Doctor in the lead: balancing between two worlds

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Abstract
The article examines the leadership of department heads in a university hospital in day-to-day practice. These ‘doctors in the lead’ bridge the medical and the management world in the hospital organization. They are better able to influence their colleagues’ clinical activities than a non-medical manager. This is, however not a trouble-free task. The concepts of Pierre Bourdieu—habitus, field and capital—guide the analysis of empirical material. The medical habitus influences the questions and dilemmas department heads face, as well as the ways in which they can exert influence on their colleagues. ‘Janus-faced’ they look at the medical and the management world with their two different logics. Sometimes they display managerial behaviour, but the medical habitus remains their second nature. Based on these findings we argue that the formal hierarchy of the hospital organization should be brought more in line with the informal professional hierarchy.

Keywords
doctor, habitus, health care, hospital organization, leadership
It is difficult to create integrated hospital organizations using the habitual management practices (like formal planning and control systems). Research on this topic describes a hospital as a place where at least four ‘worlds’ or ‘logics’ co-exist (Glouberman and Mintzberg, 2001), with frictions between the professional (medical) world and the managerial world in the focus of attention. Many see these frictions as a power struggle (Scholten and Van der Grinten, 2002). Some developments have intensified this struggle: escalating costs in health care, pressure to control public spending, and a desire to improve the quality and efficiency of care. The managerial logic seems to dominate these days, as in other professional contexts (Oakes et al., 1998; Prichard and Willmott, 1997; Townley, 1996, 1997).

To combine these various logics a linking pin structure is created (Likert, 1967). The prominent Johns Hopkins Hospital in Baltimore created the position of clinical director, based on the idea that doctors are influenced more by clinical than by non-clinical managers. After all, senior doctors normally take the expense-related decisions or authorize them. Their active involvement in management might lead to them getting a grip on the decisions and expenses of doctors (Hunter, 1992; Jones and Dewing, 1997; Preston et al., 1992). However, doctors describe this involvement as a way to have more influence on their work (Hunter, 1996). The ‘restratification’ theory of Freidson (1994) asserts that functional stratification within the medical profession helps it to maintain professional dominance in health care (see Hoff, 2000).

We find an example of this linking pin strategy in university hospitals in The Netherlands. Here medical specialists are heads of medical departments within the organizational hierarchy of the hospital, they are professionals in the lead. These heads are responsible for research, education and patient care. They fulfil this task in cooperation with their medical colleagues. At the same time, they deal with non-medical management. As such, they play a key role in the governance and management of the hospital.

The department heads in one of these hospitals were supported in their leadership by an internal management consultant who also was the main investigator of the study reported in this article (Witman, 2007). From the practice of the management consultant the idea emerged that various fundamental issues influence their leadership, visible in some recurring themes and patterns and related to the specific culture and manners of the medical world. This opened a promising path for research to improve the strategy of ‘professionals in the lead’. A literature review showed that knowledge of the dynamics of the practices and the leadership in the medical world are scarce. This prompted embedded research (Balogun et al., 2003) into the day-to-day practice of the leadership of medical department heads. This article describes the findings. But first we elaborate on the literature regarding doctors in the lead and the design of our research.

**Doctors in the lead in the literature**

One of the strategies to manage the quality and costs within hospitals is by transforming doctors into managers. They then become ‘professionals in the lead’. Through this involvement of physicians in management, two worlds are embodied in one person (Dawson et al., 1995). A clinical director usually heads the clinical directorate, forming a triumvirate together with a nurse and a non-medical manager.

A medical manager is a two-way window or a bridge between two worlds (Hoff, 1999; Llewellyn, 2001). A doctor can take this position, because he can, at least theoretically, amass knowledge of the management world, but a non-medical manager cannot amass medical knowledge (Llewellyn, 2001).
Financial expertise is important for this role. Thorne describes the way clinical directors delegate financial and other management affairs to non-medical managers who use this information to exercise supervision (Thorne, 1997).

An important aspect of leadership is the competence to influence interaction (Goudsblom, 2001). The capacity of medical managers to influence the performance of their group, clinical affairs and troublesome colleagues, is a vital aspect of their function, and it is also the most difficult part of their task (Dawson et al., 1995; Thorne, 1997). Despite their hierarchical position and responsibility for the budget, the clinical directors cannot ‘manage’ their colleagues, because medical specialists are only accountable to their national professional organizations and their patients (Buchanan et al., 1997; Kitchener, 2000). Therefore the medical managers have little formal power to influence their colleagues (McKee et al., 1999).

The selection process of clinical directors is sometimes an informal process, with professional credibility and acceptance in the organization as important parameters (Thorne, 1997). Only when the selected doctor has the support of his colleagues will any influence occur (Dawson et al., 1995; Thorne, 1997).

