.e. the managerial hospital with its market-based competition, management-based control systems, metrics-based performance-management systems, transparent accountability and standardisation of clinical practice, while retaining elements of bureaucracy, hierarchy, networks and professionalism. Their behaviours show that the managerial hospital is not a settled issue. It also shows that medical professionalism is also not given and fixed.

The next chapter discusses the implications, contributions, limitations and suggested future directions of the study.

CHAPTER 7 IMPLICATIONS, CONTRIBUTIONS AND FUTURE RESEARCH DIRECTIONS

7.1 INTRODUCTION

The previous chapter presents the integration of the literature into the GT that emerged, as discussed in Chapter 4. In this last chapter, key issues are synthesised and the implications and limitations of the study and directions for future research are suggested.

The aim of this classic GT study was to identify the main concern of the participants of the study and how they resolved that concern on a routine basis. In **Chapter 2** the background to the study was provided. **Chapter 3** presented an account of the classic GT and the methods used in the study. *Rolling with the Punches*– discussed in **Chapter 4** – emerged as the GT that explained much of the variation in the behaviours of the hospital consultants in the managerial hospital. This study concurs with those calls to open the black box occupied by embedded actors at the on-going constructions of complexity (Lok, 2010; McPherson & Sauder, 2013; Zilber, 2013). **Chapter 5** covered a wide body of literature that was delimited by the criterion of relevance to the theoretical framework that had emerged in Chapter 4. Chapter 6 provided examples in a broad range of literature of the concepts that had emerged in Chapter 4 and the integration of the literature in Chapter 5 into the grounded theory from Chapter 4.

The following concepts proved to be relevant in explicating the theoretical framework *Rolling with the Punches:*

- The wickedness of healthcare organisation (Raisio, 2009; Vartiainen, 2005);
- The hospital as a complex adaptive system (Checkland, 1999; Edgren, 2008; Nelson et al., 2002);
- Professionalism (Brock et al., 2014; Muzio & Kirkpatrick, 2011; Noordegraaf, 2007a; Suddaby & Viale, 2011);
- Discipline and control (Foucault, 1977, 1988);
- Routine resistance (Prasad & Prasad, 1998; Scott, 1985, 1990);
- Institutional theory (Reay & Hinings, 2009; Scott & Meyer, 1994);
- Archetype approaches to institutional theory (Brock, 2006; Chreim et al., 2012; Cooper et al., 1996; Kirkpatrick & Ackroyd, 2003b; Kitchener & Whipp, 1998);
- Sense-making (Ancona, 2012; Frankl, 1997; Weick, 1995);
- Agency (Battilana & D'Aunno, 2009a; Emirbayer & Mische, 1998);

- Structure and agency;
- Institutional logics (Thornton & Ocasio, 1999, 2013; Thornton et al., 2012);
- Institutional work (Lawrence & Suddaby, 2006; Suddaby et al., 2009; Zilber, 2013); and
- Institutional complexity (Blomgren & Waks, 2015; Greenwood et al., 2011; Jarzabkowski et al., 2013b; McPherson & Sauder, 2013; Smets & Jarzabkowski, 2013a; Vermeulen, Zietsma, Greenwood, & Langley, 2014).

The grounded theory is an integrated set of propositions that account for much of the variation in the routine behaviours of the participants as they go about resolving their main concern. It facilitates understandings of the kinds of choices hospital consultants are making to frame coalface (Barley, 2008) relationships between constellations of contradictory demands (Battilana & Dorado, 2010; Besharov & Smith, 2013; Goodrick & Reay, 2011; Greenwood et al., 2011) in their everyday work (Creed et al., 2010b; Jarzabkowski et al., 2009a; McPherson & Sauder, 2013; Smets & Jarzabkowski, 2013a). The ordinary, routine, everyday observed behaviours of the hospital consultants often belie extraordinary calculations.

7.2 IMPLICATIONS OF THIS STUDY

The implications of a study serve two purposes. They bring to the existing study to a point of theoretical closure and they open up new theoretical pathways for the future (Geletkanycz & Tepper, 2012). This section of the study addresses closure and the opening of policy, practice and theory pathways that had been highlighted by this study.

7.2.1 Implications for Policy

The acknowledgement of the delivery of a high quality healthcare service that meets the founding vision of the NHS (i.e. universal, comprehensive and free at the point of delivery) as a wicked problem means that no perfect solutions exist (Austrailian Publis Service Commission, 2007; Glouberman & Zimmerman, 2002; King, 1993; Rittel & Webber, 1973; Roberts, 2000). This means that radical uncertainty, ambiguity and complexity in the social organisation of healthcare delivery should be recognised and attempts at taming should be resisted. Furthermore, the unending stream of healthcare policy reforms (Exworthy et al., 2010b; Greener, Harrington, Hunter, Mannion, & Powell, 2014; Smith, Walshe, & Hunter, 2001a) that are implemented without prior policies being allowed to be fully embedded and evaluated (Vartiainen, 2005) should be discouraged as they destabilise the healthcare system. Every new set of health policy initiatives takes a few years to embed. What is required is a recognition of the wickedness of the problem of the social organisation of healthcare delivery and the need for the meaningful and deliberate participation (Raisio, 2010)of all the stakeholders, especially the users. Wicked problems (Clarke & Newman, 2006) or cross-cutting themes (Sullivan & Skelcher, 2002a) are not addressed by organisations that operate within a market-based competitive, manager-based controlled and metrics-based performance-managed environment (Farrell &

Morris, 2003; Greener, 2003; Harrison & Ahmad, 2000a). Wicked problems can include tame problems; e.g. treatments for chronic conditions of geriatric patients, and can include minor surgical procedures. Wickedness requires collaborative approaches (Ham et al., 2011b; Ham et al., 2011d) and that awareness goes against almost three decades of market-friendly approaches of quasi-competition between providers, patient choice and money following the patient, and the purchaser-provider split. In an environment of scarce resources, the public has to define its values and priorities and the role of the healthcare system in that worldview. The revolving door between management consultants and healthcare bureaucrats (Leys & Player, 2011; Pollock, 2005) is unlikely to open a passageway to the allocation and prioritisation of social values (Raisio, 2010).

Moreover, the acute hospital as a complex adaptive system (Barach & Johnson, 2006; Ferlie & Dopson, 2005; Glouberman & Zimmerman, 2002; Shiell et al., 2008; Waldrop, 1994) means that the hospital should be seen as a sum of microsystems (Nelson et al., 2002) and as a flotilla rather than an aircraft carrier (Dickinson et al., 2013b). This has implications for the aims of performance-management policies. It is difficult in such a system to control costs and the clinical frontline at an aggregate or whole hospital level. Self-organisation at subsystem level, interdependence, non-linearity and emergence imply that performance measurement and management in a complex adaptive system can never be complete (Sheaff et al., 2003; Stewart & Walsh, 1994; Talbot, 2009). Thus, a plethora of agencies, quantitative metrics, indicators, targets, rankings and league tables (Carter et al., 1992; Farrell & Morris, 2003; Hartley, Donaldson, Skelcher, & Wallace, 2008; Noordegraaf & Abma, 2003) do not really make non-linearity and emergence disappear. What happens is that the performance-management system is "gamed" (Bevan & Hood, 2006; Wilson, Croxson, & Atkinson, 2006) and some targets are met but the purposes of healthcare delivery may be missed. The Mid-Staffordshire scandal is a case in point (Francis, 2013). The lenses that are adopted to "manage" should take account of the ambiguity of public service design, delivery and performance, and the challenges posed by attempting to "control" frontline professionals.

7.2.2 Implications for Practitioners

A good theory has great practical value (Van de Ven, 1989). Scholars are encouraged to reflect deeply on the implications of their research for management practice (Colquitt & Ireland, 2009). Do managers learn something new from the study (Bergh, 2003)?

Wickedness requires the acknowledgement that there is no ultimate solution that experts and technocrats could devise. Within acute hospitals, MDTs are already attempting to overcome some of the consequences of internal fragmentation. However, on-going assessments of the effectiveness of the MDT processes are needed. The hospital should also look at better collaboration with providing an integrated service for the core group of patients. This is a group of patients whose needs transcend the organisational boundaries and competencies of the social care, primary and acute hospital service providers. They pose a need inside the hospital for integrated teams of clinicians – and outside professionals- to work together and apply their

collective mind (Weick & Roberts, 1993) as a deliberative democracy (Raisio, 2010). All stakeholders should be involved in designing the healthcare delivery system for a local health economy despite the fragmentation and competitive ethos between service providers that follow from the national policy bias. Inside acute hospitals, patients with multiple acute and chronic conditions require integrated solutions.

Within the organisation, it is important to take account of the roles of professionals in facilitating or impeding change (Kirkpatrick & Ackroyd, 2003b; McNulty & Ferlie, 2004). Opportunities should be created to involve the creative and intellectual capital of the NHS (Walshe & Smith, 2011) in the change process. *Rolling with the Punches* shows how professionals are able to respond to change, especially when their interests are ignored.

7.3 METHODOLOGICAL CONTRIBUTION

In a *Special Form on Research Methodology*, a content analysis of 76 papers, the editorial panel concluded that a methodological contribution involves three issues: importance and significance, adequate conceptual grounding, and adherence to methodologically sound and accurate strategies (Bartunek, Bobko, & Venkatraman, 1993). The same article proposes that "significance" refers to the value added by the use of a given methodology in explicating a substantive area in ways that other methodologies have not been able to do. The use of classic GT enabled me to identify a main concern of the hospital consultants and to provide a theoretical account that explains how they routinely resolve that concern. The relationship between doctors, managers and the managerial hospital has been the subject of extensive scholarly discourse in the literature. The use of classic GT has added to the scholarly discourse by facilitating an understanding of what is happening, why it is happening and what might happen. Classic GT has solid conceptual foundations that have stood the test of time over almost six decades. Moreover, the study has once again shown that a novice researcher with rigorous adherence to the strategies of classic GT would be able to pierce the veils of misunderstanding around an area that has been described as a problem without a solution. This study has also shown that classic grounded theory, as a general research methodology, can retain its integrity whilst still being in conversation with other "versions" of grounded theory. The same can be said about its dialogue with qualitative research methodologies. In many instances, I touched on some of the debates raised amongst scholars. I did that not because of methodological confusion or slurring. On the contrary I showed how classic grounded theory stands its ground.

7.4 THEORETICAL CONTRIBUTION

It is important to have a good grasp of organisation phenomena (Smith & Hitt, 2005). A good theory is the conceptual rendition of a messy and complex empirical reality in the phenomenal world (Suddaby, 2015). A theoretical contribution specifies the factors that explain a particular phenomenon, how those factors are related and why they have the relationships that are suggested (Whetten, 1989). In this study the GT, *Rolling with the Punches*, is a conceptual

account of the latent patterns of behaviour in which hospital consultants are engaged as they resolve their main concern; i.e. the managerial transformation of the hospital. It is therefore a theoretical account of a phenomenon within an organisation with a significant footprint in a local health economy. The wickedness of healthcare organisation (Raisio, 2009; Rittel & Webber, 1973; Vartiainen, 2005) and the hospital as a complex adaptive system (McKee & Healy, 2002; McKelvey, 1999; Nelson et al., 2002) and hybrid organisation (Battilana & Dorado, 2010; Besharov & Smith, 2013; Pache & Santos, 2010) that is institutionally complex (Greenwood et al., 2011) with a constellation of logics (Goodrick & Reay, 2011) under its roof make it conceptually a very complex and untidy place. A hospital is professionally and spatio-temporally complex (Allen, 2000; Zerubavel, 1979). This GT proposes that managerialism is a significant issue for hospital consultants and it conceptualises the latent pattern of behaviour in which they are engaged as they resolve for themselves their main concern (Glaser, 1978, 1998).

