Paper NIG

Panel 10: special panel of colloquium ' Professionals under Pressure'

Two logics in the hospital: a bird never flew on one wing

Quality and safety in hospitals and the performance of medical specialists

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Introduction

In many western countries the quality of care in hospitals is subject of growing concern. International evidence indicates that as many as 10% of hospital admissions experience some form of error or 'adverse event' in the delivery of care (World Health Organization 2004). In the Netherlands the report Willems described the quality and safety in hospitals as worrisome and on the basis of recent incidents regarding the bad performance of medical specialists the media criticised the way hospitals guarantee the quality of clinical activities in hospitals (Willems 2004).
In the Netherlands, the board of directors bears the final responsibility for the quality of care. This is a real challenge for their governance, because medical specialists – besides others like nurses – are in charge of the day-to-day responsibility for patient care. Often, the board has not enough possibilities to enforce accountability of medical specialists, as is described in the recent report of the RVZ 'Governance and quality of care' (RVZ 2009). It may degenerate in a struggle for power, where both parties often are powerless. The medical staff may regularly push the board out like soccer teams their coaches, and medical specialists experience often little involvement in the hospital organization. The RVZ concludes that there is a misbalance in the relationship between the board of director and medical specialists and suggest some structural solutions like the employment of medical specialists as a way to have more control over specialists.

In countries such as Australia, the USA and the UK systems of knowledge management (KM) are being introduced to address the topic of quality and safety as a means of fostering learning around clinical risk (World Health Organization 2004). These systems facilitate knowledge sharing and learning, typically through the centralized management of knowledge within an organization. These systems are started as a big offensive of the government, also in the Netherlands, where it is called VMS.
Do these instruments influence the performance of medical specialists? The analysis of Waring and Currie suggests that the top-down managerial fixes might not be appropriate and why these systems therefore will fail to do their job (Waring & Currie 2009). They raise the question in what way medical specialists themselves will learn together in these systems and how it affects the collegial ways of learning. Waring and Currie emphasize the importance to develop quality improvement within rather than over professional practice.
Quality improvement within the medical profession, how to do so?
Instruments that supported by the Order of Medical Specialists (OMS, Orde van Medisch Specialisten) are for instance IFMS (Individueel Functioneren van de Medisch Specialist) and

Appraisal and Assessment (Geeraerts & Hoofwijk 2006). These are systems of annual individual evaluation by peers, performed mostly by medical specialists from another discipline. The appraised receives the feedback from an appraiser who gather information from relevant others (colleagues, nurses, residents). The conversation ends with agreements for the next year. In some hospitals these systems are introduced, till now on voluntary basis. Within a few years every medical specialist should participate in one of these systems. These appraisal systems are not mend to dissolve the problem of bad performing medical specialists. With regard to the incidents that happened recently, both medical staff and board of directors often hesitate to interfere (inspectie oa, Crommentuyn 2009). For medical specialists it is difficult to 'betray' each other and when they do so, sometimes the board of directors waits too long to take measures, perhaps afraid for the costs or to damage their reputation. The scientific order of surgeons (NVvH) set up a committee that may not only advise but also mediate partnerships and hospitals when a specialist or partnership as a whole is bad performing (Crommentuyn 2009).

Though there are many attempts that address the issue of quality and safety and the performance of medical specialists, we want to highlight here an alternative strategy for managing the quality from within the medical profession: to create managers out of doctors to become professionals in the lead. Medical professionals in the lead could influence the clinical activities of their colleagues, more than a non-medical manager. They could also be a bridge between two worlds, the medical and the management world, each with its own logic (Hunter 1992, Preston et al 1992, Jones & Dewing 1997). Even though this does not appear to be a trouble-free task, we think that the management 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 (Witman 2007).
In this paper we focus on the way medical department heads in a university hospital influence the performance of their colleagues from within. We demonstrate the role these doctors in the lead enact in this way in the self-regulation of their group and the meaning of the performance appraisal in the medical world. We argue in favour of the principle of the medical professional in the lead also in other hospital organizations and of a combined play between the board of directors and the medical staff in the responsibility for the quality of care.

This paper is structured as follows. First, we describe the introduction of medical professionals in the lead in the hospital organization. After outlining the methods of our initial study, we demonstrate the role of department heads in influencing the performance of medical specialists in the setting of a university hospital, in review meetings and individual encounters. More specifically we describe the meaning of a management instrument such as the performance appraisal in the medical world. We then discuss the implications of our findings for other hospitals regarding the topic of quality and the performance of medical specialists.

Medical professionals in the lead and the hospital organization

Mintzberg suspected 'that running even the most complicated corporation must almost be child's play compared to managing almost any hospital' (Mintzberg 1997: 16). He described the hospital as a professional bureaucracy (Mintzberg, 1983). Ouchi considers a professional bureaucracy as 'a response to the joint need for efficient transactions within professions (clan) and between professions (bureaucracy)' (Ouchi, 1980: 136). Perhaps, as a professional archetype, the hospital is shifting towards a Managed Professional Business, MPB (Hinings et al, 1999).

