Professional Pride and Prejudice:

Negotiating leadership in an era of interprofession-based organizing

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‘Training is to teach the nurse how to handle the agencies within our control which restore health and life, in strict obedience to the physician’s or surgeon’s power and knowledge...’

Leadership has always played a peculiar role in the context of profession-based operations. Within bureaucratic yet decentralized organizational configurations – where conventional notions of labor management fall short in explaining executive functions – distributions of authority and influence have historically been inherent in strong hierarchies and meritocracies. Contemporary societal trends have, however, started to challenge traditional ways of organizing professional work. In the light of an emerging discursive antagonism, knowledge bases now to a fuller extent overlap each other, while diversified forms of professionalism add further to the complexity of interprofessional work arrangements. Where multifaceted social problems today command organizations to move beyond professional boundaries and assemble different occupations in interprofessional management teams, conflicting expectations of authorities and influence render the leadership concept more ambiguous than ever. Still, perspectives allowing for an understanding of how organizational direction is established among the many competing conceptions of professional practice prove to be limited. On a practical level, it has further been noted how ambiguities concerning influence and authorities foster a continuous negotiation that not only comes to impede interprofessional excellence, but also affects the quality of services offered to a client or a patient. In order to reap the potential of interdisciplinary collaboration in service provision, the understanding of this negotiation needs to be advanced. This can be achieved by shedding light on how organizational direction is established.

Acknowledging how contemporary organizational arrangements call for new perspectives on leadership, the present work sets out to explore how dominant notions of professional practice are (re)produced in leadership processes. Informed by a social constructionist ontology, the theoretical frame of reference enriches a relational perspective on leadership with a negotiated order perspective on interaction. This approach moves beyond context-free conceptions of heroic leaders who are expected to bring their competencies to any suitable place, and rather
recognizes how organizational direction is produced in more complex relationships between culturally situated actors.

Through a case study at a Swedish university hospital, abductive assessment of mundane (non)interaction situations shed light on the pattern of basic assumptions that organizational arrangements of professional workers (re)construct in negotiation to cope with conflicting understandings of influence. While dominant conceptions of professional practice interfere with power bases in establishing recurrent patterns of interrelating, social practices within these patterns further stabilize a social order where (sub)professions associated with superior knowledge bases are – through collective, ‘humorous’ mechanisms – assigned an interpretative prerogative in organizational development. Rather than opening up for interprofessional collaboration in leadership work, mundane instances of interrelating thus (tacitly) reinforce a hierarchical structure, allowing established professions to retain control over the managerial apparatus. This further implies that organizational direction is more about informally reinforcing an organizational hierarchy than about pursuing change and moving beyond professional boundaries in decision-making structures – that is, contrary to how contemporary organizational arrangements presume dispersed forms of leadership. These insights reveal a clash between formalities and realities, which helps explain why change initiatives encounter obstacles, why production processes often prove inefficient, and why many multi-professional teams find it hard to excel. The dynamics and organizational consequences of leadership processes are productively summarized in a hierarchical leadership culture, where a general phenomenon of professional pride and prejudice sets the tone for recurrent patterns of interrelating.

**Keywords:** leadership, profession, interprofession-based organizing, negotiated order, discourse, power base, subject position, space of action, organizational humor, leadership culture, healthcare
SAMMANFATTNING

Ledarskapsbegreppet har alltid haft en särpräglad ställning inom professionbaserad verksamhet. Där en decentraliserad byråkrati komplicerat förståelsen för exekutiva funktioner har distributionen av auktoritet och inflytande historiskt byggts in i starka professionella hierarkier och meritokratier. Dock har samtida samhällstrender börjat utmana traditionella sätt att organisera professionellt arbete. Som följd av en framväxande diskursiv antagonism överlappar nu kunskapsbaser i större utsträckning varandra medan nya former av professionalism öppnar upp för ytterligare komplexitet i professionsbaserade arbetsformer. När multifacetterade samhällsproblem idag ställer krav på organisationer att röra sig bortom tidigare utpräglade professionsgränser och samla olika yrkesgrupper i interprofessionella managementteam blir det tydligt hur konkurrerande förståelser över auktoritet och inflytande gör ledarskapsbegreppet mer komplicerat än någonsin. I denna komplexitet saknas fortfarande perspektiv som tillåts beskriva hur organisationer skapar och utvecklar organisationella riktningar i den ständiga förhandlingen.

Föreliggande avhandling tar avstamp i behovet av nya perspektiv på ledarskap och syftar till att utforska hur dominanta förståelser om professionell verksamhet (åter)skapas i ledarskapsprocesser. Utifrån en socialkonstruktionistisk ontologi etableras en teoretisk referensram där ett relationellt perspektiv på ledarskap utökas med en förståelse av social interaktion som en förhandlad ordning. Detta perspektiv når bortom kontextlösa förståelser om heroiska ledare som okritiskt förväntas flytta runt sin kompetens och uppmärksammar istället hur organisatorisk riktning skapas i komplexa förhållanden mellan kulturellt situerade aktörer.

 Nyckelord: ledarskap, profession, interprofessionsbaserad organisering, förhandlad ordning, diskurs, maktbas, subjektsposition, handlingsutrymme, organisatorisk humor, lederksamhetskultur, sjukvård
‘For physicians there is only one kind of science and that is randomized double-blind studies. Everything else is crap. And we learn it from day one.’

Listening to the sound of my own laughter echoing across the picturesque little café in Lund, southern Sweden, I couldn’t help but feel fascination at how the medical student, who just had mocked the profession he was about to enter, somehow succeeded in navigating the fine line between awareness and superiority. The sarcasm in the utterance was striking. At the same time, there was also somewhere a confidence implying that the elitist approach to knowledge construction should be considered legitimate, or – at least – accepted. Furthermore, the socialization aspect of medical training became particularly intriguing, especially since it appeared to be working excellently in fulfilling its purpose.

‘Just by being physicians, you will all become leaders.’

When some weeks later I got to hear that ‘the extremely limited leadership training in medical school begins with a clarification of how all physicians will take on the role as leader’, I was convinced that the unfolding ‘leadership’ presented certain challenges. If physicians are seen as the natural leaders, how are organizations affected when flows of authority and influence depart from limited understandings of knowledge? Is it problematic that different occupations experience diverging status – or could hierarchies rather be considered an opportunity in service provision requiring autonomous assessments and instant decisions? In any case, what happens when formal managers without a medical background enter the healthcare arena? And what happens when professional boundaries become increasingly contested while new ways of organizing work advocate distributed forms of leadership?

I had just finished my 5-year training in Industrial Engineering and Management at the Royal Institute of Technology, and was now – boosted by my own socialization – ready to naively launch myself on the world and start diagnosing organizations.
However, while many friends chose the track as ‘20-something unskilled dude from Stockholm School of Economics’ (surgeon slang for management consultant), I rather consulted the theories behind the models and embarked on the process towards becoming a PhD. And indeed, it has been a process to remember. I have pushed myself to the limits and beyond. I have floated between euphoria, despair and everything in between. On this emotional roller coaster, I have also had the privilege of meeting inspiring physicians, nurses, business developers and fellow researchers. Linking their many stories together, I have come to realize that complex social phenomena cannot be measured or objectively assessed (maybe this would have been possible with randomized double-blind studies?). Still, the understanding of how leadership is enacted in everyday practice has truly expanded my frame of reference, and I bring with me a reflecting attitude that will be indispensible in future encounters with people from different ontologies.

Coming to an end of this five-year journey, I would like to express my sincerest gratitude to all the people who have made it possible from the very beginning. First and foremost, I want to direct a huge thank you to the business developers, nurses, and physicians who so openly have received me in their organizations. Special thanks to Louise Hagander for showing interest in the research project and opening so many doors. I further direct my deepest appreciation to all the patients, women in labor, and relatives of these strong people who have borne with my presence in the most exposed of situations. This work would not have been possible without your curious and unselfish welcome.

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unconditional support means the world to me. Thank you for treating me like a queen when I needed it the most!

For PhD students there are certainly different kinds of science but only one true feeling of freedom. Everything that might seem as crap actually turns out to be something rewarding in the end. And we learn it when we’re finally done.

_Erika Lokatt_
Lidingö, February 2019
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1. Introduction

In September 2010, HRH Crown Princess Victoria of Sweden broke ground on the New Karolinska Hospital (NKS) project in Solna, Stockholm. Almost eight years and 14.5 billion SEK later, the circle was closed when her father in May 2018 formally opened the gates to 36 operating theaters, 630 treatment rooms and two helipads. The journey towards an ultramodern hospital has, however, been dogged by controversies. While ambitions to meet the most challenging illnesses and injuries with the most advanced healthcare have guided the process forward, critical voices have accused the project of promising much but delivering little. A major stream of criticism centers on the market mechanisms that have been claimed to permeate the undertaking – from planning to completion. Originating in visions of efficiency through patient-centered care, a flow-oriented design has called for built-in flexibility where any medical function could be placed anywhere within the hospital’s walls. The resulting construction – where all areas accordingly have been dimensioned to handle the heaviest and most advanced equipment – has not only been criticized for inefficient use of resources, but has also been referred to as a flexible ‘shell’ supporting competition-driven business strategies stemming from notions of New Public Management. Beyond the many controversies and references to New Public Management, it is critical to acknowledge how leadership structures have been informed by the patient-centered, flow-oriented business model. Recognizing how the future of healthcare to an even greater extent will build on interdisciplinary collaborations between different professions and functions, NKS’s organizational chart originates in a vision to facilitate teamwork and share leadership across professional boundaries. Within interprofessional management teams, an appointed ‘head of patient flow’ is today expected to share responsibilities for strategic decisions with physicians, nurses, researchers, economists, business developers, representatives of patient groups, and other occupations. Regardless of underlying political agenda, the NKS project thus clearly illustrates how contemporary societal trends have started to challenge traditional notions of leadership in professional services.

Patient-centered care, with care flows and teamwork across professional boundaries, is – however – nothing unique for the ultramodern hospital in Solna, but can today be discerned throughout the whole Swedish healthcare system as well as internationally. Many hospitals have in recent decades incorporated ideas of Lean production (with special focus on emergency clinics and operating theaters), but have also embraced patient-centered solutions where healthcare comes to the patient rather than the other way around (e.g. through
multidisciplinary clinics for heart-, kidney- and diabetes disease). The emphasis on increased collaboration across healthcare functions and medical specialties not only reduces the distance between knowledge bases, but also puts expectations on different professions to share responsibilities and together find organizational direction in the advancement of healthcare. It is evident how new organizational logics thus formally interfere with previous hierarchical orders of authority and influence, where the most established profession (medicine) typically has exerted undisputed control over strategic decisions.

The healthcare system in general – and NKS in particular – is further only one of many arenas where contemporary restructuring confirms how profession-based organizations are seeing a shift towards more interprofessional ways of organizing work. Physicians, solicitors, accountants, and other institutionalized professions have during the last decade started to approach foreign occupational groups through different forms of joined-up services, multidisciplinary and multi-agency teams, multi-professional and multi-agency partnerships, inter-professional collaborations, multi-professional practices, integrated services, etc. While this trend presents favorable preconditions for increased quality and efficiency in professional services, it also – inevitably – comes to challenge previous well-established structures for influence and decision-making. Where legitimate notions of interprofessional work arrangements have historically been inherent in strong hierarchies and professional meritocracies, ambiguous interprofessional boundaries now open up for new interpretations of authority and control. Although executive management structures might be formally established in organizational charts, it has been noted how conflicting expectations and struggles for influence not only come to impede interprofessional excellence, but also affect the quality of services offered to a client or a patient. In order to reap the potential of interdisciplinary collaborations, the (hidden) power dimension of the ambiguous leadership processes that unfold has to be further assessed.

The present work will take its point of departure in the emerging ‘inter-professional’ landscape that challenges traditional, hierarchical notions of authority and influence by reconceptualizing the understanding of professional organizations. By exploring how organizational direction is established in this new era of profession-based organizing, the power dimension of leadership practices can be better understood. Regardless of what formal structures suggest, who is enabled to exert influence? What dominant notions of profession-based organizing are constructed? And what implications do these notions have for leadership in professional services?
1.1. Traditional conceptions of profession-based organizing – The superfluous leadership

Although the concept ‘Division of labour’ originally was coined within a manufacturing context (Smith, 1776), it should be acknowledged how the ideas about efficiency through specialization link to the professionalization of our society. The rise of closed professional communities through extensive, standardized training could productively be understood as a specialization of knowledge with the aim of efficiently meeting the most fundamental human needs (justice, health, economic wealth, etc.). Institutionalized professions have thus for many centuries enjoyed considerable privileges in our society, where the possession of exclusive, highly regarded knowledge bases – accompanied by an altruistic drive to serve society rather than personal interests – has granted them power, prestige and autonomy over their own work (Sarfatti Larson, 1979).

Defined as ‘an ideal type where the organization of, and control over work is realized by the occupation instead of by the market or by an hierarchy’ (Freidson, 2001, p. 9), professionalism as a concept has originally emerged in the belief that some areas of work are too specialized to be performed by individuals lacking extensive education and experience, while also being too complex to become standardized, rationalized or commercialized. Professional practice in its traditional form has accordingly become characterized by a certain mystification, spanning beyond the technical knowledge of a subject into philosophical areas of moral and ethics. While many occupations can rely on standards or praxis, the established professions are more often confronted with situations where their ability to critically evaluate context-dependent circumstances is brought to a head. When decisions cannot be made objectively, ethical reasoning and emotional involvement become central in the evaluation of different outcomes. For the medical profession, critical decisions typically arise when possible benefits of treatment have to be assessed in the individual case. Physicians are also repeatedly faced with situations where the quick onset of a medical intervention must be weighed against a complete assessment of a patient’s medical record or somatically complicating circumstances. Within the legal system, professions make instant decisions about whether to act in self-defense or not, but are also facing situations where they might convict an innocent person, or defend a guilty client. The professional practitioner must thus not only master an esoteric knowledge base, but should also consult the emotional compass and trust their own judgment where no rules seem applicable. Daily decisions can provide
justice or save people’s lives, but might as well have devastating consequences, whether in an emergency room or in a court.