The theoretical contribution did not emerge from a gap in a literature review that had been undertaken before the fieldwork began. However, the theoretical contribution emerged as a conceptual account of what is already going on in the field (Glaser, 2003). The theory emerged from a commitment to the full package of GT steps (Artinian et al., 2009; Glaser, 1998) without preconception. With constant comparison of fractured data, theoretical sampling, memoing and trusting in the emergence of concepts, categories and theoretical relationships the GT emerged incrementally (Smith & Hitt, 2005). The GT process is open to all types of data (Glaser, 1998); hence, interview data, document analysis and observational notes from the field were used as data sources. Given the life-and-death dramas that inevitably occur in an acute hospital and the difficulties associated with gaining ethical approval and access, it was useful to have an insider who helped to secure the availability of participants. That insider was also an important sounding board for the evolution of the theory. The logic of the theory is discovered through the process of memoing, which starts from the time the study begins. Memos are written down to slow down the analytical process because preconception is always an open door. Memoing enables the researcher to record thoughts, ideas and hunches, which form the basic building blocks of the conceptual links of the theoretical framework. Theoretical ideas are written, stored, revisited and refined. All the time, the memos are shifted around as the fit between the core category and related categories emerges. Thus, the GT - that emerges - fits, works, is relevant and is modifiable (Artinian et al., 2009; Glaser, 1998). Novice researchers (Glaser, 2009b) should feel confident that if they faithfully follow the steps of GT then they should generate a novel theory that is likely to make a theoretical contribution (Smith & Hitt, 2005).

This study makes a theoretical contribution to the micro-foundations of an institutional theory approach to organisation studies. Embedded actors (Battilana & D'Aunno, 2009a; Battilana et al., 2009b) inhabitant of institutions (Hallett & Ventresca, 2006; Scully & Segal, 2002). They do not stand aside from the institutional complexity but are bearers of this complexity (Delmestri, 2006; Jepperson, 1991). These actors creatively and routinely (Prasad & Prasad, 1998; Scott, 1985, 1990), without drama (March, 1981; Meyerson & Scully, 1995; Smets et al., 2012), manage wickedness (Austrailian Publis Service Commission, 2007; Conklin, 2006a; King, 1993;

Rittel & Webber, 1973; Roberts, 2000) in the social organisation of healthcare delivery (Raisio, 2009; Vartiainen, 2005). They do this by innovatively using the space provided within the hospital as a complex adaptive system (Ferlie & Dopson, 2005; Nelson et al., 2002; Shiell et al., 2008; Waldrop, 1994) to structure relationships between institutional logics. Their activities, at the coalface, creatively (Barley, 2008) respond to immediate demands (Jarzabkowski et al., 2009a; Jarzabkowski et al., 2013b; McPherson & Sauder, 2013; Smets & Jarzabkowski, 2013a). The study challenges the assumed macro-institutional incompatibility (Greenwood et al., 2011) between managerialism and medical professionalism. Responses to immediate demands have institutional work (Lawrence & Suddaby, 2006; Smets & Jarzabkowski, 2013a; Suddaby et al., 2009) implications; i.e. they maintain, disrupt and create institutional arrangements.

As noted above*, Rolling with the Punches* challenges the assumed incompatibility between managerialism and professionalism within organisation studies (Postma et al., 2015). Medical professionalism has always involved key features of managerialism; i.e. organisation, coordination and integration (Noordegraaf, 2007a). *Rolling with the Punches* is a theoretical account of professionalism within an organisational context (Faulconbridge & Muzio, 2008; Muzio & Kirkpatrick, 2011). The different components of the GT manifest varying degrees of coexistence between managerialism and medical professionalism at the coalface where managerialism and medical professionalism are translated into procedures through which healthcare services are delivered. The discussion of medical professionalism might be different if *Rolling with the Punches* were taken as a point of departure because it would provide an account of how the real world already integrates the multiple demands raised in earlier paragraphs.

Rolling with the Punches emphasises the importance of sense making as a process of determining the meanings (Ancona, 2012; Brown, Colville, & Pye, 2015; Weick, 1995; Weick et al., 2005) of multiple demands (Battilana & Dorado, 2010; Friedland & Alford, 1991b; Greenwood et al., 2011; Pache & Santos, 2010; Raaijmakers, Vermeulen, Meeus, & Zietsma, 2015) and what could be done about these demands. This understanding is determined on an individual (Cox & Ferguson, 1991; Lazarus & Folkman, 1984, 1987) and a social interactional basis (Berger & Luckmann, 1967; Blumer, 1971; Giddens, 1984; Hughes, 1971; Strauss et al., 1963). Weighing up, appraisal and sense-making shape the effort, intentionality and agency (Battilana & D'Aunno, 2009a; Emirbayer & Mische, 1998). Given the prestige hierarchy in medicine (Album & Westin, 2008; Creed, Searle, & Rogers, 2010a; Norredam & Album, 2007), not all consultants have the same leverage to influence the sense-making processes (Pettigrew, 1985; Ranson et al., 1980b; Walsh, Hinings, Greenwood, & Ranson, 1981). This suggests that weighing up is also an issue of power, which should be taken more seriously in institutional theory and management studies scholarship (Lawrence, 2008; Munir, 2015; Suddaby, 2015; Willmott, 2015).

Sense-making highlights the point that institutional demands do not necessarily impose themselves on participants (Friedland & Alford, 1991b). The diversity in the latent pattern of behaviours points to a nuanced account of agency (Battilana & D'Aunno, 2009a). The

intentionality of the participants is directed mainly at completing the jobs at hand. The agency that underpins this is practical-evaluative agency. They can choose to accomplish the tasks in traditional ways or in new managerially inspired ways. The first manner of doing work is underpinned by iterative agency and the second way by projective agency. The dimensions of agency reflect a framing of relations between institutional logics and have institutional work consequences. The participants are not grand entrepreneurs who are motivated by completed visions of maintaining, disrupting or creating institutions. The dimensions of agency provide a more subtle account of intentionality than is implied in institutional work (Lawrence & Suddaby, 2006; Suddaby et al., 2009). The participants are primarily interested in doing the immediate work at hand and in so doing i.e. just doing their daily work; their actions may have iterative or projective consequences. The focus on immediate tasks at hand points to the limitations of radical change (Kirkpatrick & Ackroyd, 2003b; McNulty & Ferlie, 2004). Iterative agency does not mean being an unthinking cultural dope (Garfunkel, 1984), merely following cultural scripts or lacking intentionality (Smets & Jarzabkowski, 2013a). The combination of practical-evaluative and iterative agency can reflect an intention to keep managerialism and professionalism, which results in maintaining existing institutional arrangements. This is significantly different from the isomorphic accounts of early neo-institutionalism (DiMaggio & Powell, 1991; Greenwood & Hinings, 1993; Scott et al., 2000). Maintaining existing institutional arrangements is a reflexive, intentional and effortful accomplishment (Emirbayer & Mische, 1998; Smets & Jarzabkowski, 2013a).

Regarding the point made about the mutual entanglements between managerialism and professionalism, the same can be said about the relationships between the multiple demands that make up institutional complexity (Greenwood et al., 2011) and the constellation of logics (Goodrick & Reay, 2011), which are not incompatible by definition (Besharov & Smith, 2013; Friedland & Alford, 1991b; Thornton et al., 2012). The range of latent behaviours that emerge in the GT shows that the adoption or dismissal of particular practices associated with given logics is the enactment of a constructed relationality between logics (Smets & Jarzabkowski, 2013a). Inhabitants of institutions (Hallett & Ventresca, 2006; Scully & Segal, 2002), who themselves are carriers of the contradictions (Delmestri, 2006; DiMaggio, 1988; Jepperson, 1991; Zilber, 2002), frame and recast relations between conflicting logics as they work through dilemmas in the process of accomplishing real day-to-day work.

The use of GT allowed me to get beyond the organisational-level structural responses to institutionalism (Battilana & Dorado, 2010; Pache & Santos, 2010) and open the black box of institutionalism (Zucker, 1991) below the organisational level to examine closely what might be happening at the coalface (Barley, 2008). Hence, the study managed to clarify some of the micro-foundations of institutionalisation (Smets & Jarzabkowski, 2013a; Smets et al., 2012; Thornton et al., 2012) to show how embedded actors routinely respond to institutional control by acquiescing, compromising, avoiding, defying and manipulating (Oliver, 1991) the resources at their disposal. Acquiescing concurs with the idea of managerial hegemony, proletarianisation, deprofessionalisation and McDonaldisation (Waring & Bishop, 2013), which are discussed in

Chapter 5. This study fills a gap in the literature in that it shows how embedded actors push back against, deflect, make concessions to, and steer clear of institutional controls (Lawrence, 2008). It also adds to the few studies that show professionals resist routinely (Thomas & Hewitt, 2011) and how doctors make decisions about the organisation (Correia, 2013a).

Rolling with the Punches connects agency, institutional logics, institutional work, medical sociology and organisation studies.

7.5 EMPIRICAL CONTRIBUTION

An "empirical contribution" refers to whether a study contributes to existing knowledge in a particular research domain. Studies that explain high degrees of variance are likely to make an empirical contribution to a research domain (Colquitt & Ireland, 2009).

This study presents a conceptual account of a latent pattern of real-life behaviour. In a scoping report for the Health Foundation of the United Kingdom, it is claimed that medical professionals are exhausted by having to cope with constant changes in the demand for healthcare, the social organisation of healthcare delivery and the state of medicine itself (Christmas & Millward, 2011). In fact, the scoping report suggests that unless the sense that doctors have of being under siege is reversed, patients and staff could be at risk. Furthermore, the report expresses the fear that even the idea of an NHS could be in danger. The need to discuss what a new medical professionalism might look like is acknowledged, given the changes in society, the nature of the state, medical technology, the patterns of illness from acute to chronic, and the relationships between the state and the medical profession and what they mean for medical professionalism.

In a report for the King's Fund, medical professionalism is described as the link between values, the environment within which care is delivered and the formulation of healthcare policy (Levenson et al., 2010). The report is a summary of 11 consultation events that were conducted between 2009 and 2010 and builds on a number of similar series of events in 2007 (Levenson, Dewar, & Shepherd, 2008). Once again, one can see the links between conceptions of medical professionalism and institutional theory, especially institutional logics (Thornton & Ocasio, 1999, 2013; Thornton et al., 2012) and institutional work.

A report for the Royal College of Physicians (RCP, 2005) also discusses values, attitudes and behaviours that are relevant and fit for the times so that medical professionalism remains a positive influence that shapes society and serves patients. The same comments as made about the report to the King's Fund apply to this report.