In any case, a hospital is a place where at least two worlds come together: the professional (medical) world and the management world. In the literature attention has been paid to the conflicts between these worlds, which are often characterised as power struggles (Scholten & Van der Grinten, 2002). In the Netherlands, as in many other countries, there have been developments that have intensified these struggles: the escalating costs in health care, the pressure to control public spending and a desire to improve the quality and the efficiency of care. According to the growing number of management instruments in the medical world, e.g. quality management and performance appraisals, the management world seems to dominate these days. In other professional worlds comparable developments are observed (Prichard & Willmott, 1997; Oakes et all, 1998; Townley, 1996, 1997).

The principle of doctors in the lead is to be considered as one of the strategies to connect the two different logics of the professional and the management world. In many western countries, medical specialists are becoming more and more integrated into hospital management, after the example of the famous Johns Hopkins hospital.
Perhaps we can speak of a new domain in the hospital, with medical managers as the 'new bosses' (Hoff, 1999; Hunter, 1996; Llewellyn, 2001). However, in different studies this situation seems critical: Sometimes professionals in the lead miss management knowledge, such as financial expertise, and have difficulties in leading their colleagues.

In the Netherlands medical specialists are integrated in management according two mutually exclusive principles (Scholten & Van der Grinten 2002). In Dutch general hospitals this integration takes the form of a juxtaposition of medical specialist and hospital organization. In university hospitals, medical specialists are integrated by including them as medical chairs in the organizational hierarchy of the hospital, as professionals in the lead.

The university hospital in the Netherlands where our study took place applies 'the professional in the lead' as leading management principle. This means that the medical department heads are responsible for research, education and patient care. They have to fulfil this task in cooperation with their staff, their colleagues. Department heads also have to deal with the non-medical management in order to provide sufficient means and funding. In this way they play key roles in the governance and management of the hospital.

Our initial research goal was to find clues for the design of support activities to develop medical specialists into leaders and administrators within a university hospital. The department heads in this hospital were supported in their leadership by an internal management consultant who was also the main investigator of the study reported in this paper (Witman 2007). Analysis of the practical experiences of this consultant revealed some recurring themes and patterns, such as the search for authority and for ways of influencing staff. From the experiences of this consultant, the assumption arose that these themes are related to the specific culture and manners of the medical world; a study was set up to explore that assumption.
Despite the changes in health care, the medical world gives evidence of firm and steady characteristics of practices and results: '*On the other hand, 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).
Studying the issue of leadership by medical professionals (Witman, 2007) we had to face the issue of the deeply embedded and embodied cultural practice. The reproduction of this practice is taking place in a socialization process has been described as 'the liturgy of the

clinic, with meetings, patient rounds and the importance of medical talk'(Atkinson, 1995), and also by 'teaching by humiliating' (Sinclair, 1997). Here future doctors learn also unwritten rules, the specific logic of the medical world. This socialization process is also called 'the hidden curriculum' (Hafferty, 1994; Windolf, 1981) to emphasize the contrast with the more formal curriculum which is written down as goals, compulsory subject matter for examinations, competences and so forth. They learn to behave according to the specific professional and collegial norms of the profession, that is 'as important as the science and art of medicine, although it is learned through a socialization process rather than classroom lectures' (Rosenthal, 1995). In the literature much attention has been paid to this socialization process (e.g. Atkinson, 1995; Bosk, 1979; Hafferty, 1994; Luke, 2003; Sinclair, 1997). This process is intense, through individualizing, but also through separation of the 'normal' world (Sinclair, 1997; Freidson, 1970).
Although conducted in different times and places the various studies of this socialization process in the medical world point at striking similarities. The result of the process seems to be an exclusive professional identity, the medical habitus (Becker, 1961; Freidson, 1970; Shuval, 1975; Bosk, 1979; Hafferty, 1994; Atkinson, 1995; Sinclair, 1997; Luke, 2003; Pratt, 2006).
With regard to these remarkable stable outcomes, we should not be surprised that changes from the outside have little impact on the culture of the medical world and the medical habitus.

Our initial study addresses the question: how does the medical habitus influence the leadership of the medical department head? In this paper we focus on one topic of this study: the influence of medical professionals in the lead on the performance of their colleagues regarding the quality of the clinical activities.