The mystification permeating traditional understandings of professionalism is reflected in the ways that professional work has historically been organized. Rather than ascribing power to an administrative apparatus, profession-based organizations have traditionally been coordinated through the standardization of skills (Mintzberg 1980; Mintzberg 1983). Within a bureaucratic yet decentralized structure, trained professional practitioners have been trusted to make autonomous decisions without interference from other occupational groups. Acknowledging how influence thus rests within the closed professional communities in the operating core, the concept of leadership has become particularly peculiar in these contexts. Huq et al. (2017) emphasize how the role of formal management typically is downplayed in profession-based organizations:

‘[…] managerial influence over professional work is limited, at best […]. More often, professionals themselves develop solutions related to issues concerning their own work…’

– Huq et al., 2017, p. 515

This links to Mintzberg’s (1980) description of how professional workers ‘maintain collective control of the administrative apparatus of the organization’ (p. 334). As middle line managers typically belong to the established profession – while also sharing administrative tasks with the operating core – the professions make sure that they are in control not only of their own work, but also of administrative decisions that affect them (e.g. hiring of professional workers, promotions, distribution of resources, etc.). These structures render traditional notions of labor management inapplicable in profession-based forms of organizing. Rather, the privilege of autonomy and self-regulation has historically constructed bureaucratic structures with implicit action repertoires for organizational influence and decision-making (Mintzberg, 1980; Mintzberg, 1983). Where a professional rather than an administrative hierarchy has distributed organizational responsibilities, the practice of leadership – commonly understood as exerting authority and influence – has historically been attributed to the most prestigious profession within an organization, as explained by Huq et al. (2017):
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‘Within healthcare, but also in other professionalized settings, there is an established and well-accepted status hierarchy that affects decision-making (Abbott, 1988; Freidson, 2001). For example, medical professionals (physicians) hold the highest status in comparison to other health professionals. [...] Nurses are subordinate to doctors; physicians delegate tasks to nurses and oversee this delegated work (Abbott, 1988; Freidson, 1989).’

– Huq et al., 2017, p. 518

Hierarchical notions of authority and influence have thus traditionally pictured leadership as being inherent in the professional role, inferior to heroic notions of professionalism as overarching organizational logic. Where the coordination of work is achieved through standardized training – and decisions are made autonomously in closed professional communities – an explicit leadership concept becomes superfluous. Interestingly, this understanding has constructed a reality where leadership is not exclusively perceived as something positive, extraordinary and ‘fancy’, which often becomes the case in other organizational contexts (cf. Alvesson & Sveningsson, 2003).

Although established professions still today enjoy considerable influence in our society, external factors have come to challenge the traditional, hierarchical understanding of profession-based organizations. Acknowledging how notions of professionalism are informed by values and assumptions in the surrounding sociocultural context, it should be stressed how professional practice becomes part of a larger complex landscape where political, economic, educational and social trends all interact and continuously shape the preconditions for professional work (Noordegraaf, 2011; Butler et al., 2012). In recent decades, competing understandings of professional practice have accordingly emerged through a variety of external pressures.

1.2. Towards interprofession-based organizing – The ambiguous leadership

The changing preconditions for professional practice partly derive from an increased professionalization in society, where different occupational groups have succeeded in reaching professional accreditation and consequently have started to compete with more institutionalized professions for the same (or similar) knowledge credentials (Freidson, 2001; Ackroyd & Muzio, 2007; Brante, 2010). While management and nursing practices have slowly started to encroach upon the mysterious world of
medicine (Banh & Connelly, 2002; Dent, 2008), solicitors simultaneously feel a rising competition from claim handlers and will writers, but also from more established professions such as accounting and different forms of business advisory (Muzio et al., 2008; Muzio & Ackroyd, 2005; Dezalay, 1995; Dezalay & Garth, 2001). The rise of corporate professionalism (Muzio et al., 2011; Paton et al., 2013) has further opened up for more entrepreneurial communities to claim professional status and compete for knowledge credentials. Consultancy, project management, information technology, advertising, supply chain management, human resource management and other occupations have in recent years successfully relied on market mechanisms to stimulate a demand for new specialties. Similarly, also Knowledge Intensive Firms (KIFs) have succeeded in claiming professional jurisdictions (Kipping & Kirkpatrick, 2008; Kärreman et al., 2002). The increased professionalization can be traced to an education hype and new understandings of knowledge credentials (Brante, 2010), but also to a more conscious gender debate (Noordegraaf, 2011), where women-dominated occupations – historically restricted to notions of semi-professionalism – have reached professional recognition. An illustrating example of the latter is how nursing, which was long considered ‘a natural extension of women-hood’ (Lindgren, 2000), in recent decades has been able to draw on knowledge credentials in its quest for professionalization (Yam, 2004).

A stronger emphasis on managerialism and organizational efficiency (Leonard, 2003; Agevall & Jonnergård, 2007; Levay & Waks, 2009) has further challenged professional autonomy. Many formal rights of decision-making have recently moved from a professional to a managerial level (Andersson, 2015), while operational procedures have become more standardized (Parding et al., 2012). In healthcare practice – where the medical profession has historically claimed unquestioned autonomy over strategic planning – chief nurses are today responsible for budgeting and cost control (Bolton, 2005), while quality registers are frequently consulted on treatment decisions (Hansen, 2007). These structural changes typically derive from innovations and technical advancements (Noordegraaf, 2011), where a demystification of esoteric knowledge bases has exposed professional practice to outside scrutiny and – accordingly – advocated more evidence-based work procedures.

Also, new forms of organizational arrangements (e.g. joined-up services, multi-disciplinary and multi-agency teams, multi-professional and multi-agency
partnerships, inter-professional collaborations, multi-professional practices, integrated services) have added to the complexity of profession-based organizing (Noordegraaf, 2011). In a changing society where new authority relations, conflicting cultural norms, new household compositions, and many other factors now present more multifaceted forms of social problems than ever, Noordegraaf (2011) emphasizes how these problems make new demands on professional practice. In healthcare, it has specifically been stressed how aging populations and a ‘growing awareness of complex intersections between biological and social determinants of health’ render professional practice more complicated (Reeves et al., 2009, p. 634). As many complex cases become difficult to assess by single professions specialized in one academic field, the changing nature of societal needs calls for multiprofessional perspectives in service provision. Within these new forms of work arrangements, different professions are expected to collectively engage in the production of organizational direction, as explained by Huq et al. (2017):

‘[…] with the increasing trend in organizations to combine the services of multiple professionals, new challenges arise (Noordegraaf, 2011). Today, organizational strategies call for inter-professional collaboration (IPC), an attempt to resolve complex problems by combining professionals’ different problem-solving approaches.’

– Huq et al., 2017, p. 518

While strongly institutionalized, hierarchical ways of organizing work for many decades have guided professional practice, the traditional bureaucratic yet decentralized structure has recently become challenged by a plethora of external factors. Having enjoyed unchallenged autonomy for many years, professional practitioners in the operative core must now not only share formal power with other organizational functions, but should also learn to engage with foreign occupational groups and together find direction in the provision of professional services. It could – therefore – be argued that professional practice is currently facing a ‘reversed division of labour’, where different knowledge bases meet each other in an era of interprofession-based organizing. This era puts emphasis on cooperation between professional groups within the same organization, but also fosters interprofessional work relations across organizational boundaries. It is characterized by diversified professionalism, increased competition and ambiguous power relations.
Acknowledging how the golden age of professional practice has seen its day, Ackroyd & Muzio (2007) describe an ‘increasingly hostile ideological, institutional and economic environment in which professions operate’ (p. 732). The many conflicting understandings of profession-based organizing have fostered an increased competition within the interprofessional landscape, where emerging discourses on professionalism, managerialism and organizational efficiency together have started to challenge previously unopposed ways of exerting authority within interprofessional work arrangements. Where notions of organizational influence were earlier established in professional status hierarchies and meritocracies, shifting power balances have now overthrown the former pre-established action repertoires, calling for new understandings of leadership within these contexts. As stressed by Chreim (2013):

‘When different professions work together, they bring with them different sources of expertise and different professional cultures that must be bridged and mobilized to generate collaborative action (Leathard, 2003; D’Amour et al., 2005). In such settings, the authority, legitimacy and expertise needed to solve problems is necessarily distributed among different individuals, rendering traditional hierarchical conceptions of leadership problematic.’
– Chreim, 2013, p. 202

Conflicting expectations and structural inertia add further to the complexity of leadership practice in an era of interprofession-based organizing. Whereas contrary demands on structures for decision-making create unclarities in mundane work relations, hierarchical notions of organizational influence seem to be protected through prevailing power orders. A distinguishing stage in the traditional professionalization process has always been – and is still – the formation of a closed community through regulated training (Sarfatti Larson, 1979). This normalization process, seeking to protect the profession’s esoteric knowledge base from outside scrutiny (Brint, 1993), still comes to portray professionals within established professions as natural leaders. At the same time, upcoming professions start to take on managerial roles where they formally exert influence over organizational decisions that lie in the more established professions’ interest to control. Thus, while traditional conceptions of autonomy and self-regulation are still being reinforced through professional education, these conceptions often stand in contrast to formal notions of a more distributed leadership. Although being challenged by new discourses on organizing, it has also been noted how the established professions
often succeed in (superficially) protecting traditional conceptions of professional practice. As contended by Huq et al. (2017):

‘[…] professionals hold sufficient power to sustain traditional ways of working even when pressured to change…’

– Huq et al., 2017, p. 518

Within healthcare, this phenomenon has manifested itself through different forms of medical dominance (Reeves et al., 2009; Nugus et al., 2010), but also through how professionals respond to external pressures by ‘bypassing managerial systems and by building their own devices for improving patient safety and quality’ (Noordegraaf, 2011, p. 1355). Within the legal profession, Muzio and Ackroyd (2005) have similarly described how a hierarchy dominated by professionals is preserved through internal stratification. It is critical to note how diverging interpretations of authorities open up for increased ambiguity within organizational arrangements. When established professions no longer maintain formal control of the administrative apparatus – and different professions continuously compete for influence – conflicting understandings of power structures typically come to impede efficient collaborations. Noordegraaf (2011) uses the term organized responses to emphasize how contemporary external pressures not only call for new ways of providing effective services, but also for new ways of understanding professional practice. In these ‘liquid times’, where knowledge bases and responsibilities overlap each other, he argues that strict distinctions between management, profession and organization should be avoided:

‘Instead of portraying professional and organizational domains as oppositional, they can be seen as interconnected, and new professional/organizational configurations can be traced. More specifically: organizational tasks – planning, scheduling, allocating resources, management development, and the like – are not necessarily at odds with professional work. Increasingly, organizing and managing must be seen as professional issues.’

– Noordegraaf, 2011, p. 1358

New forms of work arrangements thus suggest that managerial and organizational activities are closely interlinked with professional practice. Noting how neither ‘a return to professionalism’ – where occupational structures and professional values are protected – nor ‘a move beyond professionalism’ – where organizational control
is modernized – succeeds in capturing organizational dynamics, Noordegraaf (2011) stresses how contemporary restructuring calls for notions of an organized professionalism, where organizational logics are embodied in professional practices. Still, he concludes that research typically continues to make dichotomies between professionalism and organizing as well as between profession and management.

1.3. The clarion call for clarification
Within traditional understandings of profession-based organizing, the leadership concept has been superfluous for assessing how authority and influence are exerted. However, new ways of understanding and organizing professional practice have in recent decades put leadership in the limelight. Where discourses on societal problems and organizational efficiency now start to question traditional understandings of professional autonomy and influence – at the same time as ideas about shared responsibilities across professional boundaries challenge the established hierarchy between professions – power structures become more ambiguous than ever. Within this complex era of interprofession-based organizing, dispersed perspectives on leadership hold the promise of shedding light on how organizational direction is established among the many competing understandings of professional practice. On a practical level, it has further been noted how struggles for influence foster a continuous negotiation that not only impedes collaboration across professional boundaries, but also affects the quality of services offered to a client or a patient. In order to reap the potential of interprofessional collaboration, the understanding of this negotiation needs to be advanced. This can be achieved by shedding light on how organizational direction is established.

1.4. Leadership as relational process
In order to reach beyond dichotomies and assess how dominant notions of professional practice are constructed, leadership as a phenomenon must nevertheless be understood in a productive way. The leadership concept has traditionally been approached from individual-oriented perspectives, focusing on the appointed leader and the leader-follower relation (see Carlson, 1951; Burns, 1978; Bass, 1990; Kirkpatrick & Locke, 1991; Bryman, 1993; Portugal & Yukl, 1994; Gill, 2002; Brown et al., 2005; Hay, 2014). These perspectives have typically described heroic notions of ‘the leader’, where masculine constructs lay the foundation for leadership ideals (Crevani et al., 2010). When seeking to understand how organizational direction is established in contemporary forms of interprofession-based organizing, however,
other perspectives are called for. Where ambiguous interprofessional boundaries, strong hierarchical traditions, an increased emphasis on interprofessional collaboration and formal notions of a distributed leadership now present conflicting expectations of organizational practice, it becomes critical to move beyond the understanding of individual leaders/managers and assess how leadership is enacted in complex relational processes, as pointed out by Empson and Langley (2015):

‘Conventional models of leadership are predicated on the assumption that leaders, by definition, must have followers. […] In a professional service firm (PSF), the distinction between ‘leaders’ and ‘followers’ is problematic as traditional hierarchical dyadic relationships are replaced by more ambiguous and negotiated relationships amongst professional peers.’

– Empson & Langley, 2015, p.163

Acknowledging how distributed understandings of leadership have scarcely been adopted in profession-based forms of organizing, the present work seeks to increase the understanding of how dominant notions of professional practice are collectively constructed in these contexts. Informed by a relational, processual perspective on leadership (Uhl-Bien, 2006; Drath et al., 2008; Crevani et al., 2010; Crevani, 2011), it becomes possible to scrutinize everyday activities that have a significant bearing on the production of organizational direction, but nevertheless tend to be overlooked from a view of leadership as something exercised by a limited set of individuals. By exploring how mundane instances of interrelating (re)construct legitimate notions of professional practice, the unfolding organizational direction can be captured beyond dichotomies and formal management structures. The relational, processual understanding of leadership departs from a social constructionist approach (Berger & Luckmann, 1966) where reality and knowledge are seen as socially constructed in interactions between individuals. These interactions are in turn acknowledged to involve the negotiation of a social order, where sociocultural understandings of organizational practice inform how organizational actors are enabled to claim influence (Uhl-Bien, 2006; Hosking, 2007). In mundane instances of interrelating, cultural values and assumptions guide behavioral patterns (Schein, 1984). Leadership can thus be conceptualized as a set of relational processes by which organizational direction – informed by the social order – is produced. Uhl-Bien (2006) elaborates on how the social order not only informs interactions, but also becomes reinforced as interdependencies are established within the organizational context:
'Interdependencies are organized in ways which, to a greater or lesser degree, promote the values and interests of the social order [...].'

– Uhl-Bien, 2006, p. 662

Building on the same logic, Crevani et al. (2007) highlight the ‘performativity of leadership discourse’ by stressing how dominant conceptions constructed in leadership processes in turn come to enable and constrain action repertoires for different organizational actors. It is important to stress, therefore, how a relational, processual perspective on leadership in no way assumes leadership processes to be egalitarian or harmonious. While flows of influence indeed emerge in collective processes, it is critical to highlight how individuals or groups often have conflicting interests and also different possibilities of influencing the organizational direction that unfolds (Crevani et al., 2010). Still, when describing how influence is distributed between organizational actors, relational perspectives on leadership tend to overlook this power dimension.