Maintaining a professional identity—the practice of medicine—is important for medical managers in order to exert influence on their colleagues and to diminish the risk of being seen by them as a ‘traitor’ to the profession (Hoff, 1999). Kitchener finds no evidence to sustain the deprofessionalization hypothesis: clinical directors maintain the closeness to their profession, they maintain a high level of autonomy and they resist attempts to increase the management control of medical practice (Kitchener, 2000).

However, medical managers practice less and less medicine and therefore tend to lose their unique value (Hoff, 1999) and job satisfaction (O’Connor, 2002). According to Thorne, the role of the clinical director threatens the professional identity, the collegiality and the autonomy of the group, as well as the person who acts as director (Thorne, 1997). Others also mention the possibility of personal and professional stress for medical managers. They link this to the necessity of uniting various roles and the troublesome task of maintaining credibility in two worlds (Guthrie, 1999; Hoff, 1999; Kitchener, 2000; Llewellyn, 2001; Thorne, 1997).

In short, the strategy ‘the professional in the lead’ is ambiguous. Sometimes they fall short of expectations with regard to their key role in influencing clinical activities and their colleagues. So they follow different forms of management training to amass the knowledge of the management world (Fitzgerald, 1994).

We doubt that this additional knowledge alone will help the medical managers—the ‘new bosses’ (Hoff, 1999; Hunter, 1996; Llewellyn, 2001)—to play their role as linking pin. In the consultancy practice of the first author, the problems as well as the successes of doctors in the lead seem primarily to be connected to the culture and socialization of the doctors, to the logic of the clan (Ouchi, 1980).

In the literature much attention has been paid to the socialization process in medicine (e.g. Atkinson, 1995; Bosk, 1979; Hafferty and Franks, 1994; Luke, 2003; Sinclair, 1997). The way in which future doctors learn to behave according to the specific norms of the profession, is ‘as important as the science and art of medicine, although it is learned through a socialization process rather than classroom lectures’ (Rosenthal, 1995). This socialization process is also called ‘the hidden curriculum’ (Hafferty and Franks, 1994; Windolf, 1981) and is in contrast to the more formal curriculum in higher medical education. Through this hidden curriculum doctors internalize norms that point the way to professional and collegial manners and power relations. The result might be conceptualized as a common professional identity, the medical habitus (Sinclair, 1997; Luke, 2003, referring to Bourdieu).
The formation of the habitus is an intense process of socialization, through individualization, but also through separation from the ‘normal’ world (Freidson, 1970; Sinclair, 1997). Sinclair speaks of ‘teaching by humiliating’ (Sinclair, 1997). In the various studies of this socialization process in the medical world, which are set in different times and places, there are striking similarities that point to a more or less exclusive professional identity, the medical habitus (Atkinson, 1995; Becker et al., 1961; Bosk, 1979; Freidson, 1970; Hafferty and Franks, 1994; Luke, 2003; Pratt et al., 2006; Shuval, 1975; Sinclair, 1997). This habitus can be seen in practice in ‘the liturgy of the clinic, with meetings, patient rounds and the importance of medical talk’ (Atkinson, 1995). Despite the changes in health care, these practices have firm and steady characteristics:

Many of the cultural forms I address have shown remarkable stability (...). The ceremonials and liturgies of the clinic express not just contemporary knowledge and practice. They also recapitulate long-standing and deeply embedded idioms of medical thought and practice. (Atkinson, 1995)

The literature made us aware of a systematic bias. Most studies are based on interviews, where people tell what they think they are doing, not always exactly what they do (Argyris, 1992/1999). We need more information: how does leadership take shape in the day-to-day practice? What are these doctors in the lead doing exactly? What determines their authority, what are their dilemmas? Do they influence their colleagues and the collegial relations and if so, how? How do they perform their management task, within their group and in the hospital organization? Empirical work needs to be done by observation, to get more valid insights (see also Hoff, 2000).

We designed a study to address the question: how does the medical habitus influence the way in which medical department heads, with their threefold responsibilities—research, education and patient care—fulfil their leadership task? The concept of habitus has been developed by Bourdieu. Our study uses his concepts—habitus, field and capital—to include different levels of analysis: the individual doctor, the group of medical professionals and the interaction with the management world. We will discuss his concepts after a brief introduction to the outline of our study.

The purpose of this research is to generate both scientific insights and recommendations for the actual practice of medical leadership in a hospital organization.

The site: an academic hospital

The research site is a university hospital, an integrated structure of a teaching hospital and a medical faculty under the guidance of one board of directors. The organization has ten divisions that contain each between two and seven clinical departments of comparable specialties. Some divisions contain non-clinical departments. The management of a division, who report to the board, generally consists of two people: a department head as the chairing medical manager and a nurse. A non-medical manager is positioned ‘subordinately’. The chairs of the divisions have a double position: they head several other departments besides their own.

Department heads are usually medical professors of a specialty. The size of the specialty group varies from about four to 30 colleagues, registered as medical specialists. Large groups often have subdepartments with subspecialties. Also residents and interns are part of the department.