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 hospital

This study was performed in a university hospital, an integrated structure of a teaching hospital and a medical faculty under the guidance of one board of directors. The organisation has a divisional structure. There are ten divisions that contain between two and seven clinical departments of more or less comparable specialties. Some divisions contain non-clinical departments. The management of a division, who fall directly under 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' and is subservient to this management. The chairs of the divisions are also one of the department heads in the divisions. This means 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 in a specific division. The size of the staff group of a specialty varies from about 4-30 staff members, registered as medical specialists. Large groups often have sub departments with subspecialties. Besides staff colleagues, residents and interns reside in the department. Thus the department heads are integrated into the organisational hierarchy.
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 our initial research

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

We purposely selected a number of different specialties to observe (Pope & Mays, 2000). One of the assumptions was that there might be differences between medical, surgical and supporting specialties. Another distinction was the amount of experience in being a department head. Based on these criteria we selected six department heads: one rather inexperienced and one more experienced department head from each specialty – medical, surgical and supporting. Each of these six department heads 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 or non-medical managers.

These department heads, staff 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 – effective or not – they 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 department heads in the hospital were interviewed about the topic of performance appraisals in order to investigate the way in which this management instrument is used in practice in the medical world, 42 persons in sum.

Small learning groups with five (once six) department heads made up the third data source. These learning groups involved 33 sessions with 26 participants in sum. In these sessions department heads reflected on different issues regarding their leadership task. Starting these small learning groups supported the wish of department heads themselves: to talk with congenial colleagues about mutually experienced problems. It seemed useful also from a theoretical perspective: 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). Balogun breaks a lance for interactive discussion groups, like focus groups, as a method for data collection (Balogun et al, 2003). Group dynamics have advantages over individual interviews. For instance, participants are more open, because they are among peers and the investigator is in the minority. The telling of stories and critical incident analysis may be a means to explore practice-based tacit knowledge. These arguments of Balogun are in favour of using small learning groups as a basis for data collection, even though these kinds of groups have never been used in this research strategy before, as far as we know. Facilitating these small learning groups belongs to the regular tasks of the investigator / consultant. For this reason no special selection was made. 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 analysing the empirical material we followed Bourdieu, using his concepts as tools: his theoretical notions receive meaning by empirical investigation and the other way around (Bourdieu & Wacquant, 1992).

His most important concepts are field, habitus and capital. The concept of field refers to social space. It is to be considered as a world, like the medical world. 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, 1989c). 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).

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).

In a socialization process, external rules become internalised. The socialization process is therefore to be considered as a form of social control. The habitus ensures that people in their social practice have a 'feel for the game'. Through the habitus we take the social world for granted. Elias speaks of a 'second nature' (Elias, 2001). Dispositions of the habitus can be considered as the grammar of a person, and the longer and more intensive the socialization process, the more internalised – and unconscious – this grammar is. A good comparison is the young child who speaks his mother tongue, using the right grammar, without knowing that he does.

Bourdieu equates the concept of capital with that of power (Bourdieu, 1986). 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, especially the habitus as a form of cultural capital. Cultural capital 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, 1989d).

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 and different logics struggle about which of the capital and logics, and therewith 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 such a field of power.

Leadership from within, wise man en spokesman

To understand the impact of the leadership of a doctor in the lead, we first summarize our findings with regard to the medical habitus that we described earlier (Witman 2007, Witman submitted).

The medical habitus

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. Dispositions

are, like the rules of grammar, not directly visible, but they reveal themselves in certain visible patterns of behaviour, manners and beliefs. We therefore examined four different academic practices – meetings where physicians discuss patients (review meetings), patient rounds, operations and research meetings – for characteristic patterns of behaviour. In this way we distilled four dispositions of the medical habitus: the clinical, the scientific, the professional and the collegial disposition (Witman 2007, Witman submitted).
Through the *clinical* disposition the physician perceives a patient, not just a person. A non-doctor may see a woman with remarkable striking eyes, but a doctor will see someone with large bulging eyes which may be the symptoms of a disease of the thyroid gland that has to be cured: 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 detected and cured. To acquire this disposition, but also to preserve it and let it develop, the doctor has to see many patients and acquire experience, because 'every patient is different'. 'Seeing patients' means passing through the whole medical path, from examining and diagnosing to treating. The disposition manifests itself in specific patterns of reasoning during the presentation of the patient, in asking a specific kind of questions and in certain arguments during discussions.
The *scientific* disposition means that a physician sees medicine as a natural 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 professional disposition is to be considered as the professional conscience of the physician.
The *collegial* disposition refers to the inextricable relationship between group membership and individual performance. Cooperation in a group is characterized by a number of typical collegial manners, mostly in accordance with unwritten rules. Corresponding strategies are: treating one another as equals, never letting a colleague down and never allowing a colleague to lose face. The collegial disposition gives rise to three forms of collegial manners.
Firstly: to give no orders, not to control each other, decision-making by consensus. These manners are related to the professional disposition in accordance with the physician who decides for himself – gives himself orders – and is considered to take responsibility.
Secondly: to be collegial: to do each other favors 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 principle of reciprocity is important here.
The third form is not to criticize each other openly. Criticism is mostly disguised in questions.
These strategies are to be considered as investments in the membership of the group. To have discourse to this disposition leads to a feel for relations and contributes to the membership of the group: social capital.