Acknowledging how the relation between leadership and management has been heavily debated over the years (cf. Zaleznik, 1977; Bennis & Nanus, 1985; Kotter, 1990; Drucker, 1955; Carroll & Levy, 2008), it is important to stress how strict distinctions between these organizational phenomena complicate an understanding of how influence is produced in relational processes. While formal management positions could prove to be critical for possibilities of informing the organizational direction, the social order might instead ascribe influence to other organizational actors through political processes. It is, therefore, critical to move beyond a dichotomic divide between leadership and management, and recognize how organizational actors (formal leaders, informal leaders, ‘not even informal leaders’) collectively engage in leadership practices. This shifts the unit of analysis from individual actors (leaders/managers) to relational processes, as clarified by Denis et al. (2012):

‘These studies conceptualize leadership as a social phenomenon, as a collective process in which formally designated individuals may play a role, but from which it is impossible to ignore other actors. The place of individuals is thus reduced: actors are present in leadership— enacting it, influencing it, and creating it—but they are not ‘containers’ of leadership.’

– Denis et al., 2012, p. 254
These insights further call for a clarification of leadership practices. While leadership work indeed involves strategic decisions, it predominantly plays out in mundane instances of interrelating (Crevani, 2011; Lindgren & Packendorff, 2011). When different occupations discuss strategies, distribute work tasks or even trashtalk each other during lunch breaks, they articulate notions of organizational practice while simultaneously (re)establishing the social order. This emphasizes the potential of leadership in every social situation. Within profession-based forms of organizing, a relational, processual understanding of leadership implies that leadership processes produce flows of influence by (re)constructing legitimate notions of professional practice. Leadership is expected to play out in mundane instances of interrelating – in any situation where the social order is consolidated or challenged. Exploring leadership from a relational, processual perspective, it is accordingly possible to reach beyond formal structures and assess how flows of influence emerge among competing understandings of professional practice. These insights should advance the understanding of who is enabled to exert influence, what dominant notions of profession-based organizing are constructed, and what implications these notions have for leadership in professional services.

1.5. A negotiated order-perspective on interprofessional interaction

Stressing the performativity of leadership discourse, the dynamics of interprofessional interaction become imperative in the processes by which dominant notions of professional practice are (re)constructed. Still, the area of interprofessional interaction remains underdeveloped (Fitzgerald, 2016). Embracing the need for a more dynamic understanding of this field, a growing research tradition has started to scrutinize the healthcare organization as a negotiated order (Svensson, 1996; Allen, 1997; Reeves et al., 2009; Nugus et al., 2010). Rather than deriving behavior from formal structures, this perspective draws attention to how a continuous negotiation between organizational actors establishes assumptions about organizational practice. Elaborating on how these micro-processes accordingly constitute ‘the key factor to the development and maintenance of social order within organizations’ (Reeves et al., 2009, p. 642), studies within the negotiated order tradition have predominantly been able to shed light on different forms of medical dominance. Reeves et al. (2009) conclude that formal as well as informal interaction between physicians and other healthcare workers often unfolds as unidirectional, where physicians request information from other occupations that are anxious about engaging in medically
oriented dialogues. Nugus et al. (2010) further describe how the medical profession in some situations employs ‘collaborative power’ to discuss strategic undertakings with other healthcare occupations, but more often falls back on ‘competitive’ forms of power in order to avoid discussions and thereby ‘dominate’ other occupations.

While these insights stress the context-dependency of interprofessional interaction, the understanding of how notions of medical dominance are sustained in the organizational context remains limited. Seeking to scrutinize the dynamics of interaction – and explore how the medical profession seems to succeed in maintaining influence over healthcare practice – the understanding of a negotiated order has to be advanced. While discussions between physicians and other healthcare providers indeed constitute an important aspect of negotiation, it should be stressed how also the absence of discussions between professions challenges or reinforces notions of (inter)professional practice. Rather than referring to this lack of communication as ‘a non-negotiated order’ (cf. Allen, 1997), it is critical to acknowledge how any pattern of collective interrelating potentially informs the social order. Salhani and Coulter (2009) highlight the limited understanding of power within the negotiated order tradition by suggesting that ‘these studies stop just short of exploring an explicit political analysis of interprofessional relations’ (p. 1222). Seeking to advance the understanding of micro-political struggles in interprofessional interaction, the authors further describe how nurses’ strategic endeavors to increase their professional status can be explained through different forms of power. For example, ‘power over’ depicts how nurses embark on a form of domination (different from the one described for physicians above) by simply ignoring and refusing to legitimize orders from other professions (particularly medicine). Similarly, ‘power to’ refers to how nurses seek to transform their formal control to a more ‘substantive control of the unit and related interprofessional work processes’ (p. 1227) by making their own decisions without consulting other professions. While these mechanisms shed light on how political processes play out in the absence of direct communication, they still fall short in explaining how power actually interferes with the social (hospital) order and distributes influence through collective processes of interrelating. In order to advance the understanding of interprofessional interaction, power has to be recognized as a relational phenomenon (Willmott, 2013). Rather than ascribing power to individuals or groups, it should be acknowledged how power emerges in collective processes where the social order is consolidated or challenged. While the social order informs the distribution of power
by articulating dominant notions of professional practice, power also informs the social order through its productive, defining role. This implies that dominant notions of professional practice are challenged or reinforced through the power dimension of collective processes. Stressing how power stands in close proximity to the social order, there is thus a need to scrutinize the patterns of interrelating (which includes interaction as well as ‘non-interaction’) in order to understand how power mechanisms play out in mundane instances of daily work. This more dynamic understanding of a negotiated order becomes productive for assessing the relational processes by which organizational direction is (re)established. The relational, processual perspective on leadership could thus be advanced by recognizing leadership processes as a continuous negotiation for influence, where power mechanisms become central in informing the unfolding organizational direction.

1.6. Aim and research questions

In an era of interprofession-based organizing – where traditional hierarchical dyadic relationships are replaced by more ambiguous and negotiated relationships amongst professional peers – the present dissertation aims to explore how dominant notions of professional practice are (re)produced in leadership processes. Leadership processes will be conceptualized as a continuous negotiation for influence, where established and upcoming professions collectively construct organizational direction through mundane instances of interrelating. Stressing the power dimension of these processes, the study will be guided by the following two research questions:

RQ1: How do power mechanisms enable and constrain certain directions in leadership processes within contemporary arrangements of interprofession-based organizing?

RQ2: What dominant notions of interprofession-based organizing are (re)constructed when these mechanisms play out in practice?

The first research question draws attention to the dynamics of leadership processes. Increasing the understanding of how different power orders interfere with each other in mundane instances of interrelating, a conceptual model of the continuous negotiation for influence will be established. This model will shed light on how sociocultural assumptions about professional practice enable and constrain possibilities of engaging in social practices, but also how social practices in turn come to challenge or reinforce dominant sociocultural assumptions about professional practice. Shifting focus to the organizational consequences of leadership processes,
the second research question will be approached by identifying how established patterns of interrelating construct images of organizational roles and further relate these roles to expectations of how strategic goals should be achieved. In this way, it is possible to explain not only who is enabled to take part in organizational development, but also why some notions of interprofession-based organizing are (re)constructed in the continuous negotiation for influence.

Embracing the potential of a negotiated order-perspective in leadership research, the dissertation will primarily focus on the healthcare context. Nevertheless, the results are expected to have broader relevance. While the healthcare organization indeed is unique in its composition of internal professional networks, many other professional environments are currently seeing the same shift towards distributed forms of formal leadership (in the form of joined-up services, multi-disciplinary and multi-agency teams, multi-professional and multi-agency partnerships, inter-professional collaboration, multi-professional practices, integrated services, etc.) (Noordegraaf, 2011). It is, therefore, legitimate to assume that the dynamics of interprofessional negotiation in the healthcare case to some extent are also transferable to other fields of interprofession-based organizing, where they are expected to present similar preconditions for the unfolding organizational direction.

1.7. Expected contributions
The work sets out to enrich a relational, processual perspective on leadership with a negotiated order-perspective on interprofessional interaction. Acknowledging how notions of relational leadership have scarcely been explored in profession-based contexts, the main objective is to increase the understanding of how leadership processes manifest themselves in an era of interprofession-based organizing. Situating the study within the complex healthcare organization, the thesis also adds to the negotiated order tradition by advancing the understanding of dynamics within interprofessional interaction. Stressing the power dimension of these processes, the aspirations are further to highlight the critical aspect that is often found to be lacking in common understandings of relational leadership (Denis et al., 2012; Endres & Weibler, 2016). Noting how contemporary research tends to construct professionalism and organizing, as well as profession and management, as diverging phenomena (Noordegraaf, 2011), the thesis finally seeks to problematize these dichotomies and explore how leadership practices are established within professional responses to external circumstances. Such an understanding should add
a relational, processual dimension to the emerging field of organized professionalism.

On a practical level, the results should provide valuable insights for policy makers as well as professionals and appointed leaders (e.g. medical- and non-medical managers) in different fields of profession-based organizing. A more nuanced understanding of the power dimension of leadership practice could make it easier to see why change initiatives encounter obstacles, why production processes often prove inefficient, and why multi-professional teams find it hard to excel.

1.8. Structure of the thesis
In this first chapter of the thesis, a research aim has been formulated and expected contributions have been discussed. Positioning the present work in relation to previous studies within the generous fields of leadership and profession-based organizing, a theoretical framework will in the following be established (Chapters 2–4). Chapter 2 develops a relational, processual perspective on leadership and suggests that an increased understanding of leadership dynamics should be obtained by studying mundane instances of organizational practice. Chapter 3 introduces competing notions of professionalism and contends that the concept is productively conceptualized as negotiated products of values and assumptions. Building on this perspective, it is further being explored how a plethora of external factors have started to challenge previous understandings of professional practice, calling for notions of interprofession-based organizing. Scrutinizing the relational, processual perspective on leadership within an era of interprofession-based organizing, the chapter concludes by suggesting that leadership processes could be understood as a continuous negotiation for influence. Elaborating on how this negotiation should theoretically be assessed, Chapter 4 develops a conceptual framework for studying leadership processes in an era of interprofession-based organizing. Acknowledging how a negotiation for influence is productively studied within the healthcare context, Chapter 5 further explores preconditions for professional practice within this curious setting. Chapter 6 proceeds by discussing the study’s research strategy. Arguing how interviews and observations at a large university hospital should provide valuable insights into the interplay between different power orders, a case study is outlined. Chapter 7 provides an introductory description of the social rooms observed within the empirical field. In Chapters 8 and 9, results from the empirical study then lay the foundation for an analysis of power mechanisms within leadership processes.
Chapter 10 elaborates on the organizational consequences of these power mechanisms. Findings are taken beyond the healthcare context, and the dynamics of interprofessional negotiation are summarized in a dominant leadership culture. Chapter 11 proceeds by discussing practical implications of the findings. In Chapter 12, the major contributions of the dissertation are finally summarized.
2. We don’t need another hero: Developing a relational, processual perspective on leadership

Leadership as a phenomenon has for many decades fascinated researchers as well as practitioners within different disciplines. Like professionalism, the concept has almost achieved a mythical status in our society, where it – despite an obvious dissensus on how it is to be interpreted (Stogdill, 1974; Burns, 1978) – continues to be perceived as something heroic and extraordinary (Alvesson & Sveningsson, 2003). Emphasizing the seductive nature of leadership, Calás and Smircich (1991) conclude that ‘without seduction, the leadership literature wouldn’t have been possible, it would have lost its (sex) appeal’ (p. 594). Adding to the problematization, Alvesson and Sveningsson (2003) propose that ‘leadership might not be as heroic and special as indicated in most of the literature’ (p. 1437) and – further – that ‘in many cases, the meaning and significance of leadership may be more closely related to the mundane than to the carrying out of great acts or the colourful development and implementation of strategies and changes’ (p. 1437). Still, they contend that leadership commonly continues to be ascribed some special and symbolic meaning.

Acknowledging how leadership is often romanticized in academic writings as well as in practice-oriented literature, it is important to point out how the concept should not uncritically be adopted to provide explanations about organizational phenomena. Conceptualized in a productive way – however – leadership becomes imperative in the understanding of how organizations find direction to move forward. The present chapter will elaborate on how a relational, processual perspective on leadership captures the dynamics of mundane instances of interrelating, in turn presenting possibilities to advance the understanding of how flows of influence emerge in a continuous negotiation for influence.

2.1. The relational turn in leadership research

Conventional leadership research tends to depart from individual-oriented perspectives, where the appointed leader and the leader-follower relation constitute the unit of analysis (Gronn, 2002). Studies of this unitary approach have, for example, explored the everyday work of leaders (Carlson, 1951), leadership traits (Stogdill, 1948; Kirkpatrick & Locke, 1991), the situational aspect of leadership (Vroom &
Yetton, 1973), the transactional, transformational and charismatic aspects of leadership (Willner & Willner, 1965; Burns, 1978; Bass, 1990; House & Howell, 1992; Bryman, 1993), notions of authentic leadership (George, 2003; Avolio & Gardner, 2005), the ethical (Brown et al., 2005) and spiritual (Fry, 2003) dimensions of leadership, leadership in organizational change (Gill, 2002), leadership for coping with social change and environmental issues (Portugal & Yukl, 1994), and leaders’ continuous identity work (Hay, 2014). While these studies provide insights into executive processes, it has been argued that many interactional aspects that have a significant bearing on how strategic decisions unfold easily are overlooked from the traditional view of leadership as something exercised by a limited set of individuals. Specifically, uncritical understandings of masculine leadership ideals have been argued to overshadow the dynamics of how organizational direction is actually established (Lindgren & Packendorff, 2011).

In recent decades, it has been acknowledged how an understanding of leadership as a collective phenomenon, distributed or shared between individuals, better succeeds in capturing organizational dynamics. This pluralistic understanding of leadership typically encompasses four different streams: (1.) sharing leadership in teams, (2.) pooling leadership at the top of organizations, (3.) spreading leadership across boundaries over time, and (4.) producing leadership through interaction (Denis et al., 2012). While the first three streams ‘tend to equate leadership with what specific individuals identified as leaders do, starting with the existence of these distinct individuals and considering various elements such as their qualities, their behaviors, or their effectiveness’ (Denis et al., 2012, p.254), the last stream emphasizes that ‘leadership is fundamentally more about participation and collectively creating a sense of direction than it is about control and exercising authority’ (Denis et al., 2012, p. 254). Rather than relying on the context-free conceptions of heroic leaders who are expected to bring their competencies to any suitable place, the interactional understanding of leadership thus recognizes how organizational direction is produced in more complex relationships between culturally situated organizational actors (Lindgren & Packendorff, 2011).