All (acting) department heads and other professors are participating members of the medical staff committee. They advise the board of directors on matters of quality in patient care.
Design of the study

Following the concepts of Bourdieu—habitus, field and capital—we wanted to include different levels of analysis: the individual doctor, the group of medical professionals and the interaction with the management world.

Three sources were used to gather the empirical material: observations, interviews and interactive discussions within small learning groups of department heads. The choice of these methods was based on a close fit with the practices.

We purposely selected a variety of specialties to observe (Pope and Mays, 2000). We assumed that there are differences between medical, surgical and supporting specialties. Another distinction was the amount of experience in being a department head. We selected six department heads: one rather inexperienced and one more experienced department head from each group of specialties—medical, surgical and supporting. Each of them was observed during a period of one week, with a focus on moments of face-to-face interaction, i.e. group meetings such as staff, review and research meetings, patient rounds, surgery or individual meetings of the department head with residents, staff colleagues and non-medical managers.

These six department heads and their colleagues, residents and non-medical managers were interviewed, 29 persons in sum. The interviews included topics regarding the authority of the department heads and the ways in which they—effectively or not—enacted their leadership; the evolution of their leadership in the course of time; the performance of a medical group; relations between the different specialties and the relationship with the management world. The observations of the investigator were the other important topic in the interviews. In addition, all 42 department heads in the hospital were interviewed about the topic of performance appraisals in order to investigate the way in which management instruments are used in practice in the medical world.

Discussions in small learning groups with five to six department heads made up the third source, 33 sessions with 26 participants in sum. In these sessions department heads reflected on various issues regarding their leadership task. They wanted these learning groups, to talk with congenial colleagues about mutually experienced problems. The learning method in these groups was characterized by reflection. Reflection can contribute to the socialization process of department heads (Guthrie, 1999). Also, Schön points to the importance of reflection of professionals (Schön, 1983/1999).

All department heads included in the observations also participated in one of the small learning groups. The sessions were taped with a tape recorder and transcribed.

We applied Kwalitan software for qualitative analysis (Kwalitan, 2000). We coded the material inductively and made clusters of codes. The codes and the clusters of codes developed while commuting between the empirical material and the theoretical concepts of Bourdieu through advanced understanding in the course of the enquiry. We started the coding after most of the data had been collected. When the remaining data were added, few new codes could be added, which pointed to saturation of the amount of data.

The tools of Bourdieu

In the analysis we used the concepts of Bourdieu—field, habitus and capital—as tools: these receive meaning by empirical investigation and the other way around (Bourdieu and Wacquant, 1992).

The concept of field refers to social space. A field is a relatively autonomous space, built around specific positions and institutions and with an internal logic of its own. A social space can be called a field when there is something at stake and people are willing ‘to play the game’ (Bourdieu, 1989b).
While the concept of field denotes the external social structure of a world, the habitus can be considered as the internal model of social reality. The habitus develops in a process of socialization and can be defined as a system of dispositions: durable, subconscious schemes of perception and appreciation that activate and point the way to practice (Pels, 1989). The dispositions of the habitus give rise to a limited amount of strategies. These strategies manifest themselves in certain visible patterns of behaviour, manners and beliefs: in practices (Bourdieu, 1990).

Under common conditions, a common habitus comes into being. A common habitus enables practices to be harmonized objectively, without any conscious reference to an explicit norm, and to be mutually adjusted in the absence of any direct interaction, like an orchestra without a conductor: ‘The practices of the members of the same group or, in a differentiated society, the same class, are always more and better harmonized than the agents know or wish’ (Bourdieu, 1990: 59).

Through the habitus they take the logic and the social world for granted. Elias speaks of a ‘second nature’ (Elias, 2001).

Capital can take different shapes: economic, cultural and social capital. As economic capital is a well-known notion, Bourdieu underlines the other forms of capital. Cultural capital refers to the habitus and encompasses an individual’s background, social class and education. Social capital refers to ‘connections’. When capital yields profits of distinction, Bourdieu speaks of symbolic capital which often appears as authority (Bourdieu, 1989c).

The capital in a field is always unequally distributed, which gives rise to different positions in the field and competition for the capital at stake. Between fields—a field of power in terms of Bourdieu—the owners of different kinds of capital struggle about which of the capital, and with which world, will dominate (Bourdieu, 1996). A hospital accommodates different worlds, at least the medical and the management world. In the context of this research, we consider the hospital as a field of power.

**Doctor in the lead**

First we explore the role of the habitus in the distribution of authority and in group cooperation and struggle. Armed with an understanding of these two topics, we arrive at the leadership of the medical department head him/herself leadership within the group and balancing between two worlds in the encounters with the management world. We highlight the performance appraisals as a management instrument and conclude with the dilemmas for the department head.

