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The role of professional elites in healthcare governance: Exploring the work of the medical director

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ABSTRACT

Medical leaders occupy a prominent position in healthcare policy in many countries, both in terms of the governance of quality and safety within healthcare organisations, and in broader system-wide governance. There is evidence that having doctors on hospital boards is associated with higher quality services. What is not known is how they have this effect. Analysing data collected from observations, interviews and documents from 15 healthcare providers in England (2014–2019), we elaborate the role of medical directors in healthcare governance as ‘translation work’, ‘diplomatic work’, and ‘repair work’. Our study highlights the often enduring emotional effects of repeated structural changes to clinical services. It also contributes to theories of professional stratification, showing the work of medical directors as regional ‘political elites’, and as ‘corporate elites’ in publicly-funded healthcare systems.

Author contribution

Lorelei Jones: Concept and design of study, data collection, Formal analysis, drafting of manuscript and approval of manuscript. Naomi Fulop: Concept and design of study, Formal analysis, drafting of manuscript and approval of manuscript.

In many high income countries healthcare policy allocates ‘medical leaders’ a prominent role, both in terms of the governance of quality and safety within healthcare organisations, and in broader system-wide governance. There is evidence that medical leadership is associated with healthcare quality (Clay-Williams et al., 2017). Research from the US has found positive relationships between medical involvement on boards and both financial and service quality outcomes (Molinari et al., 1995; Prybil 2006; Goodall 2011). Similarly, a study from the NHS in England found a significant positive association between the proportion of doctors on the board and the quality of the service provided by the organisation (Veronesi et al., 2013). It is not known how doctors on the board have this effect, although it has been suggested that positive effects are down to doctors’ knowledge in relation to the ‘core business’ of the organisation, which may help with decision-making and strategy (Goodall 2011), and the potential for medical leaders to engage doctors at all levels in quality improvement initiatives (Weiner et al., 1997).

This paper explores the work of Medical Directors in healthcare

governance. While the term ‘governance’ has been used to refer to the workings of inter-organisational networks (Rhodes 1996) we use it in its broader sense, following Bevir:

Governance refers to all processes of governing, whether undertaken by a government, market or network; whether over a family, tribe, corporation, or territory; and whether by norms, power, or language. Governance is a broader term than government because it focuses not only on the state and its institutions but also on the creation of rule and order in social practices. (Bevir, 2013, pi).

An analytical perspective that captures the interactions between multiple actors and arenas, and both formal and informal processes, provides a fuller and richer understanding of the way welfare services are governed in the 21st century. Our focus here is on the everyday activities and interactions of Medical Directors, looking in particular at ‘translation work’, ‘diplomatic work’, and ‘repair work’.

1. Background

Medical Directors form part of the senior management team at the apex of a healthcare organisation. Healthcare organisations are characterised by the intellectual nature of the primary tasks with control exercised through training and standardisation (Fitzgerald et al., 2013). They are inherently pluralistic with divergent objectives and distributed

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power (Denis et al., 2001). Public-sector healthcare providers, in the UK, and elsewhere, contain different belief systems, both managerial and professional, that coexist and at times conflict (Degeling et al., 2001). The NHS in England is further characterised by an organisational and political context that is resource constrained, turbulent, and highly policy dependent (Kislov et al., 2016). Healthcare services are often provided not by a single organisation, but by networks of organisations (Osborne et al., 2013), necessitating planning at a regional level, and coordination of a range of stakeholders.

In policy and organisational strategy clinical leaders are seen as essential for 'making change happen' (Ferlie 2016). In recent years 'leading service change' has also been recognised by the medical profession as a core role for doctors and incorporated into accounts of medical professionalism (Royal College of Physicians 2018). Service change is an enduring feature of the healthcare field, driven in part by technological developments (Straus et al., 1985). The current ubiquity of service change is often attributed to the influence of managerial ideas, values and techniques that spread throughout the health systems of high income countries in the 1980s and 1990s (Ferlie et al., 2016). In England, local healthcare organisations have faced sustained policy pressure to reorganise services to improve efficiency and outcomes (Fitzgerald et al., 2013). While some change programmes are introduced in a single hospital, many are introduced by regional planners and are aimed at rationalisation or redesign of clinical services across multiple organisations (Jones and Exworthy, 2016). A similar policy context for healthcare organisations is evident in other countries (World Health Organization, 2018; Denis and Van Gestel, 2016; Lega and Sartirana, 2016; Rotar et al., 2016).

Sociological scholarship has positioned Medical Directors within the restratification of the profession (Friedson 1985; Waring 2014). Friedson's (1985) thesis was that the emergence of 'knowledge' and 'administrative' elites in the medical profession could be understood as a strategic response to new forms of bureaucratic control in the workplace. Restratification served to maintain collective power and autonomy in the face of increasing bureaucratisation of professional work. While knowledge elites, such as those employed in the production of academic research and clinical standards, maintained professional control over the content of work, administrative elites, involved in planning and supervising the work of their rank and file colleagues, served to retain control over the organisational context of professional work.