Leadership from within

Department heads exert their influence mostly in daily practice, like review and staff meetings, rounds and the theatre, besides individual encounters. First, we describe the review meeting and the meaning of the power relations. Then we more specifically focus on the

leadership of the department head in these meetings and in individual encounters, especially in the performance appraisal.

The review meeting

In review meetings doctors discuss patients which they did see for a consultation, hospitalize, operate or patients which had complications. They discuss patients, who are not present in person; stories and information of patients pass through. In review meetings, patient care and the training of the residents are inextricably bound with each other.
The meetings often take place on regular moments, in the same room; they can change in frequency, composition, style and atmosphere. The duration depends on the available time, the objective of the meeting and the size of the department. The length ranges from fifteen minutes to two hours. Time is limited for instance in a meeting on Monday morning when they have to discuss lots of patients. Everyone has to be in time to take his or her clinic, to make the patient round or to operate. On these moments the goal of education is of secondary importance.
The review meeting shows some typical regular moments, characteristic behaviour and interaction between the colleagues. The presentation of a patient is always the starting point. Thereafter members of the meeting can ask questions and make remarks as a response on the presentation. Then what follows are phases of discussion and decision-making. We discuss these moments chronologically, however, in practice the different phases sometimes are mingled.

The presentation of the patient

The presentation of the patient, mostly done by the residents, to the colleagues who did not see the patient in person happens according a regular structure. In this story the doctor 'translates' the complaints of the patient and the course of the disease in his medical habit of thought (Abbott 1988). In their presentation the residents show to what extent they master this translation. The presentation is not only telling the story of the patient, it is also the story of the doctor. The doctor presents *his* story of the patient and by that himself. In the presentation the colleagues may hear if there are any inconsistencies in the story about the patient, incomprehensible reasoning, omissions or inaccuracies of his clinical reasoning. That leads to the next characteristic phase of the review meeting: to ask a lot of questions.

Questions, questions, questions

After the presentation the chair of the meeting and the other specialists may respond. The responses remarkably often have the form of questions. These questions have different and greater purposes. Sometimes a question is for explanation. In that case the inquirer needs more information. Three other aims of questions are testing, criticizing and showing off one's knowledge. The question aimed at testing may switch to a form of criticism. The question: *"Did you consider to perform a puncture?"* may have a learning goal. This question gives the resident a suggestion. But it may also mean that he should have considered or that he should have given his considerations with regard to the puncture.
The critical question happens to be an important collegial manner also between staff members. The critical question plays a major part as a way not to criticize each other openly: criticism is mostly disguised by questions. It does not mean that physicians do not criticize each other. The critical questions function well for the good listener. It prevents that a colleague is losing face, a very threatening situation for a physician. This collegial manner refers to the collegial disposition.
Asking the right questions commands at the least as much respect as being able to give the proper answers. In this way one may show his competence. A good question may show that

the storyteller overlooked something, but that the inquirer did come to think about. A question may also be the introduction to bring down a study, guidelines, or to the description of an interesting patient who once the inquirer has treated himself.

Discussion: 'good arguments with respect to content'

When doctors disagree about a diagnosis or treatment fierce discussions may arise. Questions and arguments are bringing up with ardour. They seem to leap when talking about a complicated patient: passionately and enthusiastically the Sherlock Holmes[1] are busy to catch the offender in the act. Just as it is a great challenge for the detective to find out who permitted the crime, so it is for the doctor to find out which disease may explain the complaints with a certainty as far as possible, so that the patient will be cured. How could complaints, an inexplicable course of a disease or the failure of a treatment be understood? These are all puzzles that have to be solved.
While putting forward arguments one draw from experience and scientific knowledge.
An argument from personal clinical experience can start, whether or not prefaced by a question, as follows: *"I just saw someone…"* Hereafter follows a plea about the matter *than* that, rather or not, supports the diagnosis or treatment in the present case.
Other arguments refer to the state of affairs in science. Knowledge of scientific research may point the way to diagnose or treatment. One calls upon evidence-based medicine and the results that are translated to guidelines and protocols. Evidence-based medicine is a way of thinking that assumes that it is meaningful to base medical actions as much as possible on facts which are acquired from scientific research (Offringa ea 2003). This knowledge may be put forward for example to perform a particular procedure, to make one diagnose more plausible than another, or to consider a special treatment more sensible than another. The different arguments, from experience and science, may also be put forward in relationship with each other, and sometimes they could conflict.

Another argument that emerges is the experienced urgency to have to do something for the patient. A doctor ought to offer something to the patient, even when the chances are very poor. Especially when it is about life and death. It is a powerless feeling when they can do nothing at all. Doing nothing feels like a failure, as if they did not the best they could. Arguments about time, effort or costs are not the point, the real question is whether a treatment is clinical relevant and whether a patient will benefit.