2.2. Understanding leadership as a relational, processual phenomenon

Acknowledging how organizational members in general – and professional workers in particular – do not act in isolation, but in a continuous relation to others and
embedded in context, it is critical to understand how dominant notions of professional practice are (re)constructed in relational processes between organizational actors. The present work will accordingly adopt a relational, processual view of leadership (Drath et al., 2008; Crevani, 2011; Lindgren & Packendorff, 2011). Instead of focusing on ‘objective laws of human behavior’, this perspective draws attention to how the intersubjective day-to-day experiences and practices of people involved in leadership activities construct organizational direction through ongoing interpretation and interaction among individuals. The micro-processes of intersubjectively creating social realities thus come to represent the leadership mechanism (Endres & Weibler, 2016, p. 14).

While stressing how the construction of organizational direction (organizational paths, overall goals, aims and mission) constitutes the core feature of leadership processes, Lindgren and Packendorff (2011) describe different mechanisms through which leadership plays out on the local-cultural organizational level. In their study of project management within a small biotechnology venture, they note how the constant search for organizational order and clarity fosters endeavors to process issues (e.g. through decision making and problem solving), resolve ambiguities concerning responsibility, and develop understandings of identity bases within the organization. These processes of co-orientation, where dominant notions of organizational practice become temporarily established, thus inform the organizational direction that unfolds. Images of different organizational roles are constructed and these images are related to expectations on how organizations should work in order to reach their goals. In this way, influence is distributed between organizational actors.

2.3. Addressing the seemingly inexhaustible leadership/management-debate

Elaborating on how influence is not necessarily connected to formal organizational positions, it seems important to stress that a relational, processual perspective on leadership moves beyond conventional distinctions between leadership and management. While relational perspectives have started to gain ground within leadership research, the relationship between leadership and management seems to be a constant source of contestation. Some scholars advocate a dichotomic divide between these two organizational phenomena, whereas other perspectives rather depict leadership as part of a broader management concept. Distinctions between
leadership and management typically stem from a divide between formal control and operational influence. Zaleznik (1977) argues that ‘leaders develop visions and drive changes whereas managers monitor progress and solve problems’ (Jackson & Perry, 2018, pp. 10-11). In a similar vein, Bennis and Nanus (1985) suggest that ‘managers do things right, while leaders do the right thing’ (Jackson & Perry, 2018, p. 11). Kotter (1990) further contends that not all managers are leaders, and not all leaders are managers. It is interesting to note how all these platitudes, while falling short in actually advancing the understanding of organizational complexities, add to the understanding of leadership as something heroic, extraordinary and fancy. Supporting a view that leadership is part of a broader management concept, Drucker (1955) instead argues that ‘leadership is one key task of management’ (Jackson & Parry, 2018, p. 11). Along the same lines, Carroll & Levy (2008) explain how managers, while striving for a leadership identity, tend to return to a default management identity that seems more familiar to uphold. These understandings highlight the complex undertaking of differentiating leadership from management. Still, the discussions draw heavily on individual-centered perspectives, where responsibilities, capabilities and identity work of individual actors are central in relating leadership to management, and vice versa.

From a relational, processual perspective on leadership, it seems neither productive, nor possible, to make clear distinctions between the two organizational phenomena. As complex sociocultural processes of interrelating stand in close proximity to a social order, flows of influence typically emerge beyond formal structures. An executive position could infer possibilities to claim place within the continuous negotiation for influence, but might as well be downplayed if cultural values and assumptions allow for other organizational actors (from follower-centered perspectives on leadership referred to as informal leaders) to draw on more powerful positions in the processes by which flows of influence emerge. Uncritically embracing traditional notions of management might thus challenge endeavors to advance the understanding of how leadership is collectively produced. While social interactions remain the unit of analysis, it should be stressed how not only appointed managers, but all organizational actors, engage in leadership activities. This understanding further implies that all organizational activities of interrelating could potentially be labeled as leadership, and that an exploration of relational leadership processes accordingly calls for a power analysis of mundane instances of social interaction. Still, it is important to bear in mind that formal management
arrangements could guide possibilities and limitations within the continuous negotiation for influence by informing sociocultural understandings of organizational practice. Interestingly, this understanding depicts management as being inherent in a broader leadership concept, that is, contrary to how the relation between these phenomena is often portrayed in conventional leadership research.

2.4. Exploring the ontological stance behind a relational, processual perspective on leadership

Ontologically, a relational perspective of leadership departs from the notion that reality is socially constructed (Berger & Luckmann, 1966). However, as described by Astley (1985) in Endres & Weibler (2016):

‘this is not to deny the existence of an objective reality independent of minds; . . . the point is only that our knowledge of objective reality is subjectively constructed’ (Astley 1985, p. 509). […] Therefore, knowledge about reality is neither objective nor purely subjective […]. Facts exist, but reality is not located in objective facts but in the sense and interpretations made of them on the basis of observed facts or experienced events.’

– Endres & Weibler, 2016, p. 4

Within leadership processes, constructed social realities should be understood as representations of how notions of knowledge and truth are challenged or reinforced through instances of interpretation and (non)interaction. Emerging flows of influence become the (current) representation of how notions of organizational practice are allowed to establish themselves as dominant in a certain context, for instance through the processing of issues, the resolving of ambiguities concerning responsibility and the developing of understandings of identity bases.

Elaborating on how dominant notions of professional practice are established in a continuous interplay with alternative, competing notions, it becomes productive to scrutinize the concept of discourse. Although definitions of discourse have been shown to proliferate significantly between different schools of thought, a common understanding of the phenomenon builds to a certain extent on Michel Foucault’s fundamental ideas that ‘discourses are something rather steady that set the limits for what can be understood as meaning’ and that ‘the truth is produced within the discourse’ (Jorgensen & Phillips, 2000, pp. 19-20). Commonly accepted ideas are always infiltrated with history, and discourses can, therefore, only be temporary
constructions formed by sociocultural notions prevailing within different landscapes and timescapes. This is why the social context becomes so important for understanding how certain notions of organizational practice are allowed to establish themselves as dominant.

While the Foucauldian understanding of discourse suggests that only one discourse can prevail at any specific time, the present work rather departs from the view that several discourses always co-exist beside each other and compete for acceptance (Jorgensen & Phillips, 2000). Professional practice is thus acknowledged to become overdetermined by heterogeneous acts of articulation. As important as understanding the historical rules that shape conceptions and interpretations (Bevir, 1999; Jorgensen & Phillips, 2000) is the identification of alternative interpretations, that on the basis of reigning social norms have not been allowed to establish themselves as obvious (Howarth, 2007). Conceptions that are ‘ignored’ can be seen to constitute a discursive field, in relation to which the dominating discourse is always being shaped and re-shaped (Jorgensen & Phillips, 2000). The ‘weaker’ conceptions are – despite their perceived invisibility – in fact what enables the ‘stronger’ conceptions to be accepted, since no phenomenon can be ascribed meaning without being understood in relation to a competing notion of itself. This is what the French philosopher Jacques Derrida stresses when pointing out how the constant contradictions making up humankind’s very existence become concealed through rationalization processes where unity is rewarded over differentiation (Cooper & Burrell, 1988; Hassard & Parker, 1993). The co-existence of different conceptions is also in line with how scholars have been able to conclude that ‘free and autonomous expressions often suppress alternative representations, and thus hide the monopoly of existing codes’ (Deetz, 2003, p. 24). A discourse could, therefore, be understood as a hidden reduction of possibilities, with the aim of creating unambiguousness (Jorgensen & Phillips, 2000). This implies that different notions of professional practice always co-exist beside each other and compete for acceptance, but also that some of these notions (temporarily) will become dominant in a certain sociocultural context.

2.5. Stressing the power dimension of leadership processes
In order to understand how certain notions of professional practice are allowed to establish themselves as dominant in an era of interprofession-based organizing, it becomes critical to address the constantly on-going power struggles between
different discourses. Drawing on Willmott’s (2013) critique of scholars who perceive power as an attribute to be possessed by individuals or groups, the concept of power is in the present work understood as a relational phenomenon:

‘... power does not reside in things, but in a network of relationships which are systematically interconnected.’

– Burrell, 1988, p. 227

From this perspective, power can be argued to have a productive, defining role, emerging in the co-existence of different discourses competing for accepted notions of knowledge. Opportunities for exerting influence over organizational direction are, accordingly, informed by current dominant discursive conceptions of professional practice. This connects back to the insight that explorations of relational leadership processes always call for a power analysis of social interactions. The interplay between discursive conceptions, power bases and possibilities of influencing leadership processes will be further elaborated on in Chapter 4. For now, it is concluded that power creates as well as constrains possibilities to act in the continuous struggle for dominance (Christensen et al., 2011) and accordingly has been considered ‘the positive source for social reality’ (Jorgensen & Phillips, 2000, p. 20). While some research streams have suggested that individuals merely become subjects within a discourse, lacking the possibility to challenge a prevailing social order (Knights & Morgan, 1991), the present work assumes that organizational members – although being constrained by dominant discursive conceptions – still have the possibility to challenge the dynamics of leadership processes. However, an understanding of these processes should be considered difficult to reach since power mechanisms delimit possible perceptions of reality.

It becomes important to highlight the power dimension of interrelating, as there seems to be a tendency to consider relational leadership as democratic per se. Recognizing how individuals or groups often have conflicting interests and also experience different possibilities of influencing the organizational direction that unfolds (Crevani et al., 2010), processes of co-orientation should not uncritically be considered egalitarian and harmonious. Lindgren & Packendorff (2011) have stressed how relational leadership processes typically construct different opportunities and limitations for different groups or individuals. By overlooking these power asymmetries in processes of co-orientation, relational leadership easily becomes an
ideology where different professions are expected to jointly define organizational direction. The understanding of power mechanisms embedded in leadership processes might be advanced by exploring how the interplay between discursive conceptions and power bases plays out in mundane instances of interrelating. This calls for a micro-level analysis of organizational practice, as stressed by Endres and Weibler (2016):

‘Overall, the type of research called for to understand [relational leadership] comprehensively should have a strong emphasis on communication, interactions and practice.’

– Endres & Weibler, 2016, p. 18

Having established a relational, processual perspective on leadership, it finally becomes important to point out how this theoretical positioning in no respect suggests that leadership processes construct distributed forms of leadership. As explained by Endres and Weibler (2016):

‘The social construction processes (i.e. processes of intersubjectively creating social realities through ongoing interpretation and interaction) should be differentiated from finally emerging leadership processes, which may become manifest as flows of influence (on either the interpersonal interaction level or the collective level) […].’

– Endres and Weibler, 2016, p. 12

A collective production of leadership should thus not be considered synonymous with democratic work arrangements. Returning to Lindgren’s and Packendorff’s (2011) description of leadership mechanisms on the local-cultural organizational level, relational leadership processes more typically construct different opportunities and limitations for different groups or individuals. Summarizing the essence of a relational, processual perspective on leadership, the continuous negotiation for influence will not – in the present work – be approached through a focus on designated leaders, but through the exploration of interaction dynamics that inform (temporary) dominant notions of professional practice through relational processes. In these processes, the power dimension will be acknowledged as critical for the unfolding organizational direction.
3. Mind your own business – or not: Introducing professions and profession-based organizing

Having established a relational, processual perspective on leadership, the present chapter draws attention to the changing preconditions for professional practice. Following a discussion of how professionalism is productively understood as a negotiated product of sociocultural assumptions and values, it is further being explored how different forms of external factors have started to challenge previously well-established notions of professional practice. The chapter concludes by returning to how relational leadership processes should be assessed in the complex era of interprofession-based organizing, where overlapping knowledge bases, changing divisions of responsibilities and an increased focus on interprofessional collaboration render work relations more ambiguous than ever.

3.1. Towards a social constructionist understanding of professionalism

While acknowledging how the concept of professionalism is frequently used in contemporary research as well as in everyday speech, a major dissensus on how to define it can still be noted (Butler et al., 2012). There has for many years been an ongoing discussion on which occupational groups should qualify as professionals (Noordegraaf & Van der Meulen, 2008). While some authors stress the importance of an ‘identifiable work that can be standardized’ (Whitley, 1989; Mintzberg, 2004), others contend that professions emerge in the formation of strong occupational identities (Grey, 1997; Davies, 2006). More recent takes on the concept further stress context-dependency and influence of social structures in the production of professional constructs (Muzio & Ackroyd, 2005; Muzio et al., 2008; Butler et al., 2012).

During the 1950s and 1960s, a trait approach dominated the understanding of professionalism (Brint, 1993; Saks, 2012). This perspective departed from notions that the very possession of esoteric knowledge bases and expertise – accompanied by rationality, ethical standards and public altruism – differentiated professional practices from other occupations in society. Some characteristics that distinguished professionalism from other forms of employment were suggested to be (Lindgren, 2000, p. 68):
1. **Systematic theory (a shared knowledge base grounded in a distinct science)**

2. **Authority (formal legitimization)**

3. **Occupational autonomy (legitimized self-regulation of the work tasks)**

4. **Distinct ethics (a shared system of norms for professional practitioners)**

However, this understanding soon became subject to criticism by scholars stressing how the process of professional emergence should be considered the source of acquired and sustained power and control within professional communities (Brint, 1993). The process of professional emergence was suggested to incorporate the following five stages:

‘... the full-time commitment among practitioners to a task that ‘needs doing’; the founding of a professional association to promote the interests of the occupation; the development of a formal course of study in connection with an academic institution; the adoption of the occupation by the state as requiring formal protections in the form of acceptable credentials, registration, and/or licensing; and, finally, the promulgation of a formal code of ethics to regulate the conduct of practitioners.’

– Brint, 1993, p. 261

From a processual perspective, professionalism thus emerges in a self-regulated production of producers. By controlling entrance to the profession through standardized training and shared ethics, a closed, normalized community is constructed. This community is characterized by identity, commitment and loyalty to the own group, as concluded by Sarfatti Larsson (1979).

While acknowledging how processes of professionalization exert an impact on professional values and logics through internal mechanisms of control, it is important to stress how the issue of professional identity construction also contains an aspect of external impact. As pointed out by Bloor & Dawson (1994), ‘Individuals in organizations do not ‘sense-make’ in isolation, but rather, they rely heavily upon observing the behaviour of others in social settings and upon the shared meanings others give to that behaviour’ (p. 278). Building on the same relational logic – and taking this to a professional level – Iedema et al. (2004) describe professions as socially constructed through performances:
‘... the boundary between profession and organization is seen as an effect of specific interactants’ performances, rather than as inherent to professionalism as such.’

– Iedema et al., 2004, p. 16

A social constructionist understanding of professionalism stresses how professions become part of a larger complex landscape, where political, economic, educational and social trends all interact and continuously shape the preconditions for professional work. As pointed out by Butler et al. (2012):

‘What counts as peripheral to a profession is constantly being modified by institutional reform, political restructuring and wider economic trends.’