More recently Waring (2014) has updated and extended Friedson's categories, to encompass *political elites*, *knowledge elites*, *corporate elites*, *managerial elites*, *governance elites*, and *practice elites*. In Waring's analysis, Medical Directors are a form of 'managerial elite', an evolution of Friedson's 'administrative elites', 'reflecting the widespread and pervasive influence of management theories, ideologies, and practices in the contemporary organisation of expert work' (2014, p700). According to Waring, 'in contemporary public discourse, managerial elites are also those defined as 'leaders' and often presented as transforming professional services in the absence of 'management' (2014, p700). Waring's analysis echoes Martin and Learmonth's (2012) account of a discursive shift, over the previous 15 years, from 'administration' to 'management' to 'leadership'. At the same time the term 'leadership' has been applied to increasingly heterogeneous actors. Martin and Learmonth suggest that the contemporary emphasis on 'clinical leaders' in policy discourse can be understood as an effort to reconstitute professional subjectivities, 'a co-optive means of 'governing at a distance' that complements more coercive modes of rule such as performance management' (Martin and Learmonth 2012, p283).

Professional-managerial 'hybrids' bring together what are often seen as contradictory logics, for example, a professional concern with quality and humanity with a managerial concern for efficiency and profitability. Empirical studies in organisational contexts have produced a range of different accounts of the development, and response to, professional-managerial hybrids, including managerial control of the profession;

co-optation; strategic adaptation; and professional opposition (Numerato et al., 2012). McGivern et al. (2015) distinguish between professionals who take on hybrid roles reluctantly and those who do so willingly. 'Incidental hybrids' take on a hybrid identity temporarily, through a sense of obligation, maintaining traditional professional norms. They use their position to protect or 'buffer' (Friedson, 1994) professional colleagues from managerial intrusion. In contrast, 'willing hybrids' take on a permanent hybrid identity. Willing hybrids use their position to challenge what they see as 'outdated professionalism' and promote a hybrid professionalism aligned with their hybrid identity and their managerialist healthcare context. In McGivern et al.'s sample, mid-level Clinical Directors were more likely to be 'incidental hybrids' while board-level Medical Directors tended to be 'willing hybrids'.

Recently Noordegraaf (2015) has argued that changes in the societal and organisational context of medical work have resulted in professional identities that have moved 'beyond hybridisation'. Medical professionals must now implement innovation, cooperate with other team members, and, as their careers progress, develop services with strategic and budgetary constraints in mind, all the while accounting to external stakeholders. In the process, 'organizing' has become an integral and 'natural' part of professional action and professional identity. Others have suggested that it is the very 'naturalness' of this professional identity that makes it a potentially effective conduit for government. Martin and Learmonth (2012), for example, suggest that it is partly through these new subjectivities of 'clinical leaders' that governmental objectives are accomplished.

While there has been considerable empirical and conceptual research on professional-managerial hybrids, this has, to date, focused on lower tiers of hospital management, and on the implications for professional autonomy and influence. There has been very little research on board-level hybrids and their role in policy implementation, service change, and quality improvement. In addressing this gap we ask, what forms of work do Medical Directors do, both within and outwith their organisation? What forms of interaction and connectivity are established with (a) other doctors, (b) other professionals, and (c) external stakeholders e.g. patient groups, commissioners and representatives of regulators and the NHS hierarchy?

1.1. Approach

Our approach draws on the sociological literature on work (Strauss et al., 1985; Bechky 2011). Sociological studies of work involve a close analysis of the actions, interactions and negotiations amongst social actors, focusing on what actually happens in real-world settings. This approach views action as relational and embedded in social networks (Crossley 2011). The implications for methods is a focus on the materiality and language of work, 'engaging in direct encounters with organisations by watching how people do what they do and listening to what they say about what they do' (Bechky 2011, p 1162).

We ground our analysis in data collected as part of a mixed methods study of the governance of quality improvement in hospitals undertaken between March 2014 and January 2019 (Jones et al., 2017). The research initially involved 60 h of observation of hospital board meetings in 15 organisations (12 acute care providers, 2 mental health providers and 1 community care provider), and 70 in-depth interviews with members of the senior management team, such as Chief Executives (4), chairs (4), Medical Directors (6), Directors of Nursing (6), Executive Directors (7) and Non-Executive Directors (9). We also interviewed two Associate Medical Directors, two Clinical Directors, and two leads for quality improvement. Participants were interviewed in 2014 and again in 2015 or 2016 (if still in post). We also analysed a range of documents, including annual reports, performance reports, strategy documents, reports prepared for external regulators, and meeting papers for executive board meetings, internal committee meetings, and regional planning meetings.