**The medical habitus and authority**

A surgical specialist about a good surgeon:

You derive your authority from patient care, for a surgeon that means to operate.

The dispositions of the medical habitus determine the way a doctor exists in and experiences his specific world. They determine perception, recognition, thinking and practice. We examined four different practices—meetings where physicians discuss patients (review meetings), patient rounds, operations and research meetings—for characteristic patterns of behaviour. We distilled four dispositions of the medical habitus: the clinical, the scientific, the professional and the collegial disposition.

Through the *clinical* disposition the physician perceives a person as a patient. Whereas a non-doctor may see a woman with remarkable striking eyes, a doctor will see someone with the
symptoms of a disease of the thyroid gland: the doctor sees a patient. Like a detective the doctor looks for complaints and symptoms that point the way to a disease that has to be cured. To acquire, preserve and develop this disposition, the doctor has to see many patients and acquire experience, because ‘every patient is different’. ‘Seeing patients’ means passing through the whole medical trajectory, from examining and diagnosing to treating. The disposition manifests itself in specific patterns of reasoning during the presentation of the patient in review meetings, in asking a specific kind of questions and in certain arguments during discussions (Witman and Smid, 2009).

The scientific disposition means that a physician sees medicine as science. Physicians generate and apply scientific knowledge by ‘seeing’ their patients. This disposition reveals itself in book learning and in speaking the ‘scientific medical jargon’ in the early years of training, and later on in the use of scientific knowledge in patient care, in reading scientific literature, and in visiting research meetings and conferences.

The professional disposition means that physicians perceive themselves as personally responsible for their patients. Corresponding strategies are: putting the interests of the patient first and claiming the competence to make clinical decisions on behalf of one’s own patients. This claim to make their own decisions refers to the importance of autonomy—because when things go wrong, doctors themselves are to blame. This disposition manifests itself in arguments regarding choices for treatment of patients, in working hard, sometimes in suffering physical deprivation, and in being able and having the courage to decide.

The collegial disposition refers to the inextricable relationship between group membership and individual performance. Corresponding strategies are: treating one another as equals, never letting a colleague down and never allowing a colleague to lose face. This disposition gives rise to collegial manners on which we will elaborate in the next paragraph.

The doctor who excels in the strategies of the medical habitus has authority: the cultural capital of the habitus operates as a source of power. The medical habitus can be considered as an embodied competence, by which ‘to have’ is changed into ‘to be’ (Bourdieu, 1989a). Doctors recognize the presence—and also the absence!—of this disposition in each other, for instance in the way in which they talk about patients and ask questions. Seniority, as a sign of clinical experience, is respected.

A young specialist:

Some colleagues are dominant. It shows during discussions and when things are difficult. Why? They have a lot of experience, they have seen a lot.

With regard to the scientific disposition, authority is related to the extent of scientific knowledge of which the degree of doctor of medicine and professorship can be considered formal manifestations. From the point of view of the professional disposition authority is related to ‘always’ working and to being able to act and decide on important matters for patients, especially life and death. Having a collegial disposition leads to a feel for relations and makes someone a valuable member of the group: social capital. The membership of a prestigious group gives an individual authority.

The hierarchy in the medical world becomes visible during a patient round or review meeting: the place and attitude of people reveal their position in the group. But the hierarchy also becomes manifest indirectly. Seniors ask juniors questions to test their knowledge, but not the other way around. Senior specialists discuss complicated patients, while residents are silent listeners. But these residents do see how specialists sit up straight when they discuss a complex patient; they see who does most of the talking, which arguments are decisive and who determines the decision-making process.
The meaning of authority becomes even clearer when authority is not respected: the resident who, during a review meeting, takes the ‘wrong chair’—the chair informally reserved for seniors—offends: he has no sense of proportion. The irritation lies in the lack of respect for seniority and experience, which is so highly valued in medicine.

These power relations give rise to a clear hierarchy, not only between specialists and residents, but also among specialists. There is talk of A and B surgeons, of first- and second-rate specialists. The clinical disposition plays a leading role in this informal hierarchy and herewith, as we will see later on, in the leadership of the department head.

The medical habitus arises from working in the daily practice. The review meeting can be regarded as a form of ‘reflective practice’, in which not only residents are being checked and trained, but staff are also checking each other and learning continuously. Therefore these meetings form a significant contribution to self-regulation in medicine (Witman and Smid, 2009).

**The performance of the group: cooperation and struggle**

The medical habitus also acquires significance in solidarity and struggle in the performance of these groups.

A specialist:

A shared community feeling is very important. We work very hard, under high pressure, and are often dependent on others. There should be no friction; you have to be able to do everything with each other. If you have a problem, there must be someone you can fall back on immediately, otherwise patients are in danger. Collegiality is key in safety issues. It means that you back each other up, that you don’t let each other down. It is teamwork ….