To decide with regard to his own patient

Often the decision process passes off implicitly. When there are no obvious irregularities, the next patient will be presented without many comments, sometimes only: *"Okay, next."*
Apparently, the decisions about diagnose or treatment are adopted tacitly. The moment of the decision may be unclear. After the last arguments there is no reply, so this happen to be the conclusion, or perhaps the most relevant advice. The chair of the meeting, or perhaps the 'own' doctor, ends the discussion with: *"Okay, that is the way we do it,"* or: *"Okay, this fits in the picture most closely."*
When the 'own' doctor does not want to adopt the opinion of others, there will be no mutual decision-making; the 'own' doctor decides.
The position of the 'own' doctor also becomes clearly noticeable with lack of clarities or with criticism: *"Of who is this patient?"* or : *"Who does know this patient?"* Or the resident who defends himself in advance when he has to present the patient of a colleague: *"I will read from another man's work."*

[1] Sir Conan Doyle, the author of Sherlock Holmes, was also a physician.

To decide with regard to his own patient reveals another important collegial manner, referring to the collegial disposition: not to give orders:

> 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.'

Although the own doctor decides, the decision-making during the review meeting is a social process. One checks one another through questions and the exchange of arguments and uses one another to get more certainty and to rank with each other. They try to reach consensus. In this way, the responsibility for the decision that sometimes brings risks along is shared as it were.

Reflective practice

So the own doctor decides, however, the opinions of the colleagues may actually give rise to another decision. Although a manager in an interview sighed to find it incomprehensible that doctors hardly test each other, these review meetings are to be considered as one great test. They constantly check them selves, their colleagues and the policy of the group as a whole. They may learn from mistakes and adjust bad medical management.
In the review meeting the learning community of medical professionals manifest itself (Lave & Wenger 1991). The review meeting is an example of a professional practice in which physicians improve their practice continuously through 'reflective practice' (Schön 1983, 1999). Reflection appears when 'knowing-in-action – the knowledge by which someone practices – leads to an unexpected result. Two kinds of reflection may occur: 'reflection-in-action', to think about the adjustment of the practice and 'reflection-on-action': the reflection after the experience, which means that the practice becomes a learning experience. This reflection occurs in the review meeting. Not only residents are being checked and trained, but also staff are checking each other and learning continuously. Therefore these meetings might form a significant contribution to self-regulation in medicine. As Kenny cs tells us: *"Excellence in professional practice is learned in and through experience and critical reflection on its expression in the clinical encounter"* (Kenny 2003: 1209).

The practice of the review meeting demonstrates what and how – future – doctors learn. Also the power relations of the medical world are transferred and confirmed in this meeting.

Power relations

During a review meeting the hierarchy in the medical world becomes visible: the place and attitude of people reveal their position in the group. For example, staff take their place at the table, residents are lined up at the wall. But the hierarchy becomes manifest also indirectly. Residents do the presentation of the patient; seniors ask them questions to test their knowledge, but not the other way around. Critical questions are mostly aimed to clinical reasoning. In this way residents learn to explain their policy. Only core members – the medical specialists - are entitled to ask questions about the patient ánd the presentation. Like Atkinson tells us: "The discourse itself inscribes the asymmetry in status and power of the respective parties" (Atkinson 1995).
The 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.

> A specialist:

'Only doing things that everyone can and where nothing can go wrong has less prestige.'

This citation points to two dispositions: the clinical disposition – being able to operate on very specific patients – and the professional disposition – being able and having the courage to take responsibility in a risky situation.

The varied presence of dispositions that are part of the medical habitus determines the power relations within the group, based on cultural capital. It also reveals the meaning of leadership.

Doctor in the lead: wise men and spokesmen

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. A physician with authority is to be considered, speaking in Bourdieu's terms, as a wise man, i.e. someone whose authority is mostly founded on the medical habitus. The medical habitus can be considered as an embodied competence, by which 'to have' is changed in 'to be' (Bourdieu, 1989b). The clinical disposition plays a leading role again here. Based on the clinical disposition, authority is connected to clinical experience and seniority: the physician has seen a lot of patients in the course of his or her career and is therefore able to diagnose, treat and operate on particular patients. Doctors recognise the presence – and also the absence! – of this disposition in each other, for instance by the way in which they talk about patients and ask questions.
The wise men in the group derive their authority in particular from their personal influence. Their cultural capital operates as a source of power. Seniority, as a sign of 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.'

As wise men, especially with clinical authority, department heads can put their stamp on patient meetings, but also during rounds or in the theatre. They comply with collegial manners in order to exert influence: they actively ask questions, provide criticism disguised as questions, and give advice; not only the residents, but also their staff. Staff ascribe authority to them. Like the wise men of Bourdieu they had to set an example. As a wise man the physicians' 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 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 1989b).
Notwithstanding his formal authority as spokesman, the department head needs his authority as wise man to exert his influence:

A resident in an interview:
"In my earlier work situation one said about the department head: let him just talk. Thus they did not take him seriously."

When the wise men in a medical group have also the position of spokesman, their authority of the wise man reinforces their possibilities to exert influence as a spokesman (Witman 2007). Their authority as a wise man is the deciding factor for making the most of the social capital they dispose of as a spokesman.