Our initial analysis developed a measure of quality improvement

maturity and compared the characteristics of organisations with a 'high' quality improvement maturity with those with a 'low' quality improvement maturity (Jones et al., 2017). We found that a key difference related to the activities of board-level clinical leaders. We therefore extended the research to include a period of time spent shadowing a Medical Director in an organisation with high quality improvement maturity (60 h). The shadowing element of the research enabled us to explore our initial findings in greater depth, and to compare the findings from the shadowing element with those from the broader study.

LJ shadowed the Medical Director on various occasions between December 2017 and August 2018, with a follow up visit in January 2019. Shadowing has been used previously to understand the way chief executives in NHS organisations find and use knowledge (Nicolini et al., 2014). Opportunities for shadowing were suggested by the Medical Director and included hospital board meetings, internal meetings, regional planning meetings, meetings with external agencies, and an internal organisation-wide quality improvement conference. There were also informal events and social occasions, such as coffee, lunch, and a party for a member of staff who was leaving the organisation. In addition to observation, the shadowing element included informal conversations and three formal interviews (one at the beginning of fieldwork, one at the end, and one six months after completion). As with the Nicolini et al. (2014) study, there was also a feedback session, at the request of the Medical Director, to enable him to use the experience as a development opportunity.

In the sociological tradition of 'policy ethnography' (Griffiths and Hughes 2000) fieldwork involved arriving early, leaving late, and generally 'hanging around'. The aim was to glean a more rounded picture of the work of the Medical Director by including chance encounters with a range of social actors and access to informal arenas for interaction. In total, the data set we draw on relates to 40 Medical Directors across 37 healthcare organisations in England.

The aim of analysis was to develop theoretical connections, grounded in observation of individual action of people in an organisational context and showing how effects are produced (Hedström and Swedberg, 1996). We followed the recommendations of Timmermans and Tavory (2012) for fostering abductive analysis, revisiting the data on several occasions, attempting to 'defamiliarise' what might otherwise be taken for granted, and considering the phenomena in the light of existing theoretical accounts. Analysis was facilitated by taking detailed fieldnotes, recording and transcribing interviews, coding, and writing analytical memos. By 'coding' we mean marking incidents of data we thought might be relevant to our emerging interpretative categories (Becker and Greer 1960). Fieldnotes were written by hand in notebooks at the time of observation or shortly after informal conversations and social events.

Analysis was led by the first author and was prospective and continuous. LJ wrote analytical memos during fieldwork and while reading through transcripts and fieldnotes. These memos were expanded and refined following discussion with the second author and further data collection. The developing theoretical account was shaped by our existing knowledge of potentially relevant social science literature, additional reading, discussions with other scholars, and feedback from conference presentations.

The inspiration for the key analytical categories of 'translation work', 'diplomatic work' and 'repair work' was Straus et al.'s (1985) conceptual elaboration of the different types of work entailed in the illness trajectory of a patient, such as the 'articulation work' required to coordinate tasks carried out by different types of worker. The descriptors were selected from everyday English-language vocabulary, to capture our interpretation of what the actors in our study were accomplishing in their everyday work, how this contributed to corporate objectives, such as service change, and how this was facilitated by actors' 'hybrid' status as both managers and doctors.

The category of 'translation work' was developed during the first

stage of research, across all 15 organisations (Jones et al., 2017). The shadowing element enabled us to confirm and extend this category, and to generate the additional categories of 'diplomatic work' and 'repair work', which were then considered and refined against data collected from the broader study. An opportunity for member validation arose when we were invited to present the research at a workshop hosted by the UK Faculty of Medical Leadership and Management as part of their 2020 annual conference. The workshop was attended by 12 Medical Directors and all responses from participants indicated that the findings resonated with their experience.

Ethical approval was obtained from UCL Research Ethics Committee. The study received exemption from NHS Research Ethics processes. Informed consent for interviews was obtained from all participants. We have anonymised the organisations in the study and use a pseudonym (Stephen) for the Medical Director who agreed to be shadowed.

1.2. Translation work

In organisations with a 'high' quality improvement maturity, Medical Directors translated between domains and forms of knowledge. One location of this translation work was the monthly meeting of the board. Hospital boards typically have between 10 and 15 members, made up of executive and non-executive directors. Overall leadership resides with the chair. The Chief Executive leads the executive team with each member usually responsible for a specific function such as 'finance' or 'human resources.' Non-executive directors are charged with holding the executive team to account. Executives and non-executives are expected to work together to develop organisational strategy (Chambers et al., 2013).