Rolling with the Punches is an inductively generated, conceptual account of how hospitals are already resolving these concerns by addressing immediate concerns on the frontline (McPherson & Sauder, 2013; Smets & Jarzabkowski, 2013a). It is a theory of what is already going on (Glaser, 2001a) and takes into account discussions of medical professionalism from descriptions and wish lists to latent patterns that are already operating in the real world. It is not the only – or a complete – account of medical professionalism in the NHS but it is one that

accounts for much of the variation in the behaviours of the participants and meets the criteria for a classic GT; i.e. it fits, it works, it is relevant and it is modifiable (Glaser, 1998).

The above-mentioned sections draw to a close the study. The next section illuminates the scholarly ways ahead.

7.6 FUTURE DIRECTIONS FOR RESEARCH

This study resulted in a GT that fits, works and is relevant within the substantive context. It therefore constitutes a completed body of work. However, a GT is not a final statement on a substantive area but remains open to modification in the light of new data for constant comparison. The concepts in the theory *Rolling with the Punches* would provide the anchors for theoretical sampling. It might be possible to extend the study to hospital consultants in other acute NHS hospitals to confirm the theoretical framework. It might then be possible to gain a more thorough understanding of the different concepts and theoretical relationships that constitute the theory.

Then it might be useful to see how other groups of professionals – with less power – in the hospital deal with managerialism. In so doing, one could begin to compare and contrast the areas where the patterns of behaviour are at odds and where they overlap. These insights might help one to have a broader, yet fine-grained, understanding of the ebb and flow of power in the social organisation of public healthcare.

Research on *Rolling with the Punches* should not be limited to how hospital doctors deal with the managerial hospital. It should be readily extended to other substantive areas. Given that this study was conducted under the auspices of a South African university, it is possible to see that this study has implications for understanding how professionals manage the wickedness, complex adaptive systems and institutional complexity in universities, social care, healthcare, education utilities, city management and even the national airline. It has the potential to be developed into a formal theory (Glaser, 1998, 2002a, 2006; Glaser & Holton, 2004). The grounded theory can potentially be applied in other areas where attempts are made to shape, constrain and modify the behaviours and choices of people for whom exit is not a realistic possibility.

Rolling with the Punches could be a way of being and somehow getting by, of trying to make things better in the absence of a grand vision. It could also be a way of just keeping hold of oneself when much else seems to be slipping. While on the surface very little might appear to be happening, behaviours routinely and non-dramatically (March, 1981; Prasad & Prasad, 1998; Scott, 1985, 1990; Smets et al., 2012) might be balancing a plethora of contradictions, thus resolving dilemmas as people address immediate practical concerns (Smets & Jarzabkowski, 2013a). *Rolling with the Punches* could be a process that is happening all around us.

7.7 LIMITATIONS

This study aimed to identify the main concern of participants in a substantive area and how they routinely go about resolving that concern. Chapter 4 is an account of the GT that emerged from the data and Chapter 5 is an account of the literature review and its integration into the GT. The first limitation in this study is the fact that as the researcher I did not have any experience in using GT before embarking on this PhD study. This surely affected the ways in which I used the classic GTM. I think that I also passed the readiness-to-write moment (Glaser, 2012b) due to inexperience. The core category and the subcategories were ready to be written up in the literature review, but I got carried away with wanting to go beyond conceptual completeness. Despite my vigilance throughout the process, I stumbled at the end at the door of descriptive coverage. It is an inviting door that cost me almost nine months. The use of an insider to collect some of the data may also have had an impact on the data-collection process but I trust that adherence to classic GT procedures countered limitations in this regard.

CONCLUDING REMARKS

I hope that this GT does justice to the participants who were so generous in making themselves available and vulnerable. This study generated an integrated set of hypotheses that explains much of their behaviour as they routinely resolve their main concern. It is not a complete account of their latent behaviours, nor is it the only one. It is also not a full account of medical professionalism within the managerial hospital. Some may be horrified by what this account of their behaviours says about medical professionals. However, a GT does not take a moral stance on the behaviours of participants. Whatever one might feel about this account, the clinicians, especially the doctors, still remain the social, creative and intellectual capital of the healthcare system (Walshe & Smith, 2011). As much as they struggle with huge issues that lie at the heart of the managerial transformation of healthcare, it should be remembered that clinicians, especially doctors, are at the core of the NHS, which sees 1 million patients every 36 hours. Thus, this study concludes as a tribute to those doctors who so courageously shared their innermost fears and pains. The researcher hopes that justice has been done to them. To the doctors…

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APPENDICES

APPENDIX 1: ASSOCIATION OF SOCIAL ANTHROPOLOGISTS OF THE COMMONWEALTH ETHICAL GUIDELINES

Association of Social Anthropologists of the Commonwealth Ethical Guidelines for Good Practice (ASA 1999)

Relations With and Responsibilities Towards Research Participants

The close and often lengthy association of anthropologists with the people among whom they carry out research entails personal and moral relationships, trust and reciprocity between the researcher and research participants; it also entails recognition of power differentials between them.

(1) Protecting research participants and honouring trust: Anthropologists should endeavour to protect the physical, social and psychological well-being of those whom they study and to respect their rights, interests, sensitivities and privacy:

(a) Most anthropologists would maintain that their paramount obligation is to their research participants and that when there is conflict, the interests and rights of those studied should come first;

(b) Under some research conditions, particularly that involving contract research, it may not be possible to fully guarantee research participants' interests. In such cases anthropologists would be well-advised to consider in advance whether they should pursue that particular piece of research.

(2) Anticipating harms: Anthropologists should be sensitive to the possible consequences of their work and should endeavour to guard against predictably harmful effects. Consent from subjects does not absolve anthropologists from their obligation to protect research participants as far as possible against the potentially harmful effects of research:

(a) The researcher should try to minimise disturbances both to subjects themselves and to the subjects' relationships with their environment. Even though research participants may be immediately protected by the device of anonymity, the researcher should try to anticipate the long-term effects on individuals or groups as a result of the research;

(b) Anthropologists may sometimes be better placed than (at the least, some of) their informants to anticipate the possible repercussions of their research both for the immediate participants and for other members of the research population or the wider society. In certain political contexts, some groups, for example, religious or ethnic minorities may be particularly vulnerable and it may be necessary to withhold data from publication or even to refrain from studying them at all.

(3) Avoiding undue intrusion: Anthropologists should be aware of the intrusive potential of some of their enquiries and methods:

(a) Like other social researchers, they have no special entitlement to study all phenomena; and the advancement of knowledge and the pursuit of information are not in themselves sufficient justifications for overriding the values and ignoring the interests of those studied;

(b) They should be aware that for research participants becoming the subject of anthropological description and interpretations can be a welcome experience, but it can also be a disturbing one. In many of the social scientific enquiries that have caused controversy this has not arisen because participants have suffered directly or indirectly any actual harm. Rather, the concern has resulted from participants' feelings of having suffered an intrusion into private and personal domains, or of having been wronged, (for example, by having been caused to acquire self-knowledge which they did not seek or want).

(4) Negotiating informed consent: Following the precedent set by the Nuremberg Trials and the constitutional laws of many countries, inquiries involving human subjects should be based on the freely given informed consent of subjects. The principle of informed consent expresses the belief in the need for truthful and respectful exchanges between social researchers and the people whom they study.

(a) Negotiating consent entails communicating information likely to be material to a person's willingness to participate, such as: - the purpose(s) of the study, and the anticipated consequences of the research; the identity of funders and sponsors; the anticipated uses of the data; possible benefits of the study and possible harm or discomfort that might affect participants; issues relating to data storage and security; and the degree of anonymity and confidentiality which may be afforded to informants and subjects.

(b) Conditions that constitute an absence of consent: consent made after the research is completed is not meaningful consent at all. Further, the persons studied must have the legal capacity to give consent. Where subjects are legally compelled (e.g., by their employer or government) to participate in a piece of research, consent cannot be said to have been meaningfully given by subjects, and anthropologists are advised not to pursue that piece of work.

(c) Consent in research is a process, not a one-off event, and may require renegotiation over time; it is an issue to which the anthropologist should return periodically.

(d) When technical data-gathering devices such as audio/visual-recorders and photographic records are being used those studied should be made aware of the capacities of such devices and be free to reject their use.

(e) When information is being collected from proxies, care should be taken not to infringe the 'private space' of the subject or the relationship between subject and proxy; and if there are indications that the person concerned would object to certain information being disclosed, such information should not be sought by proxy.

(f) The long period over which anthropologists make use of their data and the possibility that unforeseen uses or theoretical interests may arise in the future may need to be conveyed to participants, as should any likelihood that the data may be shared (in some form) with other colleagues or be made available to sponsors, funders or other interested parties, or deposited in archives.

(5) Rights to confidentiality and anonymity: Informants and other research participants should have the right to remain anonymous and to have their rights to privacy and confidentiality respected. However, privacy and confidentiality present anthropologists with particularly difficult problems given the cultural and legal variations between societies and the various ways in which the real interests or research role of the ethnographer may not fully be realised by some or all of participants or may even become invisible over time:

(a) Care should be taken not to infringe uninvited upon the 'private space' (as locally defined) of an individual or group;

(b) As far as is possible researchers should anticipate potential threats to confidentiality and anonymity. They should consider whether it is necessary or even a matter of propriety to record certain information at all; should take appropriate measures relating to the storage and security of records during and after fieldwork; and should use where appropriate such means as the removal of identifiers, the use of pseudonyms and other technical solutions to the problems of privacy in field records and in oral and written forms of data dissemination (whether or not this is enjoined by law or administrative regulation);

(c) Researchers should endeavour to anticipate problems likely to compromise anonymity; but they should make clear to participants that it may not be possible in field notes and other records or publications totally to conceal identities, and that the anonymity afforded or promised to individuals, families or other groups may also be unintentionally compromised. A particular configuration of attributes can frequently identify an individual beyond reasonable doubt; and it is particularly difficult to disguise, say, office-holders, organizations, public agencies, ethnic groups, religious denominations or other collectivities without so distorting the data as to compromise scholarly accuracy and integrity;

(d) If guarantees of privacy and confidentiality are made, they must be honoured unless there are clear and over-riding ethical reasons not to do so. Confidential information must be treated as such by the anthropologist even when it enjoys no legal protection or privilege, and other people who have access to the data should be made aware of their obligations likewise; but participants should be made aware that it is rarely, if at all, legally possible to ensure total confidentiality or to protect the privacy of records;

(e) Anthropologists should similarly respect the measures taken by other researchers to maintain the anonymity of their research field and participants.

(6) Fair return for assistance: There should be no economic exploitation of individual informants, translators and research participants; fair return should be made for their help and services.

(7) Participants' intellectual property rights: It should be recognised that research participants have contractual and/or legal, interests and rights in data, recordings and publications, although rights will vary according to agreements and legal jurisdiction.

(a) It is the obligation of the interviewer to inform the interviewee of their rights under any copyright or data protection laws of the country where research takes place, and the interviewer must indicate beforehand any uses to which the interview is likely to be put (e.g., research, educational use, publication, broadcasting etc).