As a member of a group, doctors can fall back on the collectively possessed capital, the capital of the group. The profit of membership lies at the root of the solidarity of the group (Bourdieu, 1986).

We identified three forms of collegial manners. The first form is: not to give orders, not to control each other, and consensual decision-making. These aspects are related to the professional disposition in accordance with physicians who decide for themselves—give themselves orders—and are supposed to take responsibility.

A specialist in an interview:

No one can ever order you to do an operation you don’t want to do. It is not like mathematics. Surgery is at daggers drawn: if I cut a bronchus, it’s me who did it. I can try to fix it, but that won’t change the facts.

The second form: to be collegial, i.e. to do each other favours and to be loyal to each other. This includes covering for colleagues in case of illness, conference attendance or private obligations, often without clear agreements about what will be done in return. To be loyal means for example not to criticize each other outside the group.

The third form is: not to criticize each other openly. Criticism is mostly disguised by posing questions.

Although the strategies of the collegial disposition are clearly important, this does not prevent them from not being followed. Two factors play a leading role here: on the one hand the measurement of the value and proportions of the granted favour is difficult. This factor can strain the reciprocity, leading to a feeling of ‘misfit’. Another factor is related to the occurrence of struggle based on mutual competition. A common habitus does not prevent internal competition, quite the contrary (Bourdieu, 1990).
The experience of a ‘misfit’ in the exchange of favours and the competition can strain collegial manners as well. To withhold collegiality can be put into effect as a means of power and the escalation of conflicts is then lurking. Conflicts are threatening to the performance of the group and thus also to good patient care.

**Leadership within the group: a two-sided coin**

We can now turn to the influence of the medical habitus on the leadership of department heads. This influence is a two-sided coin. Through this influence department heads face questions and dilemmas, but they partly also receive a repertoire of ways to exert their influence. They face dilemmas when ways of exerting influence do not match with the collegial disposition. How can they make someone do something without giving orders? To whom do they have to behave like a good colleague—being collegial and loyal—when various colleagues have opposed interests? Should they criticize a colleague openly who is performing badly? By not following the appropriate collegial strategies they risk getting into conflicts, and also becoming separated from the group.

A department head in a small learning group recounts an incident. He asked a staff member to perform a particular teaching activity, whereupon he replied:

‘Will I become a professor by that?’ The department head answered: ‘I don’t think so’. And the staff member told him: ‘Then you might aswell do it yourself’.

So he might ask a colleague to do something, but what when he receives no for an answer? In our study, we saw that department heads use five methods to exert influence on individual colleagues and on the state of affairs within the group.

Firstly: a department head needs to be a wise man or woman, i.e. someone whose authority is mostly founded on the medical habitus. The clinical disposition plays a leading role again here. As a wise man the department head’s authority is related to his or her personal contribution and is not transferable, contrary to the authority of the spokesman (Bourdieu, 1990). The authority of the spokesmen can be related to social capital: they represent the group; they speak and practice in its name, and are empowered by the collective capital of the group (Bourdieu, 1989a).

If the clinical authority of department heads is contested, colleagues often compete with them:

Fragment from a small learning group of department heads:

Department head 1: One of the reasons why I want to practice and continue my practice, is that when I run this department as a manager…

Department head 2: …Then very soon you’ll run out of things to say.

Department head 3: You have to show that you are the best.

Department head 1: So, to be honest, I think practicing as a doctor does mark your authority and position in the group.

Department head 3: As Cruijff tells us: who should be in charge? The best.
The authority of department heads risks declining over time if they perform less patient care and research. They have to remain a physician and a colleague, performing patient care, research, being on duty, supervising residents, though often to a lesser degree.

Secondly: they comply with collegial manners in order to exert influence: they ask questions, provide criticism disguised as questions, give advice, and sometimes limit damage when a colleague performs poorly.

Thirdly: department heads use peer pressure to exert influence. They can do so literally, by discussing matters in the group instead of individually, during meetings where patients are discussed, or during staff meetings. Peer pressure is exerted by using the ‘pluralis modestiae’, i.e. by speaking of ‘We’ instead of ‘I’ by speaking on behalf of the group, like an internal spokesman:

A department head about an individual conversation with a colleague:

I told him that we as surgeons had very substantial doubts about his technical capacities for this area of special attention.

Though using peer pressure is perhaps a step further than complying with collegial manners, it is still in line with the medical habitus.

Fourthly, department heads sometimes have to exert more explicit pressure. For instance they may have to criticize their colleague openly. Here they no longer comply with the collegial strategies, because of the feeling of responsibility for the performance of the group as a whole (the collective capital):

A department head in an interview about the difference between being a department head and a colleague:

Now I am responsible for the department. If something goes wrong, I have to make sure that everything turns out right. When I was a colleague and I felt that someone did something wrong, I was below him in seniority. I would have had to go to X (the former department head) and you don’t easily do that sort of thing.