Board meetings are characterised by a large volume of meeting papers, often running to hundreds of pages, containing data on financial performance and quality and safety in the organisation. These data are routinely collected, analysed, summarised in graphs, and collated in reports that are then circulated to board members. In organisations rated 'high' in terms of quality improvement maturity, the Medical Director would translate data for other members of the senior management team, both in written narratives at the beginning of reports, and verbally during meetings. Drawing on their medical training, or on additional training in quality improvement undertaken as part of continuing professional development, they would draw attention to any significant trends. From their knowledge and experience of front-line clinical work, and their communication with clinical staff on the wards, they would contribute additional analysis, identifying causes and consequences, and suggesting remedial courses of action. For example, during one board meeting Stephen presented a report of a mortality review (a process of establishing and monitoring numbers of inpatient deaths). He explained to the board the technical practice of risk adjustment and gave guidance on how to interpret the data.

Medical Directors also translated findings from recent research and academic papers. For example, during one meeting Stephen advised the board on the relative benefits of different measures of mortality, referring to papers written by clinical academics and published in the British Medical Journal. During board meetings, and other occasions, such as internal meetings and seminars, Medical Directors would also interpret developments in national healthcare policy, and the activities of various external agencies, distilling the implications for the organisation and for the work of front-line staff. At times this translation work could be quite literal, as a chair of the board of the hospital where Stephen worked admitted. The chair came from the financial sector. He described how during meetings Stephen would sit next to him, lean over and whisper in his ear, explaining healthcare acronyms and who people were when their names came up in discussions.

In contrast, in organisations with a 'low' quality improvement maturity, this translation work was often missing, as when there was no Medical Director in post, or withheld. For example, in one organisation a Medical Director appeared, during observation of board meetings, to be

primarily concerned with verbal 'sparring' with the chair, and putting a 'positive spin' on data that related to a service development programme he was overseeing in the organisation. Another Medical Director provided graphs with no explanation of how to interpret them, and appeared hostile and uncommunicative during meetings, both in verbal and non-verbal forms of communication. The following is from fieldnotes:

The chair asked a question about a graph of mortality statistics where it appeared to look worse in January. There was a pause and then the Medical Director said (in a tone of voice that might be interpreted as hostile or condescending) only 'regression to the mean'. The Medical Director was seated side-on to the table and did not look directly to the chair when he spoke. There was then another long pause. The Medical Director offered no further information and the chair appeared unsure how to respond. This interaction appeared to me to be unhelpful (in helping the board to understand). Finally the Medical Director elaborated with 'you can see a little trend here or there but they are single numbers with of no statistical significance'. (March 2016).

1.3. Diplomatic work

Much of Stephen's day-to-day work involved what we term here 'diplomatic work'. This involved sensitive and tactful dealings with doctors at different levels of the organisation informed by knowledge of professional norms, cultural differences between specialties and professional groups, and routine working practices. To illustrate, one day Stephen's work was dominated by complaints from medical staff about the introduction of an electronic sepsis alert tool. Sepsis is currently the focus of a number of national and local quality improvement initiatives, including the introduction of tools that are added to electronic patient record systems to alert staff to a potential sepsis diagnosis. On this day the introduction of the alert to existing work flows had caused, as Stephen described it, 'massive upset'. According to Stephen, it had been introduced by a manager without a clinical background who did not understand the politics. Stephen went on to explain that sepsis was a contested diagnostic category among medical staff. While some specialties, such as Accident and Emergency and Intensive Care, recognise it as a distinct diagnosis, other specialties understand the phenomena as the deterioration of a patient with an underlying infection. The non-clinical manager had also failed to understand professional norms, such as the importance of clinical autonomy, and of maintaining control over how their work was 'described, defined, sequenced, valued and evaluated' (Degeling et al., 2011):

People got upset here about the sepsis alert, that caused more angst because it's a bit irritating but also because, interesting, it was perceived differently by different groups. So A&E don't mind. A&E believe in sepsis. The medical teams don't really believe in sepsis. They think it is a concept being imposed on them by A&E and intensive care and that's not the proper diagnosis because the proper diagnosis is pneumonia or whatever. And so the alert was just badly worded. So the alert comes up and says, you know, 'sepsis alert' and what it means to say is 'deteriorating patient alert, please go and use your excellent clinical judgement to decide if this is sepsis or some other cause of a deteriorating patient.' ... It's that framing of it - makes them feel like their autonomy is being insulted basically.

The sepsis alert had also been introduced in a way that 'did not make sense' in terms of routine work practices:

... to be fair it's really irritating because it keeps popping up and it's very hard to get it in the right place in the workflow where it will pop up for people who need it and already know enough to answer the questions so in order to get it to pop up at all we have to pop it up before people know the answers which is irritating

The non-clinical manager who had introduced the sepsis alert had not been sensitive to these political issues. In contrast, when Stephen introduced changes to working practices he was careful to do so in a way that did not make staff feel, 'that they were being done to'.