– Butler et al., 2012, p. 259

In the same vein, Muzio et al. (2008) stress how ‘the initial self-conception of any occupation will be influenced by the original institutional and ideological context in which occupational development was first formulated’ (p. 6) but also how ‘the institutionalized context in which occupations subsequently operate is ... likely to have an impact on what happens to them’ (p. 7). This understanding suggests that notions of professionalism are informed by the surrounding context, further implying that professionalism – like leadership – could productively be approached from a social constructionist perspective. Professions become the negotiated products of assumptions and values – that is, representations of how notions of knowledge and truth are (re)constructed through instances of interpretation and interaction. A social constructionist understanding of professionalism further stresses the power dimension of these processes, where the sociocultural context enables certain notions of professional practice to establish themselves as dominant.

3.2. Traditional understandings of profession-based organizing – The professional bureaucracy

Recognizing how profession-based organizations have historically been bureaucratic yet decentralized by coordinating work through the standardization of skills and ascribing power to the operating core, the traditional structure for organizing professional work has been acknowledged as one of five ideal types of organizational configurations (Mintzberg, 1980; Mintzberg, 1983):
‘The Professional Bureaucracy relies on the standardization of skills in its operating core for coordination; jobs are highly specialized but minimally formalized, training is extensive and grouping is on a concurrent functional and market basis, with large sized operating units, and decentralization is extensive in both the vertical and horizontal dimensions […]’

– Mintzberg, 1980, p. 322

Within traditional notions of profession-based organizing, formal influence thus rests within the closed professional communities constituting the operating core. The authority of formal management is downplayed, as middle line managers – in order to be influential – must belong to the acknowledged profession themselves. In this way, the professional core further makes sure that they are in control not only of their own work, but also of administrative decisions that affect them (e.g. hiring of professional workers, promotions, distribution of resources, etc.). Professional influence is legitimized through the nature of professional services. The traditional conception that these operations are difficult to standardize, supervise, or evaluate, calls for professional independence. Moreover, professional services are often in great demand, which presents the practitioners with great mobility and – accordingly – possibilities to claim considerable autonomy within the organization.

With professional autonomy comes the freedom of self-governance. Neither the administrative hierarchy, nor the professional colleagues should interfere with professional work, as both direct supervision and mutual adjustment impede the relationship between professional worker and client/patient. As mutual adjustment accordingly infringes on professional autonomy, coordination between professionals is instead obtained through standardization of skills and knowledge. This process, which starts with regulated training outside the organization (in a university or special institution), further involves a substantial amount of ‘on-the-job-training’, where professional skills become perfected under close supervision. During the ‘on-the-job-training’ – which might take the form of an internship (medicine, management consulting) or articling (accounting, law) – professionals not only get to practice their knowledge in an organizational setting, but also learn what to expect from their colleagues. While each professional worker is responsible for – and has an individual relationship with – their own clients/patients, the collective control thus assures coordination between professionals. Mintzberg (1983) stresses how ‘standards of the professional bureaucracy [accordingly] originate largely outside its own structure, in the self-governing associations its operators join with their
colleagues from other professional bureaucracies’ (p. 192). This resonates well with how Morgan and Ogbonna (2008) have observed that loyalties to one’s own profession typically become stronger than those to a specific employer or organization.

3.3. Towards interprofession-based organizing
Acknowledging how notions of professional practice are informed by assumptions and values in the surrounding society, Muzio and Ackroyd (2005) point out how ‘professions must adapt to the changing business context, which is becoming more competitive as well as increasingly critical of professional practices, claims, and arrangements’ (p. 616). Although most people would probably still associate physicians, lawyers and accountants with a substantial amount of power and prestige, professional practice has been subject to extensive reforms during the last decades (Parding et al., 2012). Ackroyd & Muzio (2007) describe an ‘increasingly hostile ideological, institutional and economic environment in which professions operate’ (p. 732), referring to contemporary social, political, cultural, economic, geographical and epistemological influences (Butler et al., 2012) that have all come to challenge previously unopposed ways of directing work within established professions. Processes of professionalization and deprofessionalization have together nurtured a discursive antagonism between different stakeholders’ expectations on professional practice. While many institutionalized professions today feel a growing concern for their autonomy, other forms of expert occupations have started to reach professional accreditation, thereby challenging the concept of esoteric knowledge bases and undermining professional closure.

3.3.1. Diversified professionalism
Society stands for an increase in professional communities. Ever since the 1950s there has been an on-going specialization in terms of complex scientific knowledge (Freidson, 2001). This trend can today be considered more distinguishable than ever, noting how universities are increasing their scope of scientific education to include programs such as tourism, coaching, food science, and leisure studies (Brante, 2010). While Brante stresses how this education hype calls for stronger, more excluding definitions of professional knowledge, it could rather be argued that the increased number of expert communities opens up for new forms of professional projects with their own strong identities. Muzio et al. (2011) describe how a form of corporate professionalism is currently emerging through tactics and methods departing
significantly from the logic underlying more traditional professional projects. Practices being discussed under this umbrella include consultancy, project management, information technology, advertising, supply chain management and human resource management (Paton et al., 2013). Corporate notions of professionalism emerge through knowledge-based occupations being successful in adapting their strategies to a new hostile climate for professional practice (Muzio et al., 2011). As knowledge credentials play a smaller part in the justification of market monopolies, the occupations have started to prioritize other tactics in their professionalization projects. Using so called ‘marketization strategies’, which put greater emphasis on entrepreneurship, innovation and active engagement with the market, they are focused on ‘locking into and stimulating the seemingly inexhaustible demand for new specialties’ (Muzio et al., 2011, p. 447). Although deviating from traditional professions, many knowledge-based occupations have today received recognition within corporate notions of professionalism. Not surprisingly, the concept has, however, also been subject to scrutiny and critique. Muzio et al. (2011) emphasize how fragmented knowledge bases are expected to prevent professional jurisdictions:

‘A key problem is assumed to lie in the ‘cognitive resources’ available to these new expert occupations; their knowledge-base is regarded as too fuzzy, fragmented, indeterminate, perishable and client/context dependent to be formalized into a coherent body of knowledge and portable set of credentials that can sustain traditional processes of occupational closure … with such a broad variety of services, roles, methodologies, types of providers and workplaces there is little scope to develop the sense of community and shared professional identity (see Kyrö, 1995) which is necessary to support professionalization.’

– Muzio et al., 2011, p. 446

Although being contested, corporate notions of professionalism open up for new understandings of professional practice. Similarly, also Knowledge Intensive Firms (KIFs) have lately approached notions of professionalism by abandoning bureaucratic forms of control. While typically lacking the discrete knowledge bases that have historically been understood to be a prerequisite for professional closure, these forms of expert work nevertheless show similarities with more institutionalized professions. Kärreman and Alvesson (2009) contend that ‘knowledge work by definition includes individual judgment and discretion’ (p. 1116). Although not emerging in an altruistic drive to serve society, this judgment and discretion calls for
professional autonomy in its more traditional form. In line with institutionalized professionalism, KIF practices also build on a set of esoteric, tacit knowledge bases that seem problematic to standardize or regulate (Kärreman & Alvesson, 2009). Moreover, the client-dependent nature of these practices requires flexibility and an entrepreneurial mode of organizing, just like more established professions. Within management consultancy, the McKinsey model has embraced traditional professional notions as a means of enhancing reputational capital and charge higher fees. The model builds on ‘self-imposed standards of competence, ethics, responsibility and independence’ (Kipping & Kirkpatrick, 2008, p. 175). Within the firm, levels of seniority are clearly communicated through hierarchical titles (Junior Associate, Associate/Consultant, Junior Partner, Senior Partner, etc.). Also, new organizational members are typically recruited from a pool of young, inexperienced business school graduates, as ‘experienced executives often could not adapt to a consulting role and perhaps even less to McKinsey’s distinctive culture’ (Kipping & Kirkpatrick, 2008, p. 176). Firm members are thus conditioned to behave in ‘the right way’ through a systematic acculturation process, which shows major resemblance to the organized ‘production of producers’ in traditional notions of professional emergence. Acknowledging the many similarities between different forms of professional projects, Kärreman et al. (2002) propose that institutionalized professions (e.g. law, medicine, etc.) today should be acknowledged as one component in a more differentiated field of knowledge-intensive practices. Arguing that ‘many professionals today are employed in other forms of KIFs than core professional organizations (e.g. law firms, hospitals, and universities)’ (p. 71), they suggest that ‘a focus on the broader category is called for to understand the professional’s – the knowledge worker’s – working conditions.’ (p. 71). An increased understanding of leadership in contemporary forms of profession-based organizing thus presupposes that different forms of professionalism are acknowledged and discussed. Still, it should be stressed how professions are productively understood as the negotiated products of assumptions and values.

3.3.2. Increased competition
While recognizing differences as well as similarities between different professional projects, the phenomenon of increased competition seems to be a defining characteristic for today’s more diversified nature of professionalism. In fact, established and upcoming professions all share the common denominator of having
to defend their knowledge domains against other professional projects. As pointed out by Muzio et al. (2008), ‘professions have commonly faced competition over their jurisdictions from rival occupations’ (p. 16). This can be seen in a variety of professional contexts. While management and nursing practice now to an even larger extent are encroaching upon the mysterious world of medicine (Banham & Connelly, 2002; Dent, 2008), solicitors simultaneously feel a rising competition from claim handlers and will writers, but also from more established professions such as accounting and different forms of business advisory (Muzio et al., 2008; Muzio & Ackroyd, 2005; Dezalay, 1995; Dezalay & Garth, 2001). Also, new forms of expert occupations seem to experience this competition. Within management consulting – where a wide range of highly educated experts work together in professional teams – it has been pointed out how organizations often find it difficult to assemble the expert workers under the same corporate culture. Rather, they have to ‘rely more heavily on a mix of prior socialization (or identification with particular professional values)…’ (Kipping & Kirkpatrick, 2008, p. 165). In a complex era of interprofession-based organizing, new arrangements of interprofessional work – in the form of joined-up services, multi-disciplinary and multi-agency teams, multi-professional and multi-agency partnerships, inter-professional collaboration, multi-professional practices, integrated services, etc. (Noordegraaf, 2011) – thus put pressure on different professions (established and upcoming) to compete for knowledge credentials. There has for many years been an ongoing debate on the extent to which external forces actually impede or circumscribe traditional notions of professionalism (Ackroyd & Muzio, 2007; Muzio et al., 2008). While some authors have suggested that ‘the development of new forms of knowledge and the rise of new knowledge occupations are offering a serious challenge to the traditional or established professions’ (Blackler, 1995 in Ackroyd & Muzio, 2007, p. 729), it has also been noted how these established professions engage in strategic endeavors in order to defend their esoteric knowledge bases and sustain professional closure. Ackroyd & Muzio (2007) contend how the legal profession – as a response to the new hostile climate of professional practice – typically abandons its traditional notions of collegiality and universal service, and instead draws on increased commercialism, managerialism and routinization of work procedures. Similar mechanisms have been observed within healthcare, where medical doctors embrace evidence-based work procedures as a means to maintain professional closure at the cost of individual autonomy (Hansen, 2007).
3.4. The professional bureaucracy revisited

Whether offering a serious challenge to the most established professions or not, new discourses on organizational efficiency and professional practice have certainly come to challenge traditional understandings of professional work. Where structures of responsibilities and power were earlier established in the strongly institutionalized professional bureaucracy, the current interprofessional landscape offers a much more complex situation. The stronger focus on market mechanisms and organizational efficiency has challenged historical conceptions that professional services are too complex to be standardized. Within medicine, the advent of Lean production, evidence-based medicine, and quality registers clearly signals how market mechanisms induce more control over professional operations, both in terms of work procedures and output. A similar situation can be noted within accounting, where professionals today to a larger extent are obliged to motivate their judgments through standardized documentation.

Increased possibilities of supervision and control accordingly come to challenge professional autonomy. This phenomenon is further strengthened through the entrance of ‘upcoming professions’, as overlapping knowledge bases and distributed responsibilities within interprofessional forms of organizing work impede traditional notions of self-governance. In many profession-based organizations, new discourses on organizational efficiency have also resulted in a situation where middle line managers not exclusively belong to the institutionalized, prestigious profession (e.g. medicine, law). Consequently, the operative core is no longer in control of administrative decisions that affect their work, such as promotions and distribution of resources. Within healthcare, it is interesting to note how both the introduction of non-medical managers and an increased trend to promote nurses to higher managerial positions have formally come to impede physicians’ former control over strategic decisions. While the strongly institutionalized ways of organizing professional work for many decades have guided professional practice within the most prominent disciplines, the bureaucratic yet decentralized structure has thus recently been challenged by new discourses on professional practice. Having enjoyed unchallenged autonomy for many years, the operative core must now not only share formal influence with other organizational functions, but also engage with other occupations in the provision of professional services. This draws attention to how the era of interprofession-based organizing could be understood in terms of a ‘reversed
division of labour’, where overlapping knowledge bases, changing divisions of responsibilities and an increased focus on interprofessional collaboration render work relations more complex than ever.

3.5. Leadership processes in an era of interprofession-based organizing

New preconditions for professional practice formally imply that organizational control no longer rests within the operating core, but is distributed between several functions and professions. This has implications for contemporary notions of authority and influence in profession-based forms of organizing. Where established professions have traditionally been the undisputed leaders of their practices, the current interprofessional landscape – characterized by ambiguous interprofessional boundaries and overlapping knowledge bases – constructs competing understandings of how influence should be distributed between organizational actors. While arrangements of interprofessional work might be formally established in an organizational chart, historical conceptions of professional practice and a desire to safeguard control over professional jurisdictions foster a continuous process of competition – where formal distributions of influence often become decoupled from interprofessional practice. Adopting a social constructionist understanding of leadership, it is acknowledged how flows of influence accordingly emerge in a discursive field of competing conceptions, where values and assumptions in the surrounding context allow certain notions of professional practice to (temporarily) establish themselves as dominant. Emphasizing the power dimension of these mechanisms, it seems productive to think of leadership processes as a continuous negotiation for influence.

Addressing the complex phenomenon of negotiation, a framework for exploring leadership processes in an era of interprofession-based organizing will in the following be established. Focus will be on the interaction that permeates mundane activities, (re)constructing dominant notions of professional practice and establishing organizational direction.
4. Establishing an analytical framework for the exploration of leadership processes in an era of interprofession-based organizing

Having concluded how leadership processes in an era of interprofession-based organizing are productively conceptualized as a continuous negotiation for influence, the present chapter dives deeper into the interaction processes embedded in this negotiation. Relations between dominant discourses, power bases, subject positions and spaces of action are initially addressed. This is followed by a discussion of how language – being both enabling and constraining – could be understood as a mirror of social realities. The chapter concludes with a summary of key concepts.