(b) Under the UK Copyright Act (1988), researchers making audio or video recordings must obtain 'copyright clearance' from interviewees if recordings are to be publicly broadcast or deposited in public archives. Any restrictions on use (e.g., time period) or other conditions (e.g., preservation of anonymity) which the interviewee requires should be recorded in writing. This is best done at the time of the interview, using a standard form. Retrospective clearance is often time-consuming or impossible where the interviewee is deceased or has moved away.

(c) Interviewers should clarify before interviewing the extent to which subjects are allowed to see transcripts of interviews and field notes and to alter the content, withdraw statements, to provide additional information or to add glosses on interpretations.

(d) Clarification must also be given to subjects regarding the degree to which they will be consulted prior to publication.

(8) Participants' involvement in research: As far as is possible anthropologists should try and involve the people being studied in the planning and execution of research projects, and they should recognise that their obligations to the participants or the host community may not end (indeed should not end, many would argue) with the completion of their fieldwork or research project. [1]

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[1] http://www.theasa.org/ethics/guidelines.shtml

Accessed 13 February 2011

APPENDIX 2: SUMMARY OF RESEARCH GOVERNANCE FRAMEWORK FOR RESEARCH WITHIN THE HOSPITAL TRUST

Summary of Research Governance Framework for Research within the Hospital Trust: Dh 4108962

http://www.gmc-uk.org/legal_annexes_FINAL.pdf_31380575.pdf

Accessed 10 March 2012

General Medical Council

Regulating doctors
Ensuring good medical practice

Annex A

Legal and governance framework

This annex is a brief guide to the legal and governance framework relevant to research in the UK. It is not intended to be a comprehensive statement of the law or a list of all relevant legislation, nor is it a substitute for independent, up-to-date legal advice.

The laws and governance arrangements that apply to research vary depending on the type of research, the participants involved, how it is funded, and where in the UK it is undertaken. If you are unsure about how the law applies in a particular situation, you should consult your defence body or professional association, or seek independent legal advice.

Governance framework

The UK health departments publish good practice frameworks for the governance of research in health and social care.[1] You must follow the relevant framework if it applies to the research you are undertaking.

The *International Conference on Harmonisation Guideline for Good Clinical Practice*[2] sets out the international standards for conducting clinical trials of investigational medicinal products.

Certain types of research must be approved or licensed by a relevant authority in the UK. These authorities include, for example, the Medicines and Healthcare products Regulatory Agency, the Human Tissue Authority, the Human Fertilisation and Embryology Authority, and the Gene Therapy Advisory Committee.

1 *Research Governance Framework for Health and Social Care* (Department of Health, 2005).
See **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4108962**

Research Governance Framework for Health and Community Care (Scottish Executive Health Department, 2006).
See **www.cso.scot.nhs.uk/Publications/ResGov/Framework/RGFEdTwo.pdf**

Research Governance Framework for Health and Social Care in Northern Ireland (Department of Health, Social Services and Public Safety, Northern Ireland, 2006).
See **www.dhsspsni.gov.uk/research_governance_framework.pdf**

Research Governance Framework for Health and Social Care in Wales (National Assembly for Wales, 2009).
See **http://wales.gov.uk/topics/health/research/word/publications/researchgovernance/;jsessionid=QKVBKyDGl23PvyKp19sWTy9JZnptMzHW4V8mWYhmXyrmMQFW9nht!2078297436?lang=en**

2 *International Conference on Harmonisation Topic E 6 Note for Guidance on Good Clinical Practice* (2002).
See **www.emea.europa.eu/pdfs/human/ich/013595en.pdf**

Clinical trials of investigational medicinal products

Clinical trials of investigational medicinal products[3] are governed by the *Medicines for Human Use (Clinical Trials) Regulations 2004*, which apply in all four UK countries.[4] The regulations implement the provisions of the *European Clinical Trials Directive (EC2001/20)* into UK law. The regulations set out good clinical practice in the conduct of clinical trials of investigational medicinal products, including trials involving children or young people, and adults who lack capacity.

Other types of research involving people

Common law

The common law principles in relation to confidentiality and consent apply to research in which an adult has the capacity to consent to take part, and the research is not a clinical trial of investigational medicinal products.

Adults without capacity

Other than clinical trials of investigational medicinal products, research involving people over 16 who lack capacity is governed in England and Wales by the *Mental Capacity Act*

3 Under the *Medicines for Human Use (Clinical Trials) Regulations 2004* a clinical trial means 'any investigation in human subjects, other than a non-interventional trial, intended –

(a) to discover or verify the clinical, pharmacological or other pharmacodynamic effects of one or more medicinal products,
(b) to identify any adverse reactions to one or more such products, or
(c) to study absorption, distribution, metabolism and excretion of one or more such products,

with the object of ascertaining the safety or efficacy of those products'.

An investigational medicinal product 'means a pharmaceutical form of an active substance or placebo being tested, or to be tested, or used, or to be used, as a reference in a clinical trial, and includes a medicinal product which has a marketing authorization but is, for the purposes of the trial -

(a) used or assembled (formulated or packaged) in a way different from the form of the product authorised under the authorization,
(b) used for an indication not included in the summary of product characteristics under the authorization for that product, or
(c) used to gain further information about the form of that product as authorised under the authorization'.

4 *Medicines for Human Use (Clinical Trials) Regulations 2004*.
See **www.uk-legislation.hmso.gov.uk/si/si2004/20041031.htm**

Amendments to the *Medicines for Human Use (Clinical Trials) Regulations 2004*:

Medicines for Human Use (Clinical Trials) Amendment Regulations 2006.
See **www.opsi.gov.uk/si/si2006/20061928.htm**

Medicines for Human Use (Clinical Trials) Amendment (No.2) Regulations 2006.
See **www.opsi.gov.uk/si/si2006/20062984.htm**

Medicines for Human Use (Miscellaneous Amendments) Regulations 2009.
See **www.opsi.gov.uk/si/si2009/uksi_20091164_en_1**

Medicines for Human Use (Clinical Trials) and *Blood Safety and Quality (Amendment) Regulations 2008*.

2005 and in Scotland by the *Adults with Incapacity (Scotland) Act 2000*.[5] In Northern Ireland, there is currently no relevant primary legislation setting out the circumstances in which research (except for clinical trials of investigational medicinal products) involving adults who lack capacity to consent may be undertaken. At the time of publication, a legislative framework for new mental capacity legislation and revised mental health legislation is being developed. See *Consent to research* for further guidance on seeking consent to involve people who lack capacity in research.

Regulation of human tissue research

The *Human Tissue Act 2004*[6] provides the framework for the regulation of human tissue research in England, Wales and Northern Ireland. Scotland has its own *Human Tissue (Scotland) Act 2006*.[7] The *Medicines for Human Use (Clinical Trials) Regulations 2004* apply to the use of human tissue in clinical trials of investigational medicinal products.

The *Human Fertilisation and Embryology Act 1990 (as amended)*[8] regulates research in the UK that involves the creation, use and storage of human embryos and human admixed embryos (embryos combining both human and animal material). It also defines access by researchers to data collected by the Human Fertilisation and Embryology Authority.

Records-based research

Confidentiality[9] provides guidance to doctors undertaking records-based research that does not involve participants directly. It gives guidance on disclosing identifiable information for research or other secondary uses if the disclosure is required by law.

5 *Mental Capacity Act 2005*. See **www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_1**

Mental Capacity Act Code of Practice. See **www.dca.gov.uk/legal-policy/mental-capacity/mca-cp.pdf**

Adults with Incapacity (Scotland) Act 2000.
See **www.opsi.gov.uk/legislation/scotland/acts2000/asp_20000004_en_1**

Adults with Incapacity (Scotland) Act 2000 Part 5 Code of Practice.
See **www.scotland.gov.uk/Publications/2008/06/13114117/0**

6 *Human Tissue Act 2004*. See **www.opsi.gov.uk/ACTS/acts2004/ukpga_20040030_en_1**

Human Tissue Authority – Codes of Practice.
See **www.hta.gov.uk/policiesandcodesofpractice/codesofpractice.cfm**

7 *Human Tissue (Scotland) Act 2006*.
See **http://www.opsi.gov.uk/legislation/scotland/acts2006/asp_20060004_en_1**

The Human Tissue Authority was set up under the *Human Tissue Act 2004* but performs certain tasks on behalf of the Scottish Executive (approval of living donation and licensing of establishments storing tissue for human application).

8 *Human Fertilisation and Embryology Act 1990* (as amended).
See **www.opsi.gov.uk/Acts/acts1990/Ukpga_19900037_en_1.htm**
www.opsi.gov.uk/acts/acts2008/ukpga_20080022_en_1

9 *Confidentiality*.
See **www.gmc-uk.org/guidance/ethical_guidance/confidentiality_40_50_research_and_secondary_issues.asp**

General Medical Council

Regulating doctors
Ensuring good medical practice

Annex B

Key elements of the legislation on clinical trials of investigational medicinal products

This annex highlights some of the specific legal requirements for conducting clinical trials of investigational medicinal products in the UK. It complements the high-level principles set out in *Good practice in research* and *Consent to research*. It is not intended to be a comprehensive statement of the law or a list of all legislative requirements, nor is it a substitute for independent, up-to-date legal advice.

Consent to research gives further advice about involving adults who lack capacity in clinical trials of investigational medicinal products (see paragraphs 23-35).

The *Medicines for Human Use (Clinical Trials) Regulations 2004*[10] set out good clinical practice in the conduct of clinical trials of investigational medicinal products for human use (see schedule 1 of the regulations for the conditions and principles which apply to all trials). They apply in all four UK countries. You must be familiar with and follow the regulations at all times when conducting clinical trials of investigational medicinal products in the UK.

You should also be familiar with the guidance about conducting clinical trials of investigational medicinal products published by other organisations, such as the Medical Research Council and the Medicines and Healthcare products Regulatory Agency (MHRA).

Before starting a trial

The regulations prohibit anyone from starting or conducting a clinical trial of investigational medicinal products, and from beginning the process of recruiting participants to such a trial, until there is approval from a research ethics committee and authorisation from the MHRA. The research ethics committee must be one recognised by the United Kingdom Ethics Committee Authority.

It is a requirement for clinical trials of investigational medicinal products to be registered on the European Clinical Trials database (Eudract).

10 *Medicines for Human Use (Clinical Trials) Regulations 2004*.
See **www.uk-legislation.hmso.gov.uk/si/si2004/20041031.htm**

Seeking and withdrawing consent

It is a legal requirement to get written consent from a person to participate in a clinical trial of investigational medicinal products. The person with parental responsibility or a legal representative must give written consent for a child or young person, or for an adult who lacks capacity, to participate in a trial.

The regulations require that a person, or if relevant the person with parental responsibility or a legal representative, must have an interview with a member of the research team. The interviewer is required to give them the information they need to understand the aims, risks and burdens of the trial, and the conditions under which it will be conducted. The person must be informed of their right to withdraw themselves, or the person they represent or have parental responsibility for, from the trial at any time. It is a requirement that the person, or if relevant the person with parental responsibility or a legal representative, must be given a contact point where they can get further information about the trial.