As wise men, doctors in the lead comply with collegial manners in order to exert influence. As another strategy, department heads use peer pressure. They use the pressure of the group 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. Metaphorically they use peer pressure by using the 'pluralis modestiae': speaking on behalf of the group, like a spokesman:

> *A department head about an individual conversation with a colleague:*
> *'I told him that **we** as surgeons had extremely great 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. If these ways are not working out in the case of a poorly performing colleague, they have to take other steps, that they would not do when they were not in the lead. Here they no longer comply with the collegial strategies in the group:

> *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.'*

Regularly, after staff or meetings, staff addresses the department head that he no longer should tolerate the behaviour of a colleague. They do not want to violate the collegial manners and think that the department head has to do so. And department head do, feeling responsible for the performance of the group. Van Oorschot described the paradox of choosing between two evils: to violate the autonomy of a colleague or to endanger the group (Van Oorschot 1995). Department head pre-eminently have to handle this paradox. Mostly they comply with collegial manners, so as not to jeopardize the collegial relations. But sometimes they have to take the risk, in the interest of the group. They may have to criticize their colleague openly or threaten to expel him from the group. Mostly they try to seek a royal way out, for instance they advise to search for another employment. Then they have to exert more explicit pressure, in an individual encounter. One of these encounters is the performance appraisal.

Performance appraisals

The management world, and with it the management logic, also enters the medical world when management instruments are introduced. Performance appraisals are an example of this. For ten years, department heads were stimulated to perform these appraisals. In the beginning, there was a lot of resistance against these discussions, on the part of department heads as well as staff members. These appraisals are a symbol of a formal, hierarchical relationship that does not befit collegial relations:

> A staff member:
> "It {the appraisal} emphasizes the hierarchical relationship and you become more formally yourself also. It is enforced from above, not to stimulate, but to cover your ass. We face the danger that the organization will interfere with it. To improve or to take you in? Probably the latter, then they will catch the dolt, the others will keep in the background."

Meanwhile, most of the department heads perform these appraisals (36 out of 42), but they are hesitant to provide this 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 archives. They

use whether or not an available format, make whether or not extensive reports, whether or not signed by the staff member and the department head.
They consider the information that these appraisals produce as the greatest advantage, but sometimes they feel a barrier to make things explicit in writing it 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 is for example a fast one, but you don't have 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: "That's perhaps difficult because of the intimate details?" Department head: "Yes, exactly!"

The performance appraisal symbolizes a formal hierarchy, not suitable to collegial relations, though in actual practice a majority appears to value the appraisal in the long run also: to evaluate the state of affairs together and to look to the future for a year and longer. 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. We are about from the same generation also. I write it down as a conversation."

These appraisals have more impact, within the meaning of exerting influence, when the staff member considers the department head to be a wise man. But even then, these wise men use mostly 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….'*.
Guidelines may be of help in order to arrange things in a different way, 'without getting personal'.
Sometimes the department heads exert more explicit pressure, he threats to expel the colleague from the group:

A department head in a small learning group about a staff member:

> *"I said to him: the only thing that we do now, is make hard agreements that when you do not improve yourself in say a half year, I do not see a place for you in our group any more."*

There were two times that department heads told in the small learning groups that they have chosen for this strategy. In both situations the colleague applied for another employment. One of them left, the other one did not manage to get another job, and improved his behavior. Thereafter the relations in the group improved also.
It is for department heads a very big step to threaten a colleague to expel him, but in both situations they had to because of a very tense relationship. It is possibly for the involved staff member also one of the most harsh punishments. The department head needs the support and the mandate of his group, elsewhere he risks that he encounters fierce resistance to his way of acting.

The introduction of management instruments, like performance appraisals, is to be considered as a hidden curriculum: in addition to knowledge, tools and language, the logic of the management world is transferred also (Oakes 1998, Townley 1997). The influence of this logic is present, but the medical habitus also resists this logic. For example, department heads

performs the appraisals and herewith they emphasize their formal hierarchical position; they may talk about their employees instead of their colleagues or staff, but they appear to behave mostly according to collegial 'rules' and may exert influence when staff 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 discussion (see also Boyd 1998). In this way it is more or less appropriate in the collegial relationship, and they thus model this management instrument, as much as possible, after the logic of their own world.

Perhaps that forms an explanation for the relative appreciation of the appraisal: in the way they use it, it can be considered as an instrument for development, and hardly for judging (Townley 1997).
Department heads experience these appraisals not as a regular solution for specialists who are bad performing, because '*they have no sanctions'* and the context is also not very helpful: department heads have to keep files on someone for a long period before the organization could take some juridical steps, they risk loss of money and of manpower and in the mean time the relationship is disturbed. Conflicts threaten the group and herewith patient care.