4.1. Theoretically addressing the dynamics of negotiation

Drawing on a social constructionist ontology, it has been acknowledged how leadership acts as a normalization process, challenging or reinforcing dominant notions of professional practice through mundane instances of interrelating. In order to increase the understanding of power mechanisms within this relational process, the continuous negotiation for influence will here be described as an interplay between dominant discourses, subject positions and spaces of action, where power bases – informed by a social order – constitute enablers and constrainers.

4.1.1. Dominant discourses

It has already been stressed how different discourses always co-exist beside each other and compete for acceptance. When competing discourses construct contradictory demands on professional practice, the struggle between diverging notions fosters a complex process of antagonism (Jorgensen & Phillips, 2000). By acknowledging certain expectations as legitimate, this antagonism drives the reconstruction of professional practice. As pointed out by Butler et al. (2012), ‘what counts as peripheral to a profession is constantly being modified by institutional reform, political restructuring and wider economic trends’ (p. 259). Following the external influences of recent decades, a rise in conflicting discourses has resulted in professions becoming increasingly overdetermined. Changing preconditions put pressure on professions to act less as self-regulated societies and more as integral
parts of organizational communities. At the same time, many professions adopt different strategies for safeguarding more traditional understandings of authority and decision-making. In this complex context, notions of professional practice become continuously contested. While negotiation acts as a normalization process, seeking to reduce the ambiguity around the contested concept, the reduction of possibilities simultaneously (re)constructs the social order.

4.1.2. Subject positions

Subject positions are understood as discursive products that limit and set expectations on individuals (Jorgensen & Phillips, 2000) by locating them within hierarchies inherent to specific discourses (Holmer-Nadesan, 1996). Organizations and society thus enable and repress identities through mechanisms of underlying power. Following this logic, Clarke et al. (2009) depict professional identities as constructed within ‘organizationally based discursive regimes which offer positions, or epistemological spaces, for individuals and groups to occupy’ (p. 325). This connects back to how Lindgren and Packendorff (2011) describe how the practice of co-orientation constructs possibilities, potentials, opportunities and limitations for individual and collective action. It has further been acknowledged how individuals tend to position themselves in relation to normalized values, religious beliefs and political ideologies. As an example, Leonard (2003) notes how society’s perception of gender differences comes to define individuals as ‘in’ or ‘out’ of certain positions. How individuals locate themselves relative to different subject positions thus depends on how social and cultural practices within the surrounding context have constructed established notions of certain (gendered) qualities as desirable or undesirable in different settings. As a result of the patriarchy discourse – which can be understood as ‘a traditional system of hierarchical male authority based in piety toward tradition and toward the master’ (Holmer-Nadesan, 1996, p. 53) – women tend to be over-represented in low power/status positions where they are more vulnerable to authority and lack immediate control over work processes (Holmer-Nadesan, 1996). This makes it difficult for women-dominated occupations to draw on subject positions inferring authority and control, as there is an institutionalized conception of women being undesirable in these positions. Organizational and societal expectations thus encourage women to draw on subject positions that yield little status and rewards. From this example, it is apparent how values and assumptions inform power distributions between organizational actors.
4.1.3. Spaces of action

While discursive notions restrict professions to certain subject positions, the subject positions infer possibilities to claim a certain place within the interprofessional room. These possibilities can be understood as spaces of action (Holmer-Nadesan, 1996). Offering a set of social practices to engage in, spaces of action thus set boundaries for what is possible to think, say and do within a certain subject position (cf. Crevani, 2011; Lokatt & Sack, 2013). As organizational expectations often alter with time and place (Regnö, 2013), different rooms or situations typically come to enable different spaces of action for the same individual or group. Emphasizing this phenomenon, Holmer-Nadesan (1996) stresses how ‘space of action [is always] grounded existentially in a situation’ (p. 59).

While discursive conceptions inform social practices through restricted possibilities to draw on certain subject positions, the legitimization of these practices in turn reinforces dominant discursive conceptions within an organizational context. This interrelationship links back to how Ledema et al. (2004) have chosen to describe the boundary between organization and profession as emerging in ‘interactants’ performances’. It should further be stressed how the present work puts emphasis on the verbal aspect of action, where language is understood ‘not only as meaning making, but also as an active praxis with reality-producing effects’ (Lykke, 2010, p. 90). Adopting this perspective, it becomes critical to study social practices in terms of what is possible to say and what is not, as well as how utterances are framed. These patterns shed light on social realities, as will be further elaborated on in section 4.2. By scrutinizing the verbal aspect of action, it is possible to explore how recurrent patterns of interrelating challenge or reinforce dominant conceptions of professional practice within contemporary arrangements of interprofession-based organizing.

4.1.4. Power bases

It has been acknowledged how discursive conceptions enable and constrain the possibilities of different professions to draw on certain subject positions, and how these positions in turn infer certain possibilities to engage in social practices within the interprofessional room. But how does the surrounding sociocultural context – with its prevailing assumptions and values – enable and constrain different subject positions in negotiation? Why do some professions find it easier than others to draw on subject positions inferring a substantial space of action? Increasing the understanding of power mechanisms in negotiation, it is critical to look more closely
at status processes in social interaction (Cohen & Zhou, 1991). These status processes explain how predetermined beliefs about actors construct inequalities. In the case of interprofessional relations, beliefs about other actors (professions) can thus be understood as the preconceptions that professionals bring with them to negotiation. These preconceptions stem from dominant, context-dependent discourses on professional practice.

Cohen and Zhou (1991) define a status characteristic as ‘any characteristic of an actor that influences his or her own and other’s evaluations and beliefs about the actor’ (p. 180). These characteristics can be internal (e.g. status in the team, expert status) or external (e.g. educational level, gender, seniority in the organization, explicit leader role). While the internal characteristics result from structures within a specific team, external factors are defined in a larger sociocultural context. Individuals working together will use the status characteristics to form expectations about each other, which in turn constructs interaction inequalities. Interaction inequalities will in the present work be understood as diverging possibilities of engaging in social practices within the interprofessional room, and – accordingly – different possibilities to inform leadership processes. Status characteristics will further be referred to as ‘power bases’. The power bases will affect how different professions form expectations about each other and how these processes construct unequal preconditions within the continuous negotiation for influence. As concluded, dominant discursive conceptions constrain professions to certain context-dependent subject positions. These processes are strongly informed by power bases, as preconceptions about professional practice allow certain organizational actors to ‘benefit from’ certain status characteristics. Professions associated with power bases that are constructed as valuable typically enjoy the most substantial spaces of action. Power bases, therefore, not only defend professional autonomy and status, but can also explain why some professions find it easier than others to preserve control over influential subject positions.

Having acknowledged how interprofessional interaction is informed by values and assumptions in the surrounding sociocultural context, the external characteristics outlined above seem most important to bear in mind when exploring power mechanisms within the continuous negotiation for influence. This assumption is also in line with how Cohen and Zhou (1991) have concluded that ‘variation in interaction among team members will correspond to inequalities on external status
characteristics’ (p. 181). While these external characteristics – henceforth referred to as power bases – in the following will be discussed separately, it is important to stress how they in many cases are closely interconnected with each other.

4.1.5. Power bases in profession-based forms of organizing
The assumption that explicit leader roles construct inequalities in negotiation links back to the discussion on leadership vs. management, where it was concluded how a dichotomic divide between these two organizational phenomena might present challenges in the endeavors to advance the understanding of relational leadership processes. In profession-based forms of organizing, where notions of traditional labor management are inapplicable, it seems reasonable to assume that explicit leader roles – while adding complexity to the dynamics of negotiation – should be constructed as less important than other power bases. Educational credentials, on the other hand, are expected to prove particularly critical within this context. It has already been concluded how established professions build on esoteric knowledge bases, and how an important stage of the professionalization process is the development of a formal course of study in connection with an academic institution. Hence, it could be assumed that professional status has a strong connection to educational credentials. Similarly, traditional notions of professionalism put great emphasis on seniority. A hierarchical system of titles formally signals professional progress, and different certifications throughout the career further assure the ‘right level of expertise’. Exploring power mechanisms in leadership processes, it is thus critical to note how different professions are allowed to draw on educational credentials and seniority in the continuous negotiation for influence.

Also gender is expected to play a central role in leadership processes. Collinson and Hearn (1994) have argued that a gender perspective adds important aspects to any form of power analysis:

‘To focus upon gender … will not provide a complete account of these processes, but equally their neglect often renders critical analyses of power relations fundamentally flawed.’

– Collinson and Hearn, 1994, p. 10

This argument draws attention to how power has always been an integral part of gender analysis, and how theories originally developed within the gender field thus provide rich descriptions of how power mechanisms play out in mundane instances
of interrelating. Hence, the discussion of gender as power base will be more developed than the discussion of other power bases, eventually outlining how different power orders might interfere with each other in the continuous negotiation for influence.

It is widely acknowledged that professions have traditionally been male-dominated communities, constructed within the realms of patriarchal norms (Lindgen, 1992). Gendered power orders have accordingly been illustrated within many institutionalized professions, including medicine (Lindgren, 1992), law (Chambliss & Uggen, 2000) and accounting (Kornberger et al., 2010). Regnö (2013) concludes how ‘the power relation often, but not always, is marked by male superiority and female subordination’ (p. 41). This might imply horizontal gender segregation, where women lack access to the most established professions, but also vertical gender segregation, where female practitioners typically are found in the less prestigious subdisciplines of a profession. One of many underlying causes for this observed power imbalance is the gendered ‘structure of numbers’ (Kanter, 1977; Wahl, 2013), constructing women in established professions as an exception to the norm. It is important to stress, however, that the structure of numbers not only sheds light on interaction inequalities between men and women (or male- and female-dominated professions), but between any majority and minority within an organizational context. Kanter (1977) has shown how enabled spaces of action typically vary substantially between majorities and minorities (or norms and exceptions). Encroaching upon the majority’s territories, a minority – or minority group – is drawing on a ‘token position’ where it faces processes of visibility, assimilation and contrast.

Through the practice of visibility, an individual (or group) from the minority is scrutinized in its norm-breaking role. Success stories will typically be explained by referring to the individual in the token position as an exception to the minority group, while problematic issues will rather be attributed to the minority group in general. An example is how women in top management – who still today are outnumbered by their male colleagues, and accordingly become perceived as an exception to the norm (Holgersson, 2013; Regnö, 2013) – have come under close scrutiny. While accomplishments are often attributed to the exception of ‘ordinary women’, potential shortcomings tend to be met with a ‘look-what-happens-when-women-enter-the-managerial-world attitude’. As a result of these processes, the
token minority often seeks social invisibility by adapting to the majority’s culture, further reinforcing an unequal power order. The process of assimilation constructs stereotypes of a minority in the token position. While this might provide recognition and an instant sense of belonging, it nevertheless puts constraints on the token position and consequently constructs a limited space of action. Still, the stereotyped roles are often easier to embrace than reject. While conforming to the expected, stereotypes are therefore confirmed within the organization. Through processes of contrast, the majority reacts to the minority in a token position by further reinforcing their dominant culture. The token minority’s loyalty towards the majority is tested – and often confirmed – through informal tests. Feeling included in the majority’s culture, the minority in a token position tends to distance itself from the minority and embrace the role as exception. This process sustains, and sometimes even reinforces, a substantial distance between majorities and minorities within an organizational context.

In leadership processes, the structure of numbers should have implications for how majorities and minorities are allowed to claim place within the interprofessional room. A minority would, for example, be women-dominated professions with a substantial amount of formal influence, as these organizational entities typically are perceived as an exception to the norm. On an individual level, a minority could be a female practitioner within a male-dominated profession, or a male practitioner within a female-dominated profession. A minority could also be any organizational actor who finds themself alone in a social room with a foreign profession. This situation typically plays out in different instances of mundane organizational practice. It should be stressed that the token position is always constructed in a continuous interaction with other power orders (Regnö, 2013), implying that a minority not by definition has to draw on less influential subject positions or prove loyalty to the majority. If a physician becomes the token in a group of nurses, it does not necessarily imply that they are restricted to a limited space of action. The educational level might in fact legitimize a more generous space of action, or gender associations might present challenges to draw on influential subject positions.

1 Despite an increased professionalization – where more conscious gender debates and a managerialist discourse on organizing have attributed women-dominated professions more formal influence – signs of a still prevailing patriarchy discourse are manifested in how diminished standings for a profession (lower salary and status) is often readily connected to an increase of women within it (Chambliss & Uggen, 2000; Lindgren, 2000).
Similarly, an experienced specialist nurse in a group of resident physicians might draw on seniority in claiming a more substantial place within the interprofessional room. All these complex mechanisms link back to how power bases in the present study are recognized as highly interconnected with each other. As different power orders always interfere with each other in leadership processes, it becomes critical to explore how values and assumptions in the surrounding sociocultural context enable some power bases to manifest themselves as more influential than others, but also enable certain professions to become associated with these influential power bases. Such mechanisms will have implications for how social interaction unfolds, and – accordingly – for how dominant notions of professional practice are challenged or reinforced in mundane instances of interrelating.

4.2. Capturing negotiation through language
In order to capture the dynamics between dominant discourses, subject positions, power bases, and spaces of action, it becomes essential to scrutinize the complex nature of language. While much conventional research has assumed language to mirror an objective external world, the recent linguistic turn within social sciences has instead stressed the context-dependent side of language (Alvesson & Deetz, 2000; Alvesson & Kärreman, 2011). From this perspective, language is understood as ambiguous and constitutive rather than representational (Alvesson & Willmott, 2003), implying that references to external objects through communication of fixed meanings become impossible, as every single utterance is constructed within the realms of underlying discourse. Building on these notions, language should be understood as a constitutive force (Alvesson & Deetz, 2000). While discursive conceptions – through spaces of action – set the limits for what can be uttered (and how) through language, the language is in turn reinforcing established notions by operating disciplinarily, concealing alternative notions that challenge dominant conceptions. In profession-based forms of organizing, this mechanism implies that dominant conceptions of professional practice are reinforced in mundane interaction, as utterances that would challenge these fundamental notions become hidden in established ways of interrelating. Language thus unfolds as both enabling and constraining.

Seeking to advance the understanding of how flows of influence emerge in relational leadership processes, language could productively be looked upon as a mirror of social realities. By exploring how utterances are enabled and constrained in mundane
instances of interrelating, the continuous negotiation for influence can be captured. What is possible to say and what is not? Who is entitled to say what? How do the different professions describe each other? These interaction dynamics are informed by the continuous interplay between dominant discourses and power bases, but also challenged or reinforced in mundane social practices. By exploring why certain utterances are enabled while others are constrained, why some professions are allowed to claim a more substantial social place than others, and why different professions describe each other in certain ways, the understanding of power mechanisms in leadership processes can thus be advanced.