About three quarters of medical directors in the NHS retain some clinical commitments (Monitor 2014). Stephen did no clinical work but his professional status nonetheless continued to afford him legitimacy with the senior doctors in the hospital. This is illustrated in the following extract. Here again we see Stephen's knowledge of professional norms and values, in this case doctors as clinical purists (Degeling et al., 2001):

LJ: And does it help being a doctor?

Stephen: With doctors? Yeah absolutely. It's almost, it's still with some of them, essential. They're not going to listen to someone who's not a doctor. And also they've got that higher purpose sort of trump card, so yeah I think in order to move them you do need to be a doctor. And they need to believe, and they don't always, they need to believe that you're on the side of the good guys and trying to do something sensible.

Being a doctor helped Stephen to engage clinicians who had previous experience of multiple initiatives that had been abandoned, or replaced by something else, and as a result had become cynical or wary of becoming involved in further change initiatives. As Stephen explained during an interview:

What the urgent care doctor was saying is 'this is the sixth time in two years where I've been pulled out of the actual work to come to focus groups to put 'post its' on [mimes sticking a 'post it note' onto the wall] ... you know. So some of it is just getting people to just hope, if you know what I mean, because they're wary of, they've been let down before.

Stephen saw his ability to influence clinicians throughout the organisation as key to his effectiveness in his role:

There's an element of trying to keep enough of them onside at any one time, because if you lose the consultant body you're no longer effective. So that is an issue because traditionally they saw it as almost like a trade union rep and that's certainly not how I see it ...

What is interesting about this data extract is that it suggests that the role of the Medical Director may have changed over time. Previous research on governing boards in the NHS represent doctors as reinforcing professional dominance and advancing the interests of their individual specialty (Addicott 2008). In contrast, we found that in organisations with a 'high' quality improvement maturity the medical directors exhibited a corporate orientation, focused on the goals of the organisation, and actively contributed to organisational strategy. In board meetings the Medical Director was visible and vocal, sitting, for example, next to the chair, and contributing throughout the meeting on a broad range of agenda items. Interview accounts also suggested that Medical Directors in these organisations had an interest and competence beyond their clinical area of expertise, in areas such as organisational transformation, financial performance, quality improvement, and workforce. In contrast, in organisations that we had rated as having a medium or low quality improvement maturity, where there was a Medical Director in post, they were less vocal during meetings, restricting their contribution to a more narrow clinical remit.

Stephen was very much a 'willing' hybrid (McGivern et al., 2015), interested in general management, and an aspiring CEO. At the same time he retained a strong professional concern for clinical quality. His 'favourite part of the job' was pursuing this through service redesign. In his day-to-day work he expressed sympathy for the experience of doctors in the organisation, whose departments had been affected by previous cost cutting exercises, and during meetings was often observed to 'balance' managerial perspectives from non-clinical executives with a

professional perspective.

One way in which Stephen engaged other doctors in the organisation was through visual representations of data analysis. For example, he had introduced, for each specialty, a review of the service. Stephen showed the clinical leads for each specialty a report on their service containing tables and graphs that summarised the performance of their service on a range of measures, such as length of stay, income, market share and so forth, benchmarked against other organisations in the country. Stephen's approach was informed by an understanding of cultural traits, specifically a resistance to top-down performance management, but a willingness to engage with peer-led data analysis, especially its visual representation (Coleman et al., 2009). This approach had positive results in terms of the divisions subsequently working to improve their performance on these measures.

In organisations with a 'high' quality improvement maturity, the work of medical directors was embedded in long-standing relationships and social networks across the region. For example, when they had meetings with regional NHS managers; external regulatory agencies; and other healthcare organisations, they were often with people they knew very well, often people who they had worked very closely with in previous roles. Indeed one day during fieldwork LJ stopped to chat to a regulator who was visiting the hospital for a meeting with Stephen. LJ had met the regulator earlier in the study, working closely with Stephen in a different guise. As Stephen observes below, good relationships across the region were an important antecedent for inter-organisational collaboration and cooperation, fostering trust and reducing conflict:

I know both the [regional] Medical Directors reasonably well. I know [regional health education agency] well. All of those are important when there's a problem in the sense that people pick up the phone instead of something [...] I think they're important in stopping problems escalating inappropriately and just sort of dampening, just keeping people calm until you can get to a sensible decision about what a problem is and isn't.

According to the lead for quality improvement, a good relationship with the commissioner had enabled Stephen to negotiate dedicated funding for quality improvement activity in the organisation.

Stephen spent a lot of time maintaining relationships. For example, he would stay behind after board meetings to chat with the non-executive directors. His relationship with the director of nursing appeared friendly and supportive. In contrast, another medical director in the study, one that worked in an organisation that we rated as 'medium' for quality improvement maturity (and was rated 'requires improvement' by the regulator), had poor relationships with other members of the board. In an interview, the Director of Human Resources referred to 'a lack of connection' between the Medical Director and the Director of Nursing that had stymied the development of the quality improvement strategy, a remit which was shared between the two clinical leaders. They also referred to a 'difficult' relationship with the Director of Operations:

I think [Director of Operations] doesn't feel as tightly joined to the Medical Director as he would like to. So there's a few issues. And I think that shows, doesn't it? It's a bit like if the HR Director and the Medical Director don't work, then you lose HR and recruitment and management, and if the HR Director and Ops Director can't work together, you lose stuff again ... So there are all sorts of relationships that need to work and the Medical Director and Ops Director is one.