The regulations prohibit offering any incentive, except compensation for injury or loss, to:

- a child or young person under 16
- the person with parental responsibility for them
- a legal representative for a child or young person under 16 or for an adult who lacks capacity.[11]

In emergency situations, the regulations permit treatment to be given as part of a trial to a child or young person or to an adult who lacks capacity before getting consent only when:

- the trial needs to be undertaken urgently
- it is not reasonably practical to get consent, and
- an appropriate research ethics committee has given approval for such recruitment.

In these circumstances, it is a legal requirement to get consent from the person with parental responsibility or the legal representative (or the adult if they recover capacity) as soon as possible.[12] If consent is withheld, the person must be withdrawn from the trial.

People participating in a trial can withdraw from the trial at any time. The person with parental responsibility or a legal representative can withdraw a child or young person or adult who lacks capacity from the trial at any time.

11 A legal representative under the *Medicines and Human Use (Clinical Trials) Regulations 2004* means a person who is suitable to act as a legal representative for a minor (under 16) or an adult who lacks capacity for the purpose of the trial and is available and willing to do so. They must not be involved in the conduct of the trial. For trials involving adults who lack capacity in Scotland, a legal representative means any guardian or welfare attorney who has power to consent, or the adult's nearest relative. In all cases, if there is no such person, a doctor not connected with the conduct of the trial but who is responsible for the medical treatment of the minor or adult, or a person nominated by the relevant healthcare provider, can be approached. You should refer to the clinical trials regulations for a full description.

12 *Medicines for Human Use (Clinical Trials)* and *Blood Safety and Quality (Amendment) Regulations 2008.* See **www.opsi.gov.uk/si/si2008/uksi_20080941_en_1**

Medicines for Human Use (Clinical Trials) (Amendment No.2) Regulations 2006. See **www.opsi.gov.uk/si/si2006/20062984.htm**

Participant safety

If urgent safety measures are introduced to protect participants against harm to their health or safety during a clinical trial of investigational medicinal products, the regulations require that the sponsor must immediately notify, in writing, the MHRA and the research ethics committee of the measures taken and why they were needed.

There are specific requirements to record, notify, assess, report, analyse and manage adverse events in trials.[13] In particular, it is a requirement for the research investigator to immediately report to the sponsor any serious adverse event that occurs to a participant, unless the protocol sets out that the event does not need to be reported immediately. The sponsor is required to make sure that all relevant information about a suspected unexpected serious adverse reaction that occurs during a clinical trial of investigational medicinal products is reported within a specified period to the MHRA and the relevant research ethics committee.

13 The National Research Ethics Service and the Medicines and Healthcare products Regulatory Agency provide guidance on safety reports for clinical trials of investigational medicinal products.

APPENDIX 3: UNIVERSITY OF THE WITWATERSRAND HUMAN RESEARCH ETHICS COMMITTEE CLEARANCE

University of the Witwatersrand Human Research Ethics Committee (Non-Medical)
Clearance Protocol Number H110911

Research Office

HUMAN RESEARCH ETHICS COMMITTEE (NON MEDICAL)
H110911 Craayenstein

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER H110911**
PROJECT TITLE	On being a doctor in an acute NHS Trust: A classic grounded theory
INVESTIGATOR(S)	Mr M R Craayenstein
SCHOOL/DEPARTMENT	Management
DATE CONSIDERED	16 September 2011
DECISION OF THE COMMITTEE	Approved Unconditionally
EXPIRY DATE	30 September 2011
DATE 07 October 2011	**CHAIRPERSON** (Professor R Thornton)

cc; Prof. T Carmichael

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10005, 10th Floor, Senate House, University.

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the researcl procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to completion of a yearly progress report.**

Signature

1 / Nov / 2011
Date

APPENDIX 4: PARTICIPANT INFORMATION SHEET

Wits Business School

2 St David's Place, Parktown,

Johannesburg, 2193, South Africa

P.O. Box 98, Wits, 2050, South Africa

Participant information sheet

On being a doctor in an acute NHS trust within the context of chronic fundamental structural, financial and cultural change: A classic grounded theory

Mogamat Reederwan Craayenstein

53 St Albans Crescent, Woodford Green, Essex, IG8 9EL, United Kingdom

mrcraayenstein2@yahoo.co.uk

Research & Development Project Number: 941

Introduction

As a PhD student, I herewith invite you to participate in the above-mentioned study, which is supervised by Prof. Terri Carmichael (terri.carmichael@wits.ac.za).

Before you make your decision on participation, I would like to explain the reasons for the research and what participation would mean for you. Therefore I would appreciate if you would read the information below. If you have any further questions, or if you would like further information, please feel free to contact me (Reederwan Craayenstein- contact details above).

The study

The research project in which your participation is sought is concerned with the working life of an NHS doctor within the context of large-scale structural change in the NHS. The goal is to identify the main issues faced by doctors and how they actually go about resolving those issues on a daily basis. This study aims to reflect the views of doctors about the principal concerns and how they actually address these challenges.

Who would be involved?

There are two aspects to data gathering. The first is a participant observation role where the researcher would like to develop an in-depth sense of what doctors face as they go about their daily practice/business. Then there will be formal interviews to explore some of the issues that

emerge from the observations. So it will be people that the researcher will have found are knowledgeable and willing to talk about the issues.

What would you have to do if you choose to participate?

If you agree to take part then it would initially mean allowing the researcher to observe your everyday work activities such as formal and informal meetings. You will be asked to sign a consent form at the beginning of the study, but that would not mean that you had to participate each day that you are on duty. The researcher would check with you at the beginning of the session about your willingness to be observed. The aim will be to gain an in-depth understanding of the issues.

A further part of the study would include interviews with doctors. The focus will be on the problems that they face and how they address these on a daily basis. The interviews will not be audio/video recorded, as the researcher will make field notes. This will promote confidentiality and anonymity. The interviews would be carried out at work, in a quiet area, at a convenient time for the doctor and will last approximately 45-60 minutes.

The final part of the study will involve the study of NHS and Trust documents such as annual and monthly reports that are available online, NHS policy, clinical guidelines, protocols and standards that may illuminate matters arising from the observations and interviews.

Do you have to participate?

You are free to participate or not to participate. If you refuse to participate then you do not have to justify your refusal. If however, you do decide to participate, then you are free to withdraw from the study at any time, without having to provide an explanation and you may ask that the information that you have provided be omitted from our records.

If you decide to participate you would be asked:

- To give written consent for participant observation (the researcher will also check with you for verbal consent before each occasion of participant observation); and
- To give written consent for any interview that you grant the researcher.

You will be given a copy of this information sheet and signed consent forms to keep.

What happens next?

I would be grateful if you could consider this request for your participation sympathetically and favourably. The aim is to develop a view of what doctors consider being the major issues that they face in their work and what they consider is needed to address these concerns. Therefore you are likely to derive indirect benefit from this study. I would be pleased to address any concerns that you may have regarding your initial decision on participation. Please feel free to contact me.

Thank you for considering taking part in this research.

APPENDIX 5: CONSENT FOR INTERVIEW FORM

CONSENT FOR INTERVIEW FORM

R&D Project Number: R&D 941

Title of the Project: On Being a Doctor in an acute NHS Trust: A Grounded Theory of the main issues faced by NHS doctors within the context of major structural change.

Name of the Researcher: Mogamat Reederwan Craayenstein

I confirm that I have read and understand the information sheet dated ……. ☐

And have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without my legal rights being affected. ☐

I agree that any word that I may say during the interview can be used, anonymously, in the written record of the research. ☐

I agree for the interviewer to make notes but should I stop the interview at any time and ask for the notes to be destroyed ☐

I agree to participate in the study.

☐

Name of the participant	Date	Signature
Name of person taking consent	date	Signature
(If different from researcher)		
Researcher	Date	Signature

APPENDIX 6: CONSENT FOR PARTICIPANT OBSERVATION

CONSENT FOR PARTICIPANT OBSERVATION

R&D Project Number: R&D 941

Title of the Project: On Being a Doctor in an acute NHS Trust: A Grounded Theory of the main issues faced by NHS doctors within the context of major structural change.

Name of the Researcher: Mogamat Reederwan Craayenstein

I confirm that I have read and understand the information sheet dated ……. ☐

And have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without my legal rights being affected. ☐

I agree that any word that I may say during the participant observation can be used, anonymously, in the written record of the research. ☐

I agree for the researcher to shadow me during my everyday activities at work, subject to my continuing agreement. ☐

I agree to participate in the study.

☐

Name of the participant	Date	Signature
Name of person taking consent (if different from researcher)	date	Signature
Researcher	Date	Signature

APPENDIX 7: INTERVIEW GUIDE

INTERVIEW GUIDE

Interview Number: Age Range: Gender: M/F

Speciality: **Length of service as practising NHS consultant:**

Introduction:

1. What does being a doctor mean to you when you are at work?
    - Prompt: Structural, Cultural and Financial
2. What are the different roles that you have to "play" whilst being a doctor?
3. Please comment on the work-life balance of being a doctor
4. How important is it being part of a team, and in what ways does it aid or hinder you as a doctor?

Demands:

5. How has the role of patients evolved in the way the service is delivered?
6. How has this evolution impacted on you being a doctor?
7. How has the role of NHS managers influenced you being a doctor?
    - Prompt: Structural, Cultural and Financial

Skills:

8. Please comment on the non-clinical skills needed to be a doctor
9. In what contexts or roles are these skills needed?
10. How are doctors prepared in this regard, and how adequate is the preparation?
11. How do doctors cope in this matter?

Concerns:

12. What are the main issues/concerns/problems faced by doctors?
    - Prompt: Structural, Cultural and Financial
13. How do doctors deal with these issues/concerns/problems?
    - Prompt: Structural, Cultural and Financial

14. What should be done about those issues/concerns/problems?
    - Prompt: Structural, Cultural and Financial

Environment:

15. How has the environment of practising as a doctor changed?
16. How do NHS reforms affect being an NHS doctor in a tertiary care institution?
    - Prompt: Structural, Cultural and Financial
17. How has medical revalidation and CPD affected being a doctor?
18. What do you think of the role played by representative organisations (e.g. BMA, LNC) for doctors in terms of effectiveness? What changes or improvements should be made?

Change:

19. What needs to change in order for doctors to do their jobs better?
    - Prompt: Structural, Cultural and Financial
20. If you could change one thing, what would you do to change things for the better?
21. Why would you choose this one issue for change?
22. Is there anything that had not been covered in the interview?

Thank you for your willingness to be available and to respond frankly. If needed, would you be prepared for a shorter follow-up interview (20 minutes max) at some future date within the next 12 months? If yes, then your name will be included for later contact.