4.3. Summary of key concepts
It is apparent that previously well-established notions of interprofessional relations and boundaries are becoming substantially challenged by new preconditions for professional practice. A discursive antagonism has opened up for new understandings of profession-based organizing, where different professions are now working side by side to meet the needs of a client or a customer. In these new organizational configurations, leadership becomes formally distributed between different professions and functions. At the same time, traditional understandings of organizational influence are informally protected through a social order. Where power structures were previously inherent in strong organizational hierarchies and professional meritocracies, the current interprofessional landscape thus constructs conflicting expectations of authorities and influence. Acknowledging how notions of professional practice are (re)produced in interprofessional interaction, it is critical to scrutinize the power dimension of the continuous negotiation for influence. Within this negotiation, the interplay between dominant discursive conceptions and power bases restricts professions to different subject positions. These subject positions come to present certain spaces of action, which in turn challenge or reinforce dominant values and assumptions. Different rooms – or contexts – typically present different discursive preconceptions and, thus, allow for different power bases to be drawn upon. Still, similar fundamental dynamics of negotiation should be seen as characteristic of different fields of professional services. By exploring the interplay between discourses, power bases, subject positions and spaces of action, it is possible to assess how power mechanisms enable and constrain certain directions in leadership processes. Analytical access to leadership dynamics is obtained through the study of language, where dominant discursive conceptions and social practices
can be captured. The dynamics of leadership processes further inform notions of professional practice by constructing images of organizational roles and relating these images to expectations on how organizational goals should be achieved. In this way, influence is distributed between organizational actors.

Seeking to increase the understanding of how power mechanisms enable and constrain certain directions in leadership processes within contemporary arrangements of interprofession-based organizing (RQ1), the following questions become central:

- What (dominant) discourses set the preconditions for negotiation within interprofession-based organizing?
- What subject positions are constructed within these discourses?
- What spaces of action are associated with the different subject positions?
- How does the interplay between discourses and power bases allow for certain professions to draw on certain subject positions (in certain contexts)?
- How does the interplay between dominant discourses (prevailing social order) and spaces of action (enabled social practices) reinforce or challenge discursive conceptions of professional practice?

Seeking to identify the dominant notions of interprofession-based organizing that are (re)constructed when the power mechanisms play out in practice (RQ2), the following questions become central:

- What images of different organizational roles are constructed in the leadership processes?
- How are these images related to expectations of how interprofession-based forms of organizing should work in order to reach their goals?

The seven questions outlined above will constitute the analytical framework for exploring leadership processes as a continuous negotiation for influence in an era of interprofession-based organizing. Interrelations between critical concepts in the theoretical understanding of negotiation dynamics are illustrated in Figure 4.1.
The analytical framework will guide the structure for analysis, introduced in section 6.6. It will there be further elaborated on how the framework systematically has been approached in different phases of the analysis to explore how dominant notions of professional practice are (re)produced in leadership processes.
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As the phenomenon of interprofession-based organizing has found recognition throughout society, similar trends of restructuring have been noted in different fields of professional services. In the most typical case, the previously unquestioned autonomy of an established profession (e.g. medicine or law) has been challenged by new discourses on professional practice, where structural reconfigurations now offer upcoming professions (e.g. nursing or business advisory) to formally occupy more influential positions in interprofessional work arrangements. While it, therefore, seems legitimate to assume that similar fundamental mechanisms should inform dominant notions of professional practice within different occupational fields, an exploration of dynamics within leadership processes still calls for contextual precision.

Medicine has for many decades been referred to as the prototypical profession (Freidson, 2001), and while preconditions for professional practice have certainly changed during recent decades, Gadolin (2017) stresses how medicine is still ‘closer to the ideal type [of a profession] than any other occupation’ (p. 12). Changing preconditions for profession-based organizing have accordingly received considerable attention within the healthcare setting, where the negotiated order tradition (Svensson, 1996; Allen, 1997; Reeves et al., 2009; Nugus et al., 2010) further has been embraced to explore how interaction dynamics interfere with assumptions and values in the surrounding sociocultural context. While not being explicitly connected to leadership literature, the negotiated order tradition opens up for an increased understanding of dynamics within the relational processes by which flows of influence are (re)constructed. The healthcare setting thus offers good opportunities to explore the dynamics of leadership processes in an era of interprofession-based organizing.

An understanding of how the social order has historically manifested itself in healthcare organizations should provide important insights into how interaction dynamics are to be interpreted in this context. The present chapter will, therefore, elaborate on how professional interrelations have traditionally played out between healthcare professions, but also on how contemporary external pressures have started to challenge these established patterns.
5.1. Physicians and nurses – key partners in care

In particular, the relationship between physicians and nurses has been acknowledged as critical for contemporary forms of interprofession-based organizing. Reeves et al. (2008) emphasize how these two professions are ‘locked together as key partners in care’:

‘While doctors and nurses are certainly not the only figures in the healthcare team, there is no doubt that the status of medicine and the sheer size of nursing continue to ensure that any successful model of service delivery relies upon the effective collaboration of these two professional groups.’

– Reeves et al., 2008, p. 1

Still, Fitzgerald (2016) stresses how the relationship between these two professions has received limited attention on the interactional level:

‘Possibly the most prevalent, and undoubtedly one of the most important sets of relationships are between doctors and nurses. Despite this, there have been relatively few studies of the work-based interactions of doctors and nurses.’


While interaction patterns between physicians and nurses become critical for the leadership processes by which dominant notions of professional practice are (re)constructed, the understanding of these dynamics thus remains underdeveloped. Specifically, there seems to be limited understanding of the micro-level interaction that constitutes the core of interprofessional negotiation – referred to by Lounsbury (2007) as the ‘finer-grained mechanisms’ (p. 289). It has already been concluded how a dichotomic divide between leadership and management complicates the exploration of how flows of influence are produced beyond formal structures, in professional responses to external circumstances. Still, it is important to stress how physicians and nurses negotiate for influence within a complex sociocultural context where not only formal management structures, but also other occupational groups (if less influential), inform the preconditions for leadership processes. The present work will thus put emphasis on interaction dynamics between physicians and nurses – the key partners in care – while bearing in mind that other occupations (e.g. assistant nurses, non-medical managers) contribute to the complexity in the setting.
5.2. The doctor-nurse relationship

The relation between physicians and nurses has historically been established within a strong hierarchy, where traditional notions of legitimate knowledge – informed by a patriarchy discourse (Holmer-Nadesan, 1996) – have positioned nurses as subordinate to physicians’ orders and agendas. This is clearly illustrated in the opening quote of the thesis, where Florence Nightingale describes how nursing training is all about teaching the nurses how to excel in their own discipline while strictly obeying ‘the physician’s or surgeon’s power and knowledge’. External pressures in terms of new market logics, restructured education and gender consciousness have, however, started to challenge this social order, opening up for new understandings of interprofessional practice in healthcare.

5.2.1. From heroes to laymen?

Recognized as the prototypical profession, medical doctors have over the years been trained to independently perform complex working tasks and to trust their own experience in handling unforeseen situations without interference from other occupational groups (Agevall & Jonnergård, 2007; Dent, 2008). As a consequence of the autonomous medical profession, the 20th century was long characterized by physicians enjoying almost complete control over healthcare operations (Domagalski, 2008). During recent decades, however, economic, political and technological factors have all come to challenge the dominance of a previous well-established medical profession.

Many changes have emerged as results of the market economy influences affecting healthcare during the 1990s, commonly known as the wave of New Public Management (Levay & Waks, 2009; Leonard, 2003). Within this logic, an increased focus on patient quality and cost-effectiveness has induced new standardizations, regulations and evidence-based working procedures that have reduced the ability of physicians to make independent decisions (Walshe & Rundall, 2001; Armstrong & Ogden, 2006; Agevall & Jonnergård, 2007). The introduction of quality registers (Hansen, 2007) and evidence-based medicine (Rosenberg & Donald, 1995; Bernstein, 2004) as means of evaluating and controlling clinical activity has demystified medical practice and increased the scrutiny of physicians’ former autonomous work. Medical superiority has further been challenged through educational reforms. In the British healthcare system, a restructuring of medical training has been implemented in order
to shift the power balance from the medical profession to management and government (Bolton et al., 2011). The new form of medical training (referred to as the Modernising Medical Careers program, MMC), challenges medical autonomy by interfering with physicians’ former control over ‘the production of professional producers’. In this process, physicians fear that the fragmented education will impair professional unity and destroy a shared sense of belonging (Bolton et al., 2011). The stronger emphasis on managerialism and organizational efficiency has also integrated physicians into administrative structures where they are expected to take on formal managerial roles. Still, Andersson (2015) describes how ‘physicians who are managers frequently evoke the physician identity also when performing management tasks, as it is their main source of influence’ (p. 93).

5.2.2. From white dresses to white collars?
Where physicians feel a rising concern for their previously unchallenged autonomy, nurses have slowly but surely increased their standing within organizational arrangements of healthcare practice. Formal legitimization of nursing influence can partly be traced to a more conscious gender debate, but also result from increased professionalization and new discourses on organizational efficiency.

Historically, nurses were expected to silently play their part in the ‘doctor-nurse-game’, which was developed as a way to increase patient security while safeguarding the honor of the medical profession (Stein, 1967). Within a social order where nurses – despite their possession of unique information about patients’ health status – were constructed as subordinate to the medical profession, communication had to follow certain pre-established rules. If a nurse wished to give recommendations on a treatment or a discharge that could have critical implications for the patient’s health, this should be done in a well-established, subtle manner. The recommendation would need (1.) to appear to be coming from the physician and (2.) not to be perceived as a criticism of the physician’s own judgment. When phrasing a recommendation in this mystical way, the physician would understand what was implied and use authority in directing the nurse to carry out the treatment. The doctor-nurse game was, however, overturned in the 1960’s, when women began to claim their equality with men and advocate independence (Banham & Connelly, 2002). During recent years, nurses have also started to enter organizational arenas that were previously exclusive to the closed community of medicine (Dent, 2008). As standardizations and increased control have incorporated more administrative and
managerial work into the medical profession’s responsibilities, nurses have reduced physicians’ workloads by taking over some of their routine medical tasks (Fitzgerald, 2016). However, educational reforms resulting in increased nursing specialization have also allowed specialist nurses to engage in more complex medical tasks, including anesthetics and surgery work (Dent, 2008). While specialized Nurse Practitioners (NPs) now incorporate medical aspects in their professional identities, it has, however, been noted how they still tend to prioritize the caring aspect of healthcare (Fitzgerald, 2016). Interestingly, this caring aspect has also received increased organizational standing in recent decades – partly as a direct outcome of nursing professionalization, but also through new ways of understanding the patient and the human body (Noordegraaf, 2011). Discourses emerging within New Public Management have further induced substantial changes in nursing’s position within hospital management. Even if nurses for a long period of time have played a natural part in the management function, it was earlier questioned whether they should be included in senior management teams or solely take on line management responsibilities (Bolton, 2003). In recent decades, market logics and reconstructed notions of nursing expertise have resulted in the nursing profession taking on more diverse and influential positions within hospital management. Within these new positions, nurses exert formal influence over decisions that lie in the medical profession’s interest to control.

Interestingly, it has been noted how newly acquired jurisdictions constitute the major source of identification struggles within the nursing profession. Where former emphasis on leadership and support of nursing work allowed for full focus on caring, extended requirements in terms of financial constraints, budgeting and efficiency have now forced many nurses to take on a complex set of (sometimes contradictory) perspectives in their occupational positions (Bolton, 2005). Research on professional identities has further delved into the issue of how nurses make sense of their new medical careers, where caring no longer is considered the only aspect of ‘good professional practice’. The entrance into medical tasks earlier carried out by physicians has affected the way in which the nursing profession perceives its standing within the organization. Although engagement in clinical examinations should offer a higher organizational status, the excess of tasks that are carried out in order to ‘reduce costs’ or ‘cut the physicians’ working hours’ can sometimes make the nursing profession feeling devalued. As concluded by Banham and Connelly (2002), ‘nurses do not wish to be cheaper doctor substitutes or people who perform
tasks that ‘bore’ doctors’ (p. 262). New responsibilities within the managerial function have also added complexity to the nursing identity. Both Bolton (2003) and Dent (2008) note how nurses sometimes tend to disassociate themselves from the term ‘manager’, as they consider this as being something outside the institutionalized discourse of caring. It has further been noted how nurses who are assigned managerial positions experience a challenge to retain respect from their colleagues, who do not perceive managerial tasks as appropriate for nurses to take on (Rosengren & Ottosson, 2007). By taking over medical areas previously occupied by physicians, (reluctantly) incorporating managerial tasks into the professional role, and holding on to an increasingly influential caring logic, notions of nursing practice are reconstructed.

5.2.3. Addressing the challenges of interprofessional collaboration

While professional boundaries are becoming increasingly contested through overlapping knowledge bases and shared responsibilities, healthcare professionals are at the same time expected to gather in teams around the patient and together find direction in the delivery of care (Noordegraaf, 2011). Salhani & Coulter (2009) emphasize how the trend of inter-professional collaboration (IPC) has found expression within the healthcare setting:

‘Healthcare professionals are witnessing a clarion call from politicians, health policy analysts and scholars for improved efficiency and effectiveness through increased interprofessional collaboration.’

– Salhani & Coulter, 2009, p. 1221

Already in 1988, however, inter-professional education (IPE) was introduced as a way to foster efficient work relations between healthcare professionals (Thistlethwaite, 2012). Striving for an increased understanding of differences between professional groups, the education aimed at creating more fruitful ways of collaborating. As Bridges et al. (2011) put it:

‘IPE provides an ability to share skills and knowledge between professions and allows for a better understanding, shared values, and respect for the roles of other healthcare professionals.’

– Bridges et al., 2011, online
Despite efforts to increase knowledge about, and raise respect for, other professions within the healthcare context, IPC has always been dogged by challenges. As pointed out by Easen et al. (2000):

‘… there is a strong thread of evidence which points to the problematic nature of inter-professional collaboration.’

– Easen et al., 2000, p. 356

In particular, a conflict has arisen between the medical logic, which mainly focuses on treatment, and the more caring logic, which is concerned with patients’ social issues (Liff & Wikström, 2015). A significant distance between physicians and nurses, the key partners in care, can thus be noted. Searching for an explanation for the observed cooperation struggles, it has been argued that an ‘insider-outsider approach’ permeates contemporary forms of interprofession-based organizing, where professionals put much effort into defending their work domains from other professional groups. Acknowledging how IPC constitutes a principal precondition for the delivery of safe healthcare, Irajpour and Alavi (2015) emphasize the need to overcome these inter-professional boundaries:

‘In order to expand IPC throughout the health system, professionals must cross the boundaries that are established by sectoral, organizational, as well as professional socio-cultural contexts.’