Another aspect of diplomatic work was public relations on behalf of the organisation. One location for this work was the board meeting. In the NHS in England boards meet in public. Most of the meetings LJ attended attracted only a few members of the public, perhaps one or two, together with individuals holding formal positions, such as governors, or representatives of the local Health Watch (a body with responsibility for democratic participation in healthcare planning). There

were exceptions, such as when the board meeting was targeted as part of an organised community protest against organisational policies or plans (especially plans to close clinical facilities). At the end of board meetings there is time allocated for questions from members of the public. The response of board members to these questions varied. Some board members appeared uncomfortable, eager for the meeting to be drawn to a close, or else visibly irritated by particular individuals. The discomfort felt by some board members may stem from the marked juxtaposition, apparent at times, between the bureaucratic and administrative character of the main body of the meeting, and the often highly emotive character of the question and answer section, where questions may come from members of the public whose loved ones have experienced serious failings of care, or who may be angry about plans for change. During this part of the meeting Stephen appeared to listen attentively to questions, and in responding would acknowledge the veracity of accounts, adopting a collaborative tone ('it's a good idea actually', 'It's an interesting point', 'I agree that it is something we could talk about', 'there is no reason why we couldn't do that'), before setting out any action he would take in response.

All the Medical Directors we observed in our study were heavily involved in regional healthcare planning, working on both the 'front stage' and 'back stage' (Degeling 1996). While planning on the front stage emphasises the values of rationality, objectivity, efficiency and full and open participation, planning on the back stage recognises the political dimensions of planning, the real world constraints, and the strategies and tactics of different actors. These include, 'the selective use and release of information, agenda setting, mobilization of bias, and efforts by participants to build a coalition of support behind their specific interests and concerns' (Degeling 1996, p111). In our study an example of planning on the front stage was the work of regional clinical advisory groups, given the task, by regional executives, of producing rational plans for reorganising clinical services. Observing these meetings, it was clear that the Medical Directors who made up these committees were aware of their 'discursive work', on behalf of regional executives, in producing rational plans and communicating these to local clinicians and members of the public, often referring to themselves during discussions as being 'on the stage'.

The following is from an interview with Stephen and illustrates the activities of Medical Directors on the 'back stage' of healthcare planning. In the UK hospital closures are a politically contested issue, often the focus of 'save our hospital' campaigns from local community groups (Stewart 2019). In this case plans to close hospital facilities had been prepared by the organisation as part of financial assurance processes requested by a national regulator. According to Stephen, the plans were primarily for accounting purposes and were 'never going to happen', but following a report by a local newspaper, community groups had organised protests and, as it was in the run up to local elections, these were supported by local political leaders. In the following extract Stephen is talking about subsequent informal meetings he had with local politicians:

So we went to see the politicians and they said, "look, we understand what you are trying to do, there's nothing wrong with the plan but you've blown your coms and until next April we're going to save you".

This extract illustrates the use of informal channels of communication on the back stage of regional healthcare planning. It also suggests a recognition, among the actors, of the realpolitik of healthcare, and a mutual understanding of their respective roles. For the organisation this is to manage communication of controversial plans ('you've blown your comms'), for local politicians it is to represent the interests of their constituents and to secure re-election ('we're going to save you').

1.4. Repair work

According to Stephen, much of his work involved repairing relationships, between rank and file doctors and the hospital management, and between different organisations in the region. For example, within the hospital, relationships between managers and the clinical staff in the ophthalmology department had been damaged by previous cuts to the service, introduced by a team of management consultants before Stephen had joined the organisation. Part of the Stephen's work in service development was acknowledging previous trauma and rebuilding trust. He described the meetings he had with the doctors in the ophthalmology department as 'mainly a therapy session'.

Stephen also spent large amounts of time repairing relationships with external organisations that had been damaged by previous government reforms, such as the introduction of healthcare markets and provider competition, and structural reorganisations of clinical services. In one case his plans to collaborate with another organisation to provide more integrated care had been stymied by damage from the process of competitive tendering. In the following extract he describes how, in another case, he successfully repaired the relationship with a commissioner that had been damaged by the process of contracting:

When I got here [relationships] were very bad. They'd all fallen out over the contact which hadn't got signed until the end of March of the year they were in. So part of my role, as I saw it, was to rebuild those relationships and have successively done that.