They may also sometimes decide to expel a colleague from the group. We elaborate on this subject later in the paragraph ‘performance appraisals’.

Fifthly, department heads can intervene in processes within the group. This concerns the fair distribution of all the joys and burdens, interventions in conflicts or decision-making in the group. It takes time before he may do so in a natural way:

A department head in a small learning group says:

I now take action when necessary, more than I did in the beginning. It is much more accepted than you think and it is even appreciated when someone makes a decision. The staff members listen, like children.

He still sounds surprised while telling this story.

It is important that he is not a party. We may recognize Bourdieu’s wise men in this:

A staff member about a good department head:

It is important that he is a role model. That you think: ‘If my father says so’ ....

Department heads, speaking in Bourdieu’s terms, might be considered as the wise men and spokesmen. They derive their authority in particular from their personal influence. Their cultural capital operates as a source of power. As wise men, especially with clinical authority, they can put their stamp on patient and research meetings, during rounds or in the theatre.
Like the wise men of Bourdieu they have to set an example. The authority of the wise man reinforces their potential to exert influence as a spokesman, such as exerting influence by using peer pressure or exerting explicit pressure. Their authority as a wise man is the deciding factor for making the most of the social capital they dispose of as a spokesman. Furthermore, as spokesmen they can sidestep a number of dilemmas caused by collegial manners.

The methods that conflict with the medical habitus, such as exercising explicit pressure and intervening in processes within the group, aim towards the protection of the capital of the group. It shows the development of a new disposition, that of leadership: to see oneself as personally responsible for the performance of the group. The leadership disposition then becomes part of the habitus of the department head. Van Oorschot described the paradox of having to choose between violating the autonomy of a colleague and endangering the group in case of badly performing colleagues (Van Oorschot et al., 1995). The department head pre-eminently may have to handle this paradox. However, not every department head develops this leadership disposition.

**Encounters with the management world**

A department head in a small learning group:

> If you really don’t know what to do any more, you should say to yourself: ‘No one was ever sent to this hospital because of the manager, but they were sent here because of me!’.

As spokesmen of their group department heads move along the boundaries of their own group and travel in the hospital. Who do they meet in this field of power and how does the medical habitus influence the management task?

The chair of the division—medical manager and colleague—and the non-medical manager are the most important discussion partners of the department head in the management world.

The meeting between the department head and the non-medical manager is a meeting between two different and sometimes contradictory logics:

A non-medical manager:

> If a department head says: I want yellow sutures tomorrow, he doesn’t realise that you have to buy three of them and that you have to pay extra to have them by tomorrow. Once someone wanted to use a special endoprothesis for an operation and it was flown in from Groningen by helicopter. That’s madness!

Is this madness? Apart from the question of whether these materials are better, this quote shows how the two worlds interpret the situation in different ways: doctors do everything in their power to help their individual patient. If they let these financial considerations dominate, they would make a mistake from the perspective of responsibility, a cornerstone of the medical habitus. The professional disposition, their professional conscience, plays a leading role here. This responsibility conflicts with the managerial logic: to divide all resources, not only ad hoc but also in the long term. In this situation the logics of two worlds can clash, producing a power struggle on who may decide on these matters in the organization.

In different ways, both worlds attempt to influence each other. The management world has the power to manage and distribute money (economic capital), disposes of a shortcut to the board of directors (social capital) and has the knowledge and insights about the complicated flow of money (cultural capital).
Department heads can put their knowledge and reputation in patient care and research into action (cultural capital) or the flow of money they generate with patient care or research (economic capital).

A department head in a small learning group about his discussion with the management:

We are important for our division, because we bring in the money. And if we don’t get the extra personnel that we need and that was promised to us, I tell the manager that we have to close two beds. In the end he then says: you will get your personnel. He knows that if we close those beds, he won’t get his money.

Facilitator: So, that’s your…

Department head: That’s my weapon.

They can also create a shortcut to the board of directors (social capital). Sometimes department heads combine their power, so they can activate the capital of the group.

Department heads sense that they cannot exert much influence within the organization. By trying to integrate the two worlds into one department head, the power of the medical world—in the hospital—as a whole seems to decrease.

The voice of the management world speaks through the department head in the medical world and sometimes influences decision-making.

Observation fragment from a review meeting:

A resident discusses a patient who had to stay in the medium-care department because of a shortage of beds in the intensive care unit.

Department head: ‘Can’t we quicken the pace of his transfer?’

The resident proposes to arrange the patient’s transfer for tomorrow.

Department head: Today?

Staff colleague: It’s only the second day.

Department head: The fourth day.

Colleague: The beginning of the third day.

Department head: Let’s see how he is.

In this situation the department head speaks from the perspective of the management world, cutting across his staff. When he tries to quicken the discharge of a patient, he does not use medical arguments. According to the management logic, he has to strive for efficiency, cost reduction and increase in productivity. Decision-making that is aimed at this goal can be in conflict with decision-making based on medically professional arguments.