Discussion

In our study department heads are actually able to influence the performing of their colleague medical specialists in the group, and in this way they develop quality improvement from within the profession.
They exert their influence mostly in daily practice, for instance in review meetings, but also by performing performance appraisals. They particularly employ collegial manners in line with the medical habitus. The effects of these manners should not be underestimated. They can exert their influence only when the staff consider the department heads to be wise men. In this way department heads play a leading role in the self-regulation of the group.
Moreover, the review meeting manifests itself as a reflective practice in which physicians improve their practice.
The relationship of doctors in the lead with the organization deserves particular attention. When department heads put their responsibility for the group above the individual collegiality, and adress a bad performing colleague, the context of the organization is not very helpful to dissolve this tense situation.

In the university hospital of our study medical specialists are integrated in the organizational hierarchy of the hospital by including them as medical chairs. These professionals in the lead have to be wise men in order to influence the quality of performing of medical specialists. We think that the doctor in the lead as management principle might to be held as an example also for other hospital organizations.
In Dutch general hospitals, different from the university hospitals, the integration of medical specialists takes the form of a juxtaposition of medical specialist and hospital organization. Mostly the specialists are not employed by the hospital and they are organized in partnerships. The medical specialists are represented in the medical staff committee, which functions as the counterpart of the board. This committee only has an advisory position. Medical managers and chairs of their group are as spokesman doing the management chores. The partnerships nominate colleagues for these positions and there is no tradition to look and choose for wise men, often on the contrary (Kitchener 2000).
In the meanwhile in all hospitals medical specialists participate more and more in management. All hospitals are searching for new structures - for example the organization in units that are responsible for their own results - that are equipped for the challenge of more efficiency, quality, and the introduction of the (semi-) market.

We argue here in favour of more integration of the logic of the medical world with his informal power relations in the formal hospital organization and in the appointments of for instance medical managers. Instead of to compete the power of the informal medical culture it seems more sensible to use it and to formalize the role of wise men, also in non-academic settings. This is a real challenge for the boards of directors and the management of these hospitals, but perhaps even more for the medical staff. They have to seek for creative solutions in their own organization and may not trust blindly on only structural solutions and management instruments such as the different forms of formal quality management. For instance, the review meeting as a reflective practice deserves more attention in quality management. On the basis of our findings, we even doubt the effects of the appraisal systems such as IFMS. These systems do not consider the informal power relations within a medical group, but also not the hierarchy between the different specialties (Witman 2007). Also the solution to employ medical specialists is not a panacea to have more control over medical specialists, when the informal culture of the medical world is not taken into account. With Waring and Currie we emphasize the importance to develop quality improvement within rather than over professional practice (Waring & Currie 2009), but not without taking into account the meaning of the power relations and the role of leadership.
Another point of attention is the importance of combined action of doctors in the lead and the board of directors. They each may search for their own responsibility and seek for cooperation and complementary responsibilities.

We propose further research in day-to-day practices that strives to an integral approach to do justice to the logics of both worlds. This approach may not emphasize the conflicts between the two worlds, but may look for ways how both logics could strengthen each other and herewith address together the difficult issue of the enacting of responsibility for the quality and safety of care in the hospital regarding the performing of medical specialists.

References

Atkinson, P. (1995) *Medical talk and medical work.* London, Thousand Oaks, New Delhi: Sage Publications.
Balogun, J., Huff, A.S., Johnson, P. (2003) 'Three responses to the methodological challenges of studying strategizing'. *Journal of Management Studies* 40 (1), 197-224
Becker, H.S., Geer, B., Hughes, E.C., Strauss, A.L. (1961) *Boys in white: student culture in medical school.* Chicago, London: University of Chicago Press.
Bosk, C. (1979) *Forgive and remember: managing medical failure.* Chicago: Chicago University Press.
Bourdieu, P. (1986) 'The Forms of Capital', in J.Richardson (ed.) *Handbook of Theory and Research for the Sociology of Education:* 241-258. New York: Greenwood Press.
Bourdieu, P. (1989b) 'Economisch kapitaal, cultureel kapitaal, sociaal kapitaal', in D. Pels (ed.) *Pierre Bourdieu. Opstellen over smaak, habitus en het veldbegrip*, pp120-141. Amsterdam: Van Gennep.
Bourdieu, P. (1989c) 'Enkele eigenschappen van velden', in D. Pels (ed.) *Pierre Bourdieu. Opstellen over smaak, habitus en het veldbegrip*, pp 171-178. Amsterdam: Van Gennep.
Bourdieu, P. (1989d) 'De sociale ruimte en de genese van 'klassen', in D. Pels (ed.) *Pierre Bourdieu. Opstellen over smaak, habitus en het veldbegrip*, pp 142-170. Amsterdam: Van Gennep.
Bourdieu, P. (1990) *The logic of practice*. Trans., Richard Nice. Oxford: Polity Press.
Bourdieu P. (1996) *The State Nobility*. Oxford, Polity Press.
Bourdieu, P. and Wacquant, L.J.D. (1992) *An invitation to Reflexive Sociology*. Oxford: Polity Press.