In another example, Stephen wanted to introduce regional clinical networks. These are a collaborative way of providing a clinical service across a geographic region, by sharing rotas, or making joint appointments of medical staff. However relationships between the hospitals in the region had been damaged by what Stephen called 'history'—mostly related to a series of organisational mergers and demergers. In the following extract Stephen recounts that he has spent 'two or three years' having meetings with another hospital in an effort to repair the relationship so that he can develop a region-wide network for surgery:

that's been ... we've been going up and down, and it been looking much more hopeful recently, but it's taken two or three years to sort these things out

2. Discussion

Our empirical focus on the day-to-day work of Medical Directors contributes to an understanding of the role of medical leaders in healthcare governance. We suggest that the 'translation work', 'diplomatic work' and 'repair work' of Medical Directors improves the quality of services by enhancing the absorptive capacity of the organisation. Absorptive capacity describes an organisation's 'ability to identify, assimilate, and exploit knowledge from the environment' (Cohen et al., 1990). According to Currie et al. (2019) absorptive capacity relies on members of an organisation with skills that can help to bridge complex social systems. These include skills in formal knowledge exchange mechanisms and knowledge of environmental incentives that shape priorities; cultural mechanisms that promote a shared way of doing things and collective interpretations of reality within organisations; and coordination and liaison skills. While formal knowledge exchange has been the focus of an extensive literature (Rycroft-Malone 2004; Graham et al., 2006), less attention has been paid to the political and emotional dimensions of healthcare organisations and the diplomatic and repair work necessary for quality improvement. For example, establishing and maintaining relationships enables Medical Directors to identify innovations in external networks, while their knowledge of the cultures and routines within their organisation enable them to translate these into practice.

Most of our findings relate to the category of 'diplomatic work',

reflecting the inherently political nature of public-sector policy implementation, service change, and quality improvement (Langley and Denis 2011), and the essentially relational nature of clinical leadership in healthcare organisation (Fitzgerald et al., 2013). Fitzgerald et al. found that a foundation of good pre-existing relationships was key to the ability of clinical leaders to deliver service improvements. Conversely, poor relationships eroded the capacity of organisations to improve care. Our findings suggest that in publicly funded healthcare systems the work of the Medical Director in healthcare governance involves four key forms of connection and interaction, (1) board dynamics, (2) relationships with clinicians within the organisation, (3) relationships with other health and social care organisations in the region that underpin 'collaborative governance' (Ansell and Gash 2008), and (4) relationships with external stakeholders that make up the 'authorising environment' (Moore 1994), namely regulatory, policy, and public stakeholders.

Our study highlights the fact that changes to clinical services can leave a long emotional shadow. Much of the research on organisational change in healthcare has tended to focus on clinical outcomes, or adopt technical models of implementation that neglect the social and emotional consequences (Jones et al., 2019; Boaz et al., 2016). Our study therefore complements existing studies of organisational change in healthcare by foregrounding the experiences of loss and change, and the work of attending to emotions such as anger. Shadowing a Medical Director revealed that they spent a significant amount of time repairing relationships that had been damaged by previous government policies, such as the introduction of provider competition, and large-scale structural reorganisations of clinical services. 'Disruption' often has a positive valence in policy debate. Our study contributes to the evidence for the potential negative effects of repeated cycles of structural change, on service development, patient care, and outcomes (Fulop et al., 2005; Clack et al., 2018; Vaughn et al., 2019).

Although organisational change may be seen by staff as an opportunity, and stimulate positive emotions such as excitement, it is more often experienced as threatening, stimulating feelings such as anger, fear, anxiety, cynicism, resentment and withdrawal (Küpers and Weibler 2008). In addition to impacting on staff wellbeing and motivation, negative emotions can hinder learning, team work, innovation, and creative problem solving. According to Küpers and Weibler: 'the decreased performance, climate of distrust, stifled innovation and reduced creativity render the organisation passive and debilitated, undermining the best intentions of change initiatives, as well as incurring significant costs' (2008, p256).

Our findings also provide for a more nuanced understanding of professional 'resistance' to organisational change, showing how this may stem not just from vested interests, but from initiative fatigue and distrust borne from previous experience of change initiatives that were abandoned or replaced by 'the next thing'.

Our analysis suggests areas for theoretical refinement. Waring's (2014) development of Friedson's theory of professional restratification is conceptual, requiring empirical testing. Drawing from our research we make the following observations that suggest areas for further research and conceptual development.

First, the focus of Waring's (2014) analysis is on the relations between professional elites. This analysis implicitly assumes that elite roles are occupied by different individuals. However, we found that the work of the Medical Director encompassed a number of different categories - 'managerial elites', as originally suggested by Waring, but also 'political elites' and 'corporate elites'. As responsible officer (RO) for professional revalidation they can also be understood as a 'governance elite' (Bryce et al., 2018). Like Waring (2014), Bryce et al. make connections with the governmentality literature. They argue that, as governance elites, Medical Directors primarily advance external agendas:

... the function of ROs is not one which primarily acts in defence of professional autonomy. Rather, ROs' work, and their attitudes towards fulfilling their core task of monitoring other doctors' fitness to

practise, seem likely to expand professional regulation into the organisational sphere in new ways (2018, p104).