Performance appraisals

The management logic also enters the medical world when management instruments like performance appraisals are introduced.
For ten years, department heads in the study hospital were stimulated to perform these appraisals. At first, the department heads as well as the staff members resisted. The appraisals were a symbol of a formal, hierarchical relationship that did not seem to match with collegial relations:

A staff member:

It {the appraisal} emphasizes the hierarchical relationship and you also become more formal yourself. It is enforced from above; it doesn’t aim to stimulate, but to cover your ass. We face the danger that the organization will run off with the results.

Meanwhile, most of the department heads do perform these appraisals (36 out of 42). But they are hesitant to provide the information to the central personnel file—as they should. They are afraid to violate their collegial loyalty; 15 out of 36 therefore keep their own records.

Department heads consider the information that these appraisals produce as the greatest advantage, but sometimes they feel a barrier to make things explicit in writing them down:

Fragment from an interview with a department head:

At this moment, staff member X is performing an operation. He is a slow, but meticulous surgeon. Staff member Y, for example, is a fast one, but you don’t want to let him perform operation A or B. Physically he is not capable of doing that. I draw the lines, but don’t ask me to write it on paper.

YW: ‘Perhaps that is difficult because of the intimate details?’

Department head: ‘Yes, exactly!’

The performance appraisal symbolizes a formal hierarchy, not suitable for collegial relations, although in actual practice a majority of the department heads also appears to value the appraisal in the long run: they appreciate evaluating the state of affairs together and looking at the immediate future. In performing these appraisals, they mostly comply with the strategies of the medical habitus. They speak of ‘annual conversation’ instead of ‘performance appraisal’ and emphasize the equivalence of the relationship.

A department head:

I don’t do it very formally, that does not suit the collegial relations. Besides, we are more or less the same generation. I simply write it down as a conversation.

These wise men mostly use collegial manners—asking questions, giving advice—and the pluralis modestiae in their appraisals especially with seniors and contemporaries—if they hold the appraisal with them at all. Also, criticism is not openly described but mitigated in the records, e.g. ‘is not actively involved in research’, or hidden in agreements like ‘the challenge is to….’.

Sometimes the department heads exert more explicit pressure; they threaten to expel the colleague from the group:

A department head about a staff member:

I said to him: the only thing that we do now, is make tough agreements, for instance by saying that if you do not improve your behaviour in say six months, I do not see a place for you in our group any more.

Twice the department heads spoke in the small learning groups about the choice for this strategy. In both situations the colleague applied for another job. One of them left, the other one did not
manage to get another job, and improved his behaviour. Subsequently, the relations in the group improved as well.

For department heads it is a very big step to threaten a colleague with expulsion, but in both situations they had to because the relationship had become very tense. It is possibly also one of the harshest punishments for the involved staff member him/herself. The department head needs the support and the mandate of his group, or else he risks meeting fierce resistance to his way of acting.

Through the introduction of management instruments, like performance appraisals, the logic of the management world is transformed as well (Oakes, 1998; Townley, 1997). For example, department heads perform the appraisals, but they mostly appear to behave according to collegial ‘rules’ and may exert influence when colleagues consider them to be wise men. Sometimes they may use ‘objective’ criteria, professional or organizational guidelines, so as not to bring the collegial relations into the discussion (see also Boyd, 1998). In this way they shape this management instrument, as much as possible, after the logic of their own world.

**Dilemmas**

Being in two worlds, department heads face several dilemmas. They have to decide whether to spend their ever-scarce time on management or on patient care. When they spend too little time on management, they risk failing in getting things done for their department and missing information. When they spend their time on management, they see fewer patients and are in danger of losing their authority as wise men—their cultural capital in the medical world. They then lose the possibility of having enough influence on clinical activities and on their group. In addition, regularly they experience too little support from the management, which ‘invents work for us instead of doing odd jobs for us’. So, the bridge to the management world often lacks a pile.

Secondly: the staff wants to know whether the head is one of ‘them’ (the management) or one of ‘us’. By living in two worlds, department heads sometimes have to choose between their department and colleagues, and the management. Though this is true for every middle manager, the balance for department heads is even more important. Medical staff needs them to ‘protect’ them from the management. In doing so, they trust them to be their spokesmen and they are allowed to lead.

Thirdly: department heads experience the feeling that they have to choose—perhaps more and more—between the (individual) patient and the money. This involves the choice to see a patient, the kind of treatment they want to offer, the materials they want to use, or the length of stay of an individual patient.

Observation fragment during a staff meeting:

Topic of discussion in the meeting is the retrenchment of the hospital. The department head discusses which category of patients and which admissions make good money, because the management wants ‘to get rid of’ the most difficult and costly patients. But where do they have to go, the staff wonders. The department head sighs: ‘You really have two approaches: you choose for patient care, or you only look at what is expensive’.