Crommentuyn, R. (2009) *Aanpak disfunctioneren vereist lange adem*. Medisch Contact 64, 45: 1864-1867
Elias, N. (2001) *Het civilisatieproces. Sociogenetische en psychogenetische onderzoekingen.* Amsterdam: Boom.
Freidson, E. (1970) *De medische professie*. Lochem: Uitgeversmaatschappij De Tijdstroom.
Geeraerts, G.A.G., Hoofwijk, A.G.M. (2006) *Evaluatie van (medische) professionals.* Houten: Bohn Stafleu Van Loghum
Guthrie, M.B. (1999) 'Challenges in developing physician leadership and management', *Frontiers of Health Services Management* 15 (4): 3-26.
Raad voor de Volksgezondheid (2009). *Governance and kwaliteit van zorg*. Den Haag: Koninklijke Broese en Peereboom
Hafferty, F.W., Franks, R. (1994) 'The hidden curriculum, ethics teaching, and the structure of medical education', *Acad. Med*. 69: 861-71.
Hinings, C.R., Greenwood, R., and Cooper, D. (1999) 'The dynamics of change in large accounting firms', in D. Brock, M. Powell, C.R. Hinings (eds) *Restructuring the professional organization. Accounting, health care and law*: 131-153. London and New York: Routledge.
Hoff, T.J. (1999) 'The paradox of legitimacy: physician executives and the practice of medicine', *Health Care Manage Rev*. 24(4): 54-64.
Hunter, David J. (1996) 'The changing roles of health care personnel in health and health care management', *Soc. Sci. Med*. 43 (5): 799-808.
Kitchener, M. (2000) The 'bureaucratization' of professional roles: the case of clinical directors in UK hospitals. *Organization* 7 (1): 129-154
Kwalitan, (2000). V.A.M. Peters, afdeling Methoden, Katholieke Universiteit Nijmegen.
Llewellyn, S. (2001) ''Two-way windows': Clinicians as Medical managers', *Organization studies* 22/4: 593-623.
Luke, H. (2003) *Medical education and sociology of medical habitus: "It's not about the stethoscope!"* Dordrecht Boston, London: Kluwer Academic Publishers.
Mintzberg, H. (1983) *Structures in fives.* New Jersey / Englewood Cliffs: Prentice-Hall, Inc.
Mintzberg, H. (1997) Toward healthier hospitals. *Health Care Manage Rev.* 22 (4): 9-18
Oakes, L.S., Townley B., Cooper, D.J. (1998) 'Business planning as pedagogy: language and control in a changing institutional field', *Administrative Science Quarterly* 43: 257-292.
Offringa, M., Assendelft, W.J.J., Scholten, R.J.P.M. (2003) *Inleiding in evidence-based medicine. Klinisch handelen gebaseerd op bewijsmateriaal.* Houten, Antwerpen: Bohn, Stafleu, Van Loghum
Ouchi, W.G. (1980) 'Clans, Markets and bureaucracies', *Administration Science Quarterly* 25, March 1989: 129-141.
Pels, D. (1989) *Pierre Bourdieu. Opstellen over smaak, habitus en het veldbegrip.* Amsterdam: Van Gennep.
Prichard C., Willmott H. (1997) 'Just how managed is the McUniversity?' Organization Studies, 18/2, 287-316.
Rosenthal, M.M. (1995) *The incompetent doctor. Behind closed doors.* Buckingham, Philadelphia: Open University Press.
Scholten, G.R.M., Van der Grinten, T.E.D. (2002). Integrating medical specialists and hospitals. The growing relevance of collective organization of medical specialists for Dutch hospital governance. *Health Policy* 62: 131-139
Schön, D.A. (1983 / 1999) *The reflective practitioner. How professionals think in action.* Aldershot, Brookfield USA, Singapore, Sidney: Ashgate ARENA
Shuval, J.T. (1975) 'From "boy" to "colleague": processes of role transformation in professional socialization', *Soc.Sci.& Med.* 9: 413-420.
Sinclair, S. (1997) *Making doctors, an institutional apprenticeship*. Oxford / New York: Berg.

Waring, J., Currie, G. (2009) Managing expert knowledge: organizational challenges and managerial futures for the UK medical profession. *Organization Studies* 30, 7: 755-778
Willems, R. (2004). *Hier werk je veilig, of je werkt hier niet. Sneller beter – de veiligheid in de zorg.* Den Haag: Shell Nederland.
Windolf, P. (1981) *Berufliche Sozialisation. Zur Produktion des beruflichen Habitus.* Stutgart: Ferdinand Enke Verlag.
Witman, Y. (2007). *De medicus maatgevend. Over leiderschap en habitus*. Assen: Koninklijke Van Gorcum BV
World Health Organization (2004). *World alliance for patient safety*. Geneva: WHO

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