APPENDIX 8: SUMMARY OF INTERVIEW RESEARCH ENCOUNTERS

Consultant ID Code	Approximate Age	Years as NHS Consultant	Gender	Speciality Group	C/CL/CD/MD
IG	58	20	Male	Physician	Divisional Director
Bl	60	30	Male	Radiologist	None
Mnj	40	4	Male	Radiologist	None
Abd	55	20	Male	Paediatrician	None
Cwd	45	10	Male	Radiologist	CL
Akl	45	11	Male	Radiologist	None
Nmy	63	30	Male	Physician	Past CD
Gdst	64	30	Male	Radiologist	Acting CD
MW	40	4	Male	Surgeon	None
Sh	40	10	Male	Neuro-rad	None
BP	35	2	Male	Ophthalmologist	None
KW	40	7	Female	Radiologist	None
SN	40	7	Male	Physician	None
RG	63	30	Male	Radiologist	Past CL
H	45	6	Male	Surgeon	None
KA	45	6	Male	Endoscopy	None
WR	65	40	Male	Radiologist	None
AA	55	16	Male	Oncologist	None
HE	42	3	Female	Physician	None
AM	55	15	Male	Paediatrician	None
SM	40	3	Male	A& E	None
AV	50	13	Male	A&E	CL
MQ	55+	18	Female	Oncologist	CL
T	55+	24	Female	Gynae & Oncology	CL
RS	55-	2	Male	Radiologist	None
A- Gsp	35+	7	Male	A&E	None
Slb	50+	18	Male	Physician	CD

Consultant ID Code	Approximate Age	Years as NHS Consultant	Gender	Speciality Group	C/CL/CD/MD
Silva	55+	17	Male	Radiologist	None
R	40	3	Male	ITU	None
DH	40-	3	Male	A&E	CD
RB	45-	9	Male	Physician	None
SW	40-	4	Male	ICU	None
AI	60-	21	Male	A&E	Was CD
CH	52	13	Male	Surgeon	CL
MV	60+	30	Male	Surgeon	DD
HD	40-	2	Female	Gastro	None
MS	55+	18	Female	Physician	DD
AJ	40-	3	Male	Renal Physic	None
KH	45-	8	Female	Radiologist	CL
JA	55+	18	Male	Endocrinologist	MD
JS	40-	3	Female	47	None
DR	60++	30	Male	Paed	None
SG	55	20	Female	Surgeon	None

C: Consultant

CL: Clinical Lead

CD: Clinical Director

MD: Medical Director

DD: Divisional Director

APPENDIX 9: EXAMPLE OF FIELD NOTES FROM INTERVIEW

Field Notes
The doctor is in a very difficult situation in the NHS today.
They are no longer afforded the authority and respect as in days gone by.
Managers and their staff are being empowered at the expense of doctors.
At our trust there are two main separate sites with different cultures. At one hospital the mainly overseas-trained nurses who will go the extra mile for the patient.
At the PFI hospital site, the nurses will not easily delay going on lunch for the patient. How did this happen as we do not recruit the staff? Nurses at the first hospital feel that they have to work harder than those at the new site.
I do not always like to be at work because you can be crushed on a daily basis. You have to be diplomatic and be careful whom you speak to. Power has shifted. It is very painful when secretaries – under instructions from their managers – tell experienced consultants what they can and cannot do.
Sometimes doing the best for the patient is not sufficient to get one to come to work.
Doctors struggle without support. Managers sit in front of computers sending out emails and seldom care to justify and defend their decisions when doctors are unable to do the best for patients.
Managers decide on the number of beds, the number and quality of the staff, the equipment, the number of wards and theatres. We just deal with the patient. Yet we have the duty to deliver the best quality of care that meets the needs of every patient.
I have clinics booked at both sites, on the same day at the same time. The managers control the bookings as they have targets to meet. Moreover, the clinics at both sites are over-booked. On paper the consultant is in charge whilst in reality managers call the shots.
If I had a choice then I would leave the NHS not only this hospital, as it is the same everywhere in the NHS.
When secretaries leave they are not replaced. The administrative work of the consultant goes to a pool of secretaries. So one has staffs that are typing up work without knowing anything about the speciality. The clerical incompetence is frustrating. It takes hours to correct spelling mistakes when I should be dealing with patients.
The workload is very heavy because the demand is high and there are staff shortages. Sometimes nursing posts are frozen to balance the books. Managers for the same reasons close wards and theatres. So demand in the remaining wards is more intense.
Locum nursing staff fills the gaps in the staffing. They do not know the patient. Every time a new locum nurse is on the ward then I have to start from zero because I know more about the patient than the nurse. The demand on nurses often means that they attend to the immediate needs of patients and leave the notes for later. Sometimes the notes do not get done.
We have bed shortages. Often patients are well-enough to be discharged but because we do not control admission and discharge decisions that patient might block the bed because the home-care team has been unable to handle an extra patient.
Every day – without exception – my wife can see that I have had another dreadful day. It shows on my face. Life at home has become very mechanical. Yet, the clinical staffs are blamed for the state of healthcare in the hospital.
Please keep my details anonymous and confidential. Throughout it was painful to see a broken doctor who was prepared to speak, yet so fearful and fragile.

APPENDIX 10: EXAMPLE OF OPEN-CODED DATA FROM INTERVIEW

Field Notes	Open Code Action Verbs (Gerund)
The doctor is in a very difficult situation in the NHS today.	Facing difficulties Finding it hard Taking strain Exasperating
They are no longer afforded the authority and respect as in days gone by.	Losing control Shifting ground Losing authority
Managers and their staff are being empowered at the expense of doctors.	Losing out Suffering loss
At our trust there are two main separate sites with different cultures. At one hospital the mainly overseas-trained nurses who will go the extra mile for the patient.	Operating differently Working harder Going extra mile
At the PFI hospital site, the nurses will not easily delay going on lunch for the patient. How did this happen as we do not recruit the staff? Nurses at the first hospital feel that they have to work harder than those at the new site.	Not bothering Being unprofessional Blaming managers Feeling cheated Working harder Getting away Competing professionalisms
I do not always like to be at work because you can be crushed on a daily basis. You have to be diplomatic and be careful to whom you speak. Power has shifted. It is very painful when secretaries – under instructions from their managers – tell experienced consultants what they can and cannot do.	Hating workplace Being repelled Distancing psychologically Undermining professionalism Insubordinating Subverting discursively Finding intolerable Feeling ill Bearing hostility Being judicious Being discreet Being smart Playing the game
Sometimes doing the best for the patient is not sufficient to get one to come to work.	Feeling inadequate Failing the patient Lacking motivation Dreading workplace
Doctors struggle without support. Managers sit in front of computers sending out emails and seldom care to justify and defend their decisions when doctors are unable to do the best for patients.	Lacking support Cowering manager Managing performance

Field Notes	Open Code Action Verbs (Gerund)
	Chickening out Shirking accountability Failing patients Managing information Watching targets
Managers decide on the number of beds, the number and quality of the recruited staff, the equipment, the number of wards and theatres. We just deal with the patient. Yet we have the duty to deliver the best quality of care that meets the needs of every patient.	Controlling inputs Balancing the books Controlling costs Focusing on patient Prioritising care Competing priorities Managing resources Managing ratios
I have clinics booked at both sites, on the same day at the same time. The managers control the bookings as they have targets to meet. Moreover, the clinics at both sites are over-booked. Sometimes deliberately double-booking patients. On paper the consultant is in charge whilst in reality managers call the shots.	Over-booking Enhancing efficiency Performance managing Managing targets Sweating assets Feigning control Balancing competing demands Resisting discursively Questioning legitimacy Competing values Focusing on patient Undermining managerialism
If I had a choice then I would leave the NHS not only this hospital, as it is the same everywhere in the NHS.	Feeling trapped Overwhelming Suffocating Realising limits Questioning meaning Having to find a way Surviving the system Exiting limits Negotiating the mess
When secretaries leave they are not replaced. The administrative work of the consultant goes to a pool of secretaries. So one has staffs that are typing up work without knowing anything about the speciality. The clerical incompetence is frustrating. It takes hours to correct spelling mistakes when I should be dealing with patients.	Cutting costs Managing targets Balancing the books Under-resourcing professionals Feeling under-valued
The workload is very heavy because the demand is high and there are staff shortages. Sometimes nursing posts are frozen to balance the books. Managers for the same reasons close wards and theatres. So demand in the remaining wards is more intense.	Overloading staff Cutting costs Freezing posts Balancing the books

Field Notes	Open Code Action Verbs (Gerund)
	Pressurising wards Sweating the assets Challenging professional norms
Locum staff fills the gaps in the staffing. They do not know the patient. Every time a new locum nurse is on the ward then I have to start from zero because I know more about the patient than the nurse. The demand on nurses often means that they attend to the immediate needs of patients and leave the notes for later. Sometimes the notes do not get done.	Varying cost-base Under-manning wards Fragmenting care Compensating for systems Prioritising Falling through cracks
We have bed shortages. Often patients are well-enough to be discharged but because we do not control admission and discharge decisions that patient might block the bed because the home-care team has been unable to handle an extra patient.	Managing costs Bed-blocking Mismanaging discharge Delaying discharge Delaying transfer of care Increasing length of stay Unnecessary processing Mismanaging patient flow Needing beds Gridlocking patient flow Clogging up system Bursting seams Losing bed days
Every day – without exception – my wife can see that I have had another dreadful day. Life at home has become very mechanical. Yet, the clinical staffs are blamed for the state of healthcare in the hospital.	Taking toll Behaving poorly Disengaging family Denying recovery time Resisting psychologically
Please keep my details anonymous and confidential. Throughout it was painful to see a broken doctor who was prepared to speak, yet so fearful and fragile.	Seeking cover Hiding in the shadows Retreating

APPENDIX 11: EXAMPLE OF OPEN-CODED DATA FROM GROUP MEETING/OBSERVATIONAL STUDY

Field Notes	Open Code Action Verbs (Gerund)
10pm. More than a hundred patients in the waiting room. The numbers have not decreased. Manager is desperate to clear the backlog. Clinicians hardly making a dent.	Not coping Missing targets Staff taking strain Exasperating
Many patients have been waiting for hours. A mixture of fractures, sprains, flu, respiratory disorder, vomiting, cuts, bruises and sprains. Some patients are older people with complex conditions. Others could not secure GP appointments.	Varying clinical needs Diverging demands Varying demands Differing proximities to targets Default visiting Struggling GP appointments Failing social
Only five doctors. Three are locum or agency staff. Four junior doctors. Four nurses for the resuscitation room, two locum doctors and four nurses for majors and an SHO (junior doctor but not registrar yet) and a nurse for minors and one nurse for paediatrics. One of the nurses for minors also covers mental health patients. He also is the alcohol liaison nurse. One senior nurse oversees the nursing staff. Four nurses are also agency staff. A locum doctor and emergency nurse practitioner oversee minor traumas. The system is very fluid and separates out when demand is high in certain areas. Usually four ambulances arrive every hour. If all goes well it can take between 30 and 45 minutes to process (assess, imaging, review, treat/onward management) major trauma patients. At peak times, up to 25 patients can arrive per hour. The demand in majors, minors and paediatrics differ between them and at various times during the shift. Planning reduces bottlenecks and enhances the quality of the service.	allocating resources organising department streaming flow capacity planning fragmenting capacity segmenting potential demand balancing resources familiarising colleagues building teams getting to know scheduling creating cohesion leveraging resources tailoring resources to meet demand fast-tracking minors ticking over targets managing waiting room working with manager
The phone rings. It always rings. Nurse takes the call. Makes announcement. Major trauma. Car accident. Female went through windscreen. Ambulance will arrive in 20 minutes. Trauma team readies itself. All other plans get adjusted. Between 19h00 and midnight this phone will ring almost four or five times in an hour. This is the bread-and-butter of A & E. This is where people are rescued from the jaws of death. It is a time when managers and clinicians fight over priorities. Doctors trying to save lives and managers trying to meet targets. The A&E receives up to 150 ambulances per day. Some serious trauma or hyper acute stroke patients. Many are alcohol-related trauma and elderly patients with	Preparing Organising Priming Psyching up Setting up Advance warning Triaging Pre-warning Preparing response