When they have to decide to withhold treatment from one patient and give it to another, or to dismiss a patient because they think the treatment will be too expensive and the patient is not ‘worth it’, they violate their oath, and are in conflict with their own habitus. In this context, the burden is especially placed on the department head.

**Discussion and conclusion**

In our study we analysed the way in which the leadership of department heads takes shape in day-to-day practice.
The medical habitus to a large extent determines the limitations and possibilities of the leadership of department heads. The habitus influences the issues and dilemmas which department heads face, as well as the ways in which they can exert influence.

Only when their medical colleagues consider them to be wise men, are they actually able to influence the clinical activities and state of affairs in the group. They particularly employ collegial manners in line with the medical habitus. Sometimes they have to apply methods that are in conflict with the medical habitus, which can strain relations with their colleagues. The leadership disposition—i.e. seeing themselves as personally responsible for the performance of the group—in particular can be derived from these methods.

With ups and downs department heads are balancing between two worlds. They can be a bridge between these two worlds, but this bridge often lacks a solid foundation in the management world. They need sufficient knowledge and information of the management world to be able to exert their influence there. ‘Janus-faced’ they look at two worlds with two different logics. Sometimes they show managerial behaviour, but they remain doctor and colleague. When performing appraisals, they shape this management instrument, as much as possible, after the logic of their own world. The medical habitus remains their second nature.

Even though it is not a trouble-free task, we think that the principle of the doctor in the lead is a promising strategy to monitor and improve the quality of clinical activities from within the medical profession. But it is not enough for a doctor in the lead to be a physician. We argue here to bring the formal hierarchy of the hospital organization more in line with the informal professional hierarchy, for instance in the appointments of doctors in the lead as medical managers. Instead of competing for the power of the informal medical culture it seems more sensible to use this power and to formalize the role of wise men, also in non-academic settings.

Based on the findings in this study, several recommendations can be formulated for hospital organizations that want to apply the principle of the professional in the lead.

First: doctors in the lead need to be wise men and spokesmen.

In general hospitals in The Netherlands, medical specialists are juxtaposed to the hospital organization. Mostly the specialists are not employed by the hospital and are organized in partnerships. Medical managers and chairs of their group are doing the management chores as spokesman. The partnerships nominate colleagues for these positions and there is no tradition of looking for and selecting wise men, often on the contrary: a reluctant colleague might be appointed, because ‘someone has to do it’, or colleagues present themselves because they see it as a step forward in their career (see also Kitchener, 2000). This is a real challenge for the boards of directors and the management of these hospitals, but perhaps even more so for the medical staff.

Doctors in the lead should also remain wise men. Therefore they have to stay active in clinical practice and should avoid being considered as managers who ‘coincidentally’ happen to be doctors. They need sufficient support from the non-medical management to bridge the gap between two worlds. However, tools and instruments of the management world need to be provided to them selectively, otherwise they risk being seen as defector to the management world by their medical colleagues and thus losing their ability to influence their colleagues. The selection of the counterpart of the doctor in the lead, the non-medical manager, is also an important factor. Moreover, this manager needs to amass knowledge of the practices and logic of the medical world. Two wise men that are conscious of the sometimes inescapable differences of their worlds may use this disparity to cooperate in a productive way.

Second: with Freidson (1999) we plead for institutional ethics, which we consider to be a moral consultation on the organizational level. These institutional ethics need to ensure that the
professional conscience of the medical world plays a significant role in the organization to protect the trust in doctors and hospitals.

This study showed how the concepts of Bourdieu could be applied in the analysis of leadership and organization. Different levels of analysis could be brought together which provide different insights. Bourdieu is often criticized because of his sloppy application of concepts and his complex language that make his concepts hard to grasp. We showed that it is possible and fruitful to use concepts such as habitus and dispositions rather analytically.

We used the concepts of wise men and spokesmen to understand the different ways of domination within and between fields. The role of capital is helpful for analysing what it is all about in a particular field. And to take it one step further: leadership also has to be judged in the world concerned.

Further research needs to be done in various directions. First: comparative research—applying the concepts of Bourdieu—in general hospitals with a different organizational structure might provide a contrast to the findings in this study. Second: with Waring and Currie we emphasize the importance of developing quality improvement within rather than about professional practice (Waring and Currie, 2009; also Fitzgerald, 1994). More studies will have to be performed investigating the effects of other appraisal systems such as Assessment and Appraisal (Geeraerts and Hoofwijk, 2006). The existing systems of annual evaluation by peers often do not take into account the informal power relations and the role of leadership within a medical group (Witman, 2007).

Thirdly: comparative research should be done within other professional fields and the organizations that accommodate them. In this way, parallels between professions can be brought into a broader social perspective.

Notes
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1 Most famous soccer player in The Netherlands.
2 Groningen is about 200 km away from the research site.

References


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