Second, while Waring's category of 'political elites' describes those operating at the national-level, and in formal policy institutions and processes, our study draws attention to the role that Medical Directors play in regional-level healthcare politics, and to informal channels of communication. In their study of regional healthcare politics, Jones and Exworthy (2015) found that Medical Directors played a key role in the rhetorical strategies of local organisations seeking to introduce controversial changes to services. They caution that, to the extent that these strategies are recognised by other stakeholders, and perceived to be manipulative, they may 'backfire' by eroding trust. Similarly, Jones (1999), in an earlier study of healthcare planning in London, highlights the discursive work of clinical advisory groups, describing these as a series of meetings that were 'less a means of arriving at a set of healthcare decisions and more a means of legitimising decisions that had, more or less, already been taken' (1999, p94). In our study the Medical Directors on clinical advisory groups appeared to act in good faith in preparing plans for the rational reorganisation of clinical services across the region, but were, at the same time, aware of the discursive dimension of their work.

Third, as a member of the board of a healthcare organisation, Medical Directors also occupy an elevated position as a 'corporate elite'. Waring's analysis of corporate elites is in the context of private sector organisations, and in relation to wider capital markets. He suggests, for example, that doctors on the executive boards of large healthcare organisations 'are encouraged to align with the interests of shareholders at the expense of their commitment to the wider profession' (2014, p700). Our study enables us to consider how this category translates to a publicly funded healthcare system such as the NHS. We found that in contrast to previous research on boards in the NHS which positioned Medical Directors as aligned with the interests of their clinical speciality, Medical Directors in organisations with a 'high' quality improvement maturity aligned with the goals of the organisation. In the NHS in England these goals are related to organisational survival in a turbulent, resource constrained and policy dependent context, and typically include cost control, acquisition of additional resources, meeting regulatory requirements, and implementing national government policy. In Waring's analysis corporate elites are able to benefit personally, through ownership and partnerships in profit-making organisations. Similar opportunities are available in the mixed economy of provision in the NHS. Membership of NHS hospital boards also offers the opportunity to benefit personally through further promotion - by the end of fieldwork more than one Medical Director in our study had moved on to a higher position in the NHS hierarchy.

A key finding from our study is that in organisations with a 'high' quality improvement maturity Medical Directors were orientated to the goals of the organisation, actively contributing to organisational strategy, and representing the organisation in dialogue with external stakeholders. In contrast to previous studies of Medical Directors (McGivern et al., 2015), and doctors who have taken up roles as chief executives (Ham et al., 2011) our focus was not on career narratives or professional identity, but on activities and interaction and on what was being accomplished in day-to-day work. From our data it was unclear to what extent our findings can be interpreted as representing a modern 'hybrid professionalism' (McGivern et al., 2015). It does, however, suggest a break with what Kirkpatrick et al. (2016) refer to as 'defensive professionalism', at least in some organisations. This shift might be seen as offering a beneficial corrective to vested interests and professional intransigence. Alternatively, it may reflect a naturalisation of managerial values and organisational priorities at the expense of patient interests. In close observation of his day-to-day work, Stephen was often seen to 'balance' managerial and professional perspectives. Recent scholarship has revisited the role of professionalism in enhancing high quality healthcare in systems dominated by managerial logics (Martin

et al., 2015). It might be that an important way that Medical Directors, in their hybrid role, may enhance the quality of services provided by an organisation is through balancing professional and managerial logics. More research is needed to explore what are likely to be complex and varied consequences of corporate elites for patient advocacy, patient voice and patient interests in healthcare organisations.

Our research contributes to a gap in the literature on medical-manager hybrids at the level of the board, and their role in policy implementation, service change, and quality improvement. We have also suggested areas for theoretical development in the sociology of the professions. Our study is, however, exploratory. The analytical categories of 'diplomatic work' and 'repair work' were generated from shadowing a single individual from an organisation with a 'high' quality improvement maturity, although we nuanced and strengthened our analysis through comparisons within a larger data set, comparisons with other empirical studies, and member validation. We therefore recommend more ethnographic research, from different contexts, that 'follows' the Medical Director through interactions with different actors and across different governance arenas (Marcus 1995).

3. Conclusion

In high performing organisations Medical Directors undertake 'translation work', 'diplomatic work', and 'repair work', which contributes to the governance of quality within healthcare organisations, and to broader forms of system-wide governance. Enabled by their hybrid role, these forms of work constitute important mechanisms for the relationship between medical leaders and the quality of healthcare services.

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