Field Notes	Open Code Action Verbs (Gerund)
complex conditions.	Feeling pressured Bombarding Straining oneself Sweating blood
An intoxicated person fights with the vending machine because his money is stuck. He put the wrong coin in the slot. He calls out to the receptionist who ignores him. She probably has explained that the vending machine does not belong to the hospital. The vendor had been informed two days ago.	Side tracking Distracting Exasperating Malfunctioning Infuriating Lacking coherence Extending waiting time (not able to help staff) Requiring more from staff
An old lady lies on a trolley in the corridor. She has been there for a few hours already. She does have a heart condition as well as diabetes and mental health issues. Thus is the third time this week that she had been brought in by ambulance. Every time she had been unwell but not acutely so. However, she has to be checked out by the doctors to ensure that nothing is wrong and she has to be given a bed. It might take two days to sort her out despite her lack of life-threatening issues today. The manager is concerned about the target that is about to be breached. The doctors are already shouting that they are doing their best. They will get to her when they are able. The shift still has many hours to go.	Access/bed blocking Playing the game Waiting on trolley Bottlenecking Soaking up demand Delaying non-urgents Prioritising urgents Highlighting near-breaching Tying-up resources Competing norms Trading-off competing goals Preparing Organising Priming Psyching up Setting up Messing up targets Revolving through A & E Managing targets Routinely re-attending Unplanned re-attending Fast-tracking minors
Three young females have been brought in by ambulance. One has a severe head injury. She tripped on the steps to the underground train station and fell down a flight of 15 stairs. They clearly have had a bit too much to drink. It was a birthday that they are unlikely to forget soon. One of them seems rather loud and aggressive. She has a few scratches and a bruised eye. One shoe is still in her hand. The other one is just quietly sleeping it off. The last one is also worse for wear but apologises for having vomited on herself. She was not too well and says to whoever cares to listen that it was her birthday and they were at a club when a fight broke	Treating everyone Postponing judgements Varying demand Increasing demand Slow processing Exit blocking Reducing capacity Diminishing efficiency

Field Notes	Open Code Action Verbs (Gerund)
out. She had to defend her friend with the bruised eye. All of them were involved in a fight. On a busy night there can be about 50 to 60 alcohol-related violent injury attendances at the A&E i.e. almost half of A&E attendances can be related to alcohol. Proper examination of acutely intoxicated trauma patients can consume a lot of scarce resources – especially imaging studies to overcome diagnostic difficulties. Merely sobering up and stitching wounds are often insufficient.	Consuming monitoring resources Continuing demand Dissipating resources Depleting capacity Frittering away expertise
The phone rings. An 79-year old male. Acute abdominal pain. Ambulance expected to arrive within 20 minutes. The doctor who took the call asks the nurse to alert radiology that an abdominal scan could be needed. It might be a fatal aneurism. The trauma team readies itself again. They now have two patients being treated in the resus room. They have two more cubicles but do not have enough consultants, middle and junior grade doctors or nurses.	Preparing Organising Priming Psyching up Setting up Varying demand Watching targets Reserving resources Lengthening waiting times Increasing breaches Triaging demand Trading off-competing goals Stressing to keep up Entering the coping-only zone
A young drunken male, about 23 years old asks when he will be seen. There are doctors and nurses busy on computers, doing nothing whilst the waiting room is filling up. He has been there for six hours. He came to A&E because his GP could only see him after ten days.	Demanding attention Becoming aggressive Antagonising Annoying Ruffling feathers Misreading situation Jumping the queue Gaming the system Prioritising care Competing priorities Managing resources Managing ratios
It is only 12 o'clock. There are not any beds anywhere in the hospital and the A&E is full. Every area in A&E has patients. There are two patients in resus. In minors the junior doctor is stitching the finger of a teenage girl who cut her finger whilst peeling a pineapple. In the driveway are three ambulances with patients who are unwell but whose conditions are not life-threatening. The manager will only take transfer of the patients if it they are likely to be treated within target and the doctors will only treat them if their condition is clinically worse than anyone else who is waiting to be treated. A& E is relentless fire-fighting, prioritising, choosing and bumping.	Lacking systemic flexibility Balancing competing demands Resisting discursively Questioning legitimacy Competing values Ring-fencing system Prioritising Choosing Focusing on patient Undermining managerialism

Field Notes	Open Code Action Verbs (Gerund)
The junior doctors have the results of the urgent CT scan that had been requested for the patient with a severe head injury. The senior doctor suggests that they call the neuro-surgeon for a second opinion.	Auditing Reviewing Developing skills Calling expert help Managing information Utilising staff efficiently Idling resources Blocking flow Managing patient Processing targets Delaying exiting
01h00. Phone rings. Ambulance calls. Adult male. Gunshot wounds to the chest. ETA ten minutes. A team is assembled. Someone in another cubicle will have to wait just a bit longer. Perhaps someone more junior can take over and the more experienced clinicians could attend to this case, at least for the first twenty minutes. Hopefully the first patient will not complicate. There is always a continuum of criticality in A&E. One needs the more experienced clinicians when the situation is extreme and then the juniors can take over. However, juniors also have to be exposed to the extremes for them to learn. The operating creed learn, see, practice, prove, do, maintain. The short version is see one, do one, teach one. In A&E the short one seems more appropriate. The adrenalin is visible. The drill is automatic. The senior doctor says what is needed and the team gets everything ready. Everyone knows what to do. If only there were enough of them. The team gets ready, whilst some are still completing some tasks on other patients.	Organising Priming Psyching up Setting up Managing staff Bumping waiting times Prioritising Deploying staff Assembling teams Managing quality Teaching Heaving under Being on edge Working at limit Skating thin ice
The phone rings. The ambulance is on the way. Expected arrival time is three minutes. The pregnant patient giving birth already. The senior doctor guides the ambulance crew, reassures the family member on-board and prepares the team to receive the ambulance crew. Who can be bumped to clear a cubicle? Which doctor can be drawn to the receiving team? Which nurses can be pulled into this team? Who will be able to look after the rest of the patients, without compromising their care too much? The manager is shouting on the phone for a bed, anywhere in the hospital.	Organising Priming Psyching up Setting up Finding bed Failing to discharge Lacking staff Overcrowding Moving between locations (waiting room, assessment cubicle, radiology, observation, treatment, post-treatment) Handing over
The nurse practitioner in Minor Trauma calls the name of a man. He delivers pizzas he tells one of the other patients. He walks with a bad limp. A truck driver had turned and did not see him. The truck did not hit him but the motorbike fell over and his leg was caught awkwardly. He cannot afford to	Triaging Sharing stories Carrying injury Fretting, Worrying patient

Field Notes	Open Code Action Verbs (Gerund)
take sick leave. He is an immigrant and his family needs him to work. He only wants to know if anything is broken. The nurse practitioner checks him carefully. In A&E nothing can be taken for granted. This patient is so anxious to return to work that he might not be telling the whole truth about his condition. Ultimately, she concludes that the discomfort is due to a sudden movement and bruising of the soft tissue. He should be fine after a few days. She gives him painkillers and cream for the bruising. He waited for five hours and was diagnosed and discharged within twelve minutes. He thanks the nurse. The nurse practitioner is reminded that the waiting room is full.	Having to work Checking carefully Ignoring waiting-time target Delivering quality care Meeting needs Doing what's needed Competing expectations
In minors the junior doctor is treating a young man who had twisted his ankle whilst other procedures will follow. He had consumed too much alcohol and had fallen. His head had a big bruise. He had to wait for a CT scan to see if everything in his head is fine. He was not very helpful when the triage nurse spoke to him. A cut to his leg is from a bottle, in his hand, that had cracked as he fell. A big piece of glass, was already removed by the ambulance staff but X-rays are needed to see is there are fragments of glass in the soft tissue.	Staggering Delayed monitoring Delivering quality care Focusing on the patient in room Extending waiting times for others Stretching the staff
The phone rings. The ambulance will arrive from a neighbouring county. An evening rugby match between two private colleges. A serious injury to a male, 17 years old. Another clinical team needs to be assembled. There is not enough staff. This could be a neck or spinal injury. This could be serious. The senior doctor calls for his colleague who is on second call to please come to the hospital. Apologises for the inconvenience. It has just been unending. The staffs are mentally, physically and emotionally exhausted. They have been on their feet for four hours without even a toilet break. The clinical work has not stopped. But the fights with the blue-uniformed nurse-manager about the amount of time that is spent with patient. The waiting room is still full. Clinicians find this talk about targets, soul-destroying.	Preparing Organising Priming Psyching up Setting up Managing costs Bed-blocking Mismanaging discharge Delaying discharge Delaying transfer of care Increasing length of stay Unnecessary processing Mismanaging patient flow Needing beds Gridlocking patient flow Clogging up system Bursting seams Losing bed days Waiting-time pressures Managing staff Delivering quality care Managing information
A young couple brought their baby son to the hospital. He has had diarrhoea for two days and started vomiting in the morning. He also has a high fever. The parents did not want	Worrying Seeking help

Field Notes	Open Code Action Verbs (Gerund)
to bring him immediately but they needed assistance because he seemed not to be getting better. The paediatric nurse practitioner and the junior doctor would examine him and just check with the senior consultant before making a final decision, should it be needed. Paediatric A & E normally see children with breathing problems, fever, diarrhoea, vomiting, abdominal pain and rashes. The paediatric nurse practitioner is very experienced. The hospital has recently become a major adult trauma referral centre and that has resulted in an unexpected yet significant increase in paediatric trauma cases. Road traffic accidents and falls are most common. Most paediatric trauma does not result in hospitalisation or referral to another speciality. More serious cases require imaging, emergency admissions and beds. A 24-hour paediatric observation unit attached to the A&E is used and avoids hospitalisation in wards. There is pressure on elective paediatric beds already. Luckily this baby appears to have only a viral infection. The paediatric nurse and junior doctor agree that the parents should observe him for a further 36 hours. If there is not an improvement then they must return the hospital without delay. The parents are happy with the extensive and unhurried examination of their child. They have struggled for the pregnancy. A child coming into A&E seems to be different from an adult.	Examining Diagnosing Discharging Reassuring Emotionally draining Delivering quality care Taking necessary time Extending waiting times Getting lucky Not consuming may resources Providing leap-frogging card Pleasing family Breathing with relief
The junior doctors are waiting to discuss their patients with the consultant. They are developing their skills and confidence in dealing with acute mental health conditions, cardiac arrests, collapse, elderly falls and acute back and abdominal pains. They also develop their competence in doing suturing, ECGs and reading radiology images under pressure. However, they have been waiting for thirty minutes. Their patients are still in A & E and not completely diagnosed, treated and discharged. The waiting lists are getting longer. Teaching takes place when the patient is received, the diagnosis is made and the junior doctor wants to confirm a treatment decision. There was not much teaching tonight. Over weekends it happens more often than not. Junior doctors have increased decision-making and unpredictable workloads in A&E. The junior doctors see about 2 patients per hour. Any delay will have knock-on effects.	Suboptimal supervising Working at the limits Developing competencies Teaching Progressing patient management Conflicting goals i.e. teaching and productivity Meeting targets Processing patients Self-learning Slowing flow Bottle-necking Overrunning Submerging Engulfing
One of the locums is new and to contribute. The clinical issue be it trauma or hyper acute stroke issues are fine. It is about everything else that makes it possible to care for the patient that this doctor was unable to do well enough. New people take a few days to work things out. This place has a high turnover of locums. It is a tough place to work. It is built for 90 000 A&E attendances. It receives 140 000. Then it has a shortage of beds in every department. There is also a 60% shortage of permanently employed A&E consultants and locum and agency staff, fill in some of the gaps in the rota. Middle grade and junior doctors do not like working here	Inducting on-the-job Swimming against current Over-burdening Not fully contributing Extending waiting times Learning operating procedures Taxing the staff Demanding workplace Unrelenting work

Field Notes	Open Code Action Verbs (Gerund)
because they do not have much teaching and the pace is relentless. Nurses also choose to be locum or agency staff because it is just too hard to work here. The rota makes a life outside the hospital impossible.	No hiding place Unforgiving demands Unbalancing work-life

APPENDIX 12: EXAMPLES OF EARLY MEMOS

All names within these memos have been changed to ID codes, to preserve anonymity

A1512-7 MEMO 7 THE EXISTENTIAL PAIN 15 April, 2012

Throughout it was painful to see a broken doctor who was prepared to speak, yet so fearful and fragile.

A2312-3 MEMO 3 THE SYSTEM ALWAYS FIGHTS BACK 23 April, 2012

Openly fighting managers does not pay. Must learn to defend professional independence. Survival is the key. Managers come and go.

Has not given up the fight but working at how to deal with patients and limit the impact of managers.

J3013-17 MEMO 17 EXITING NOT AN OPTION 30 June 2013

Re-reading the field notes one notes how many times there are references to the grass not being greener elsewhere. Participants have to find ways of sticking it out and defending the interests of patients and themselves within the constraints. "Doing best for patient and defending yourself" are almost always linked. They cannot leave the arena. How they achieve these two goals varies from person to person.

S1213-20 MEMO 20 RANGE OF COPING OPTIONS 12 September 2013

Resigning, working within the system, taking up clinical leadership roles to defend profession and patients, waiting it out until retirement, waiting it out and doing what is required, fighting back and not giving in, taking up clinical management position to hold the line, thinking of leaving the country, waiting it out and practising defensive medicine, doing what you can, staying below the radar, gaming the system, looking out for number one, building coalitions, protecting self by fighting in shadows, following diktats, going with the flow, not fighting, obeying whilst cursing, calling to obeying, hitting brick walls, manipulating system, bending rules, winning managers over, persuading not fighting, using female touch, using spaces, focusing immediate tasks, gaming system, engaging under-handedly, concentrating own patch, ring-fencing commitments, focusing on patients and colleagues, struggling workload, sinking workload, feeling powerless, looking out for self, hoping for better days, practising safe medicine, flowing protocols, taking management responsibility, challenging quietly, playing poker, falling apart, working constantly, ignoring targets, focusing patient, doing best, staying positive, looking on bright side, fighting my corner, following guidelines

APPENDIX 13: EXAMPLE OF PROCESS OF ABSTRACTION FROM FIELD NOTES TO FINAL CONCEPT

Field Note	Open Coding	Selective Coding	Final Concept
Management model is problem	Fighting back; Undermining systemically	Subverting	Resisting
Management comes and goes, Consultant for has a job for life.	Slowing down managerialism	Quibbling	Resisting
* Multiple indicators from field notes would be guided by the five basic questions for open coding (Section 3.6.2.1). Note the increasing abstraction from empirical detail to concept.			

A0713-10 MEMO 10 DIMENSIONS OF RESISTING 7 AUG 2013

Both subverting and resisting are at the resistance end of the resistance-compliance continuum. However, subverting seeks to strike big body blows at the key pillars of the management model with its focus on performance management and standardisation of clinical practice. Quibbling is also at the resisting end of the spectrum. However, the quibblers aim to put spokes in the wheels. They want the managerial train to be bogged down in details.

APPENDIX 14: MAIN CONCEPTS IN THE THEORY

ROLLING WITH THE PUNCHES	
	OBSERVED PATTERNS OF BEHAVIOURS
	STABILISING TEMPORARILY
	RESISTING
	• Quibbling
	• Subverting
WEIGHING UP	
• Making sense	**LIMITING THE IMPACT**
• Deciding what to do	• Lying low
• Mode-shifting triggers	• Faking it
	ADJUSTING TO CHANGE
	• Going with the flow
	• Complying substantially
	• Complying fully
	• Waiting it out

APPENDIX 15: COMPARISON AND CONTRAST BETWEEN CLASSIC AND OTHER VERSIONS OF GTM (adapted from Jones and Noble, 2007: Table 1; and Mills et al., 2006)

	Classic GTM	Straussian GTM	Charmaz (in Denzin and Lincoln, (Eds.) 2000; 1995)	Clarke
Ontology and Epistemology	"Truth" emerges from data Multiple viewpoints but there is indeed an over-arching social reality and latent pattern of relations. Researcher "a distant expert" (Charmaz, 2000, p.513). Meaning inheres in things in the world.	Truth is enacted "1994: no pre-existing reality out there"	Consensus theory of truth. Truth can be local, relative, and historicised, situational and contextual. Perspective and values of the observer influences what is seen. Data is theoretically saturated. Reality is not objective and unitary but relative and multiple and constructed inter-subjectively. Data not a window to reality (2000, p.254). Interaction researcher and participant produce data (1995, p.35). Researcher and participant co-producers of experience and meaning.	Researcher becomes analyst, bricoleur of sorts, cartographer. Knowledge is socially and culturally produced all knowledge is local, historicised and in flux (2003, pp. xxiv-xxv). Knowledge bears the inscriptions/"scars" (p.xxxviii) of its production process. Claims of universality considered naive and hegemonic practices that silence voices on the margin or periphery. Traditional GTM lacks attention on reflexivity of research process; over-simplification of negative; searches for grounded purity rather than accepting the messiness and situatedness of subject and object.
Emergence and Researcher Distance	Discover "truth" that emerges from data. No preconception or forcing. Trust in emergence. Correct use of method reduces impact of researcher.	1987, 1990, 1998. 1994: Truth is not out there but is enacted. Multiplicity of truths and perspectives. Researcher uses prior knowledge to enhance theoretical sensitivity. Logical deduction and preconception allowed to shape theorising.	Researcher enters the research with a host of assumptions and needs to be reflexive about that. Does not enter as a blank slate. Have an open mind. Be theoretically agnostic (from Henwood and Pidgeon, 2003). Discovering an external reality, assumptions about truth and accuracy and a neutral unbiased observer are problematic, especially after the postmodernist turn. 2000: Not one	Emphasises the situation (temporal, spatial) of action. Requires enhanced researcher reflexivity and accountability. Analyses and provokes the study of power, difference and inequity. Make silences speak, which raises issues of researcher accountability.

	Classic GTM	Straussian GTM	Charmaz (in Denzin and Lincoln, (Eds.) 2000; 1995)	Clarke
			true reality but multiple realities. 2005, 2006 move from human perspective towards pragmatism (especially its interpretive and democratic aspects) considering non-human actors like institutions and organisations.	
Development of Theory	Aim of GT is to generate a conceptual theory that accounts for the pattern of behaviour that resolves the main concern for participants.	1987. Conceptually dense integrated theory the goal of GT. 1990, 1998: Generation of theory not sole aim. Conceptual description allowed. Theories are interpretations (1998, p.5).	2000: GT tells a story about people, social processes and situations. The research product is not a constitution of the reality of participants but is an interpretation, among multiple interpretations. Bring narrative/voice of participants to the fore (2000, p.256).	The goal is to tell the most interesting analytic stories, accounts of BSPs. An analysis is but a perspective and rooted in its situation (p.xxxix). Outcome is "thick analysis", takes full account of the situation rather than a basic social process (p.xxii). Voice, context, discourse, text and power. Grounded Theorising as opposed to theory.
Procedures: Mandatory/Optional etc.	GTM is a full package. All procedures are mandatory.	1987: All GT procedures are mandatory. 1990, 1998: Some procedures and techniques are optional, depending on the "tastes" of the researcher (1998, p.8). Techniques promote theoretical sensitivity.	Coding, memoing, theoretical sampling are useful techniques and can be used in a variety of theoretical frames.	Remodels GTM with situation analysis (informed by part-structuralism [Foucault]) (2003, p.xxx). Argues that: Classic GTM is naive, Straussian does not capture full situation of phenomenon of interest, Charmaz's constructivism is an improvement on Strauss. Three types of maps: Situation maps capture complexity (rather than simplification classical GT). Social worlds maps: institutional, organisational factors Positional maps: positions taken. Researcher is implicated in drawing maps. Aim to make invisible visible. Electrical pies and conduits

	Classic GTM	Straussian GTM	Charmaz (in Denzin and Lincoln, (Eds.) 2000; 1995)	Clarke
				normally hidden. Extended critique of conditional matrix (attempt to ground GTM in situation) to making the situation itself the unit of analysis.
Core Category	The theoretical construct that resolves the main concern of the participants and the goal of GT is to generate a core category. Will always emerge (1978, p.95) Classic GT is about the discovery of a core category.	1987: GT revolves around a core category that resolves the main concern of participants. But a main story line, main theme, story line or trajectory. 1990, 1998: Core category replaced by main idea (1990, p. 121), main problem, and primary issue, what seems most striking, central integrative concept. Acknowledges role of researcher in constructing narrative (1994, p.281).	1991: One care category, process not necessarily an outcome. Most important processes are tacit (2004, p. 982).	
Coding	Discover latent patterns. Substantive (open, selective) and Theoretical coding with 18 coding families (Glaser, 1978). Theoretical codes are conceptual connectors to develop relationships between categories and their properties (1992, p.38).	Open, Axial and Selective 1987: selective coding based on memo sorting and integrative diagrams. 1990: selective coding using the coding paradigm focuses on one theoretical code the "Six C's". 1998: p.129 De-emphasise coding paradigm as guide not mandatory and integrative p.199 conditional/consequential matrix. Focus on interactions. Brings broader context into analysis. Integrative diagramming and flowcharts to demonstrate complex interplay.		Like GTM since 1967. Situation maps augment basic coding.
Literature	No need to review substantive literature at beginning of study (1992, p.31).	Literature from beginning of study will promote theoretical sensitivity (1998, p.15).	Blank slate is impossible. Have open mind. Theoretical agnosticism is useful.	No researcher is a tabula rasa. Researcher should be transparent and accountable about knowledge production.
Logic of enquiry: Deduction, induction and abduction	Inductive	Inductive	Bryant argues for abduction.	Categories are inductively derived.