– Irajpour and Alavi, 2015, online

Such an undertaking does, however, call for more nuanced understandings of work-based interactions. Hall (2005) stresses how ‘each healthcare profession has a different culture which includes values, beliefs, attitudes, customs, and behaviors’ and how ‘these professional cultures contribute to the challenges of effective IPC’ (p. 188). In the same vein, Irajpour and Alavi (2015) summarize three main causes of inter-professional cooperation challenges as; (1.) motivation to engage in IPC, (2.) interaction beyond boundaries, and (3.) readiness to approach IPC. While the first category addresses organizational priorities and describes how poor acknowledgement systems or already high workloads discourage professionals from engaging in interprofessional work, the subsequent two categories highlight how an uneven power distribution obstructs productive interprofessional relations.
Elaborating on how the desire to defend professional jurisdictions impedes efficient collaboration, Liff and Wikström (2015) describe how physicians and social workers control interprofessional interaction by employing a set of protective routines. These routines allow for different knowledge bases to coexist without conflict, as standardized ways of working minimize contradictions in how to handle a certain situation. Still, the use of protective routines prevents ‘affording situations’, where ‘extra-professional’ knowledge can be gained by learning from each other. While stressing how successful teamwork requires ‘a mutual vision, commitment to mutual goals, good communications, role-valuing, clear team identity, and support for professional identity’ (p.267), the authors thus contend that the protective routines inhibit efficient knowledge sharing between professions. Drawing on these insights, it is noted how the very essence of inter-professional education (to share skills and knowledge between professions and, consequently, obtain a better understanding, shared values, and respect for the roles of other healthcare professionals) is impaired by professionals’ aspirations to safeguard their own knowledge bases.

5.3. Professional power play

A (sub)profession that has proven to be successful in safeguarding its professional jurisdictions is midwifery. Liff & Wikström (2015) explain how this occupational group defends autonomy by strategically portraying their knowledge base as something unique:

‘… midwives are skilful in highlighting their special expertise that physicians are less likely to be familiar with. The midwives thus establish their autonomy by defining their area of expertise separately from others’ jurisdictions.’

– Liff & Wikström, 2015, p. 269

However, while the authors describe how autonomy is successfully defended in an interprofessional context, they also stress how this ‘success’ presupposes that the midwives – when practicing their knowledge base – avoid challenging knowledge within the established field of medicine. In the discussion of protective routines, it is accordingly contended that the team setting typically enables physicians to reinforce their dominant role within the organization. An illustrative example is how discussions of specific patient issues – as well as treatment methods – are collectively avoided in cases where the reputation of ‘superior’ medical knowledge runs a risk of being damaged. Similarly, Fox (1993) has described how surgeons maintain control
over patient consultations by consciously steering conversations in specific directions where medical knowledge avoids becoming contested. Currie et al. (2008) have further referred to the practice of ‘shifting blame’ in describing how unsatisfying incident reporting with only little effort can be reformulated to a question of insufficient financial resources for the medical profession. Interestingly, it has also been noted how standardizations that often become portrayed as a threat to professionalism have strategically been embraced by physicians so as to reduce scrutiny by other professions. Hansen (2007) describes how the medical profession, at the cost of individual autonomy, engages in evidence-based decision-making in order to maintain control over its esoteric knowledge base. All these insights bear witness to professional power play. Where formal structures today suggest a more even organizational distribution of influence, professional practice seems to sustain an institutionalized hierarchical order. How could this phenomenon be explained?

Fitzgerald (2016) stresses how boundaries of knowledge bases today are hard to establish, and how professional acceptance from society at large becomes a continuous process of politics. This opens up for interprofessional competition, as concluded by Salhani & Coulter (2009):

‘… Under these ambiguous conditions professionals use power to assert, maintain or enhance the prerogatives and advantages of their professional projects.’

– Salhani & Coulter, 2009, p. 1227

Emphasizing the power dimension of interprofessional interaction, a growing research tradition recognizes the healthcare organization as a negotiated order (Svensson, 1996; Allen, 1997; Reeves et al., 2009; Nugus et al., 2010). Acknowledging how a constantly on-going micro-level negotiation constitutes ‘the key factor to the development and maintenance of social order within organizations’ (Reeves et al., 2009, p. 642), this perspective is productive in assessing how healthcare practice typically diverges from formal structures of authority and control. The negotiated order tradition stresses how a hospital order – similar to the social order described by Uhl-Bien (2006) and Hosking (2007) – informs organizational patterns of interrelating:

‘The way treatment and care are organized only partly derive from ‘rules’ and the unfolding pathology of the patient, but are also the product of continual negotiation, in interaction, by
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The players involved in the exercise of agency and the simultaneous creation of a relatively stable hospital ‘order’ […]

– Nugus et al., 2010, p. 899

Patterns of interrelating are thus acknowledged to be established in a continuous negotiation for influence. While actions and responses to actions are informed by prevailing contextual values, these values are in turn reconstructed in mundane instances of interrelating. This mechanism often plays out unintentionally, as emphasized by the authors:

‘Actors choose from a repertoire of what are acceptable actions and responses, befitting role expectations, under particular circumstances. These constitute patterns of influence, or power, over them of which they might not be aware. What they choose to say or do may resist or challenge this pattern, expanding the repertoire, but also possibly expanding the conditions of influence over their fellow interactants, and themselves in other times and places. … Because the character and extent of mutual influences interaction is often unknown, negotiated orders of power can exist in spite of the benevolent attitudes or intentions of individual actors.’

– Nugus et al., 2010, p. 899

Informed by these notions of productive power, the negotiated order has been able to advance the understanding of medical dominance. Reeves et al. (2009) refers to a hierarchical social order in explaining how the established profession of medicine experiences an advantage in interprofessional interaction. The social order makes it possible for the physicians to pose questions, make requests and prioritize profession-specific activities over undertakings relying on inter-professional collaboration (Reeves et al., 2009). This becomes particularly prominent during ward rounds, where interprofessional discussions and dialogues aiming at advancing patient care typically prove to be absent. Rather, communication in these situations often takes a unidirectional form where physicians request information from other healthcare professionals (Reeves et al., 2009). Nugus et al. (2010) have similarly explained how the hierarchical social order allows the medical profession to ‘dominate’ other clinicians in interaction. Even if physicians sometimes employ ‘collaborative power’ to discuss strategic undertakings with other healthcare occupations, they more often fall back on ‘competitive’ forms of power so as to avoid
discussions. These dynamics suggest ‘a socialized role expectation that doctors evaluate and determine the extent to which they will accept the input into patient care delivered by those with different professional backgrounds’ (p. 901).

While the negotiated order tradition sheds light on how interaction patterns stand in close proximity to a stable hospital order, it nevertheless falls short in explaining how instances of non-interaction reinforce dominant conceptions of this institutionalized order. Acknowledging the potential of leadership in every social situation, it should be stressed how critical negotiation situations do not necessarily comprise a direct interaction between two (or more) professions, but could be any instance where the social order is challenged or reinforced. While Allen (1997) refers to lack of interaction as a ‘non-negotiated order’, it should rather be acknowledged how the absence of direct communication indeed constitutes an important part of the continuous negotiation for influence.

Referring to limitations within the negotiated order tradition, Salhani and Coulter (2009) seek to advance the understanding of micro-political struggles in interprofessional interaction. Exploring how nurses employ different forms of ‘power’ in their struggle for increased organizational control, ‘power over’ (or dominance) is initially portrayed as a means of forming autonomous, exclusionary nursing communities. Nurses here embark on a form of domination (different from the one described for physicians above) by simply ignoring and refusing to legitimize orders from other professions (particularly medicine). ‘Power to’ (or performative power) further refers to how nurses seek to transform their formal control to a more ‘substantive control of the unit and related interprofessional work processes’ (p. 1227). By making decisions without consulting other professions, they aspire to formulate new professional boundaries while also maintaining control over these. ‘Power with’ (or collaborative power) is finally described as a way of fostering good relations with other occupational groups. While shedding light on how instances of negotiation indeed occur in indirect forms of interaction, Salhani and Coulter (2009) nevertheless tend to overlook the relation between social practice and social order. Seeking to increase the understanding of how flows of influence emerge in collective processes of interrelating, there is a need to scrutinize recurrent patterns of (non)interaction and assess how these interfere with a social (hospital) order. While the healthcare context offers good opportunities to explore leadership processes in an era of interprofession-based organizing, this exploration should thus,
in turn, provide valuable insights into the challenging aspects of interprofessional collaboration. An increased account of power mechanisms is expected to shed light on the consequences of protective routines, but also to provide a more dynamic explanation of medical dominance. Specifically, it should therefore be possible to describe how these phenomena are sustained through collective processes where not only physicians, but also other healthcare professions, take part in the (re)construction of a hierarchical social order through mundane instances of interrelating.

5.4. Power bases in the healthcare context

Guided by the conceptual framework developed in Chapter 4, the exploration of dynamics within leadership processes will dwell upon the interplay between dominant discourses, power bases, subject positions and spaces of action. Situating the study within a healthcare setting, it is important to stress how certain factors – which could be understood as power bases – have historically been acknowledged to inform mundane instances of interrelating within this context. In the early 1990s, Lindgren (1992) contended how ‘places’, ‘generations’, ‘professional knowledge’ and ‘masculinity/femininity’ unfolded as particularly critical in the social ordering of healthcare. It is interesting to note that these four factors can be connected to the status characteristics described by Cohen and Zhou (1991), suggesting that similar power bases prevail in different fields of organizing.

First and foremost, Lindgren (1992) emphasizes how different physical rooms (or ‘places’) typically present local variations in the preconditions for interaction. This observation is in line with how discourses have been described as temporary constructions formed by sociocultural notions prevailing within different landscapes and timescapes, stressing how the social context indeed should be acknowledged in the analysis of negotiation dynamics. Lindgren further describes how generations – which can be connected to Cohen’s and Zhou’s status characteristic seniority – inform social ordering within the healthcare organization. She notes how some of the more senior nurses, who for a long time have been influenced by strong patriarchal norms, seem to oppose a more influential organizational standing for the nursing profession. The senior nurses also have a ‘secret society’ that builds on unique experiences gained throughout their professional careers. While this experience could be expected to imply a rigid base of professional knowledge (and thus be considered an opportunity in negotiation), Lindgren contends that nurses seldom dictate the
conditions for healthcare practice. Rather, their success depends on quickly adapting their behavior to different (often contradictory) expectations from the more influential physicians. Lindgren also notes how the nurses’ professional knowledge of caring – which can be connected to Cohen’s and Zhou’s status characteristic educational level – despite an ongoing professionalization seems to be constructed as subordinate to the prestigious field of medicine. As a consequence of this power imbalance, nurses seek to team up with physicians in order to increase their organizational influence. However, Lindgren further contends that this can only be accomplished if the physicians simultaneously benefit from an interprofessional cooperation. It should also be stressed how the nurses in Lindgren’s study are characterized by their socioeconomically heterogeneous backgrounds. This fragmentation typically gives rise to smaller communities within the nursing profession, competing against each other in the striving for organizational legitimacy. Lindgren finally describes how power imbalances between masculinity and femininity – which can be connected to Cohen’s and Zhou’s status characteristic gender – have traditionally been preserved through processes of normalization. Seeking to safeguard the medical profession’s honor and status within the male-dominated community of healthcare, professional workers have typically stuck to established masculine routines for dealing with challenges. However, individuals or groups that have historically lacked access to the medical community might find it harder to comply with the established, invisible codes of conduct. Perceived as unpredictable, they therefore constitute a ‘threat’ to sustained medical honor. Lindgren describes how homosocial practices often (unintentionally) are employed to defend an institutionalized hierarchy when threats appear, and how the ‘threat’ (often female physicians) in this way is disciplined to the established (typically masculine) routines. A superficially homogenous group is, therefore, maintained, as compared to the fragmented nursing profession described above. The phenomenon of normalization can be compared to the token’s striving for invisibility, as described by Kanter (1977).

Having acknowledged how different power orders interfere with each other, Lindgren portrays professional healthcare workers as actors performing on a stage, where they together seek to maintain an established hierarchy in order not to violate dominant conceptions of professional practice. As physicians’ mistakes are easily interpreted as interprofessional failure, and the social cost of interprofessional failure is considered high, she describes how there seems to exist a common wish to
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collectively cover any signs of flaws within the medical profession. This connects back to notions of medical dominance. While the preconditions for interprofessional practice in healthcare have changed since the 1990s, Lindgren’s (1992) observation that a social order strongly interferes with legitimate notions of professional practice is – apparently – still critical for the understanding of professional interaction. Exploring how contextual conceptions about professional practice enable certain power bases to manifest themselves as more influential than others in contemporary forms of healthcare organizing, it should be possible to explain how the continuous interplay between dominant discourses and power bases determines how different professional groups are restricted to certain subject positions in negotiation. By assessing how prevailing assumptions and values thus enable these professions to engage in a certain (limited) set of social practices – and how these social practices in turn challenge or reinforce dominant discursive conceptions about professional practice – the understanding of leadership processes can be advanced.
6. Methodology

Exploring how dominant notions of professional practice are (re)produced in leadership processes, the analysis will be guided by the following questions:

- What (dominant) discourses set the preconditions for negotiation within interprofession-based organizing?
- What subject positions are constructed within these discourses?
- What spaces of action are associated with the different subject positions?
- How does the interplay between discourses and power bases allow for certain professions to draw on certain subject positions (in certain contexts)?
- How does the interplay between dominant discourses (prevailing social order) and spaces of action (enabled social practices) reinforce or challenge discursive conceptions of professional practice?
- What images of different organizational roles are constructed in the leadership processes?
- How are these images related to expectations on how interprofession-based forms of organizing should work in order to reach their goals?

The present chapter elaborates on how these guiding questions have strategically been approached through an empirical study within the healthcare context.

6.1. Research strategy

The research process has followed an abductive approach, where the alternation between previous knowledge and empirical insights has guided the exploration of leadership processes in an era of interprofession-based organizing. An abductive strategy introduces understanding as a central component in knowledge construction (Alvesson and Sköldberg, 2017), which becomes a prerequisite for the ontological stance where social realities are acknowledged as being complex and context-dependent (Berger & Luckmann, 1966). The deductively compiled analytical framework, where leadership processes are conceptualized as a continuous negotiation for influence (see Chapter 4), has throughout the research process been inductively developed in line with how Alvesson and Sköldberg (2017) describe abductive reasoning:

‘During the process, the empirical area of application is successively developed, and the theory (the proposed overarching pattern) is also adjusted and refined.’

– Alvesson & Sköldberg, 2017, p. 5
Theoretical fields that have empirically proven to be of major significance for the leadership processes will thus be elaborated on at a later stage – and previous knowledge within these fields will be considered an important addition to the initial analytical framework. This typically applies to the concept of organizational humor, which will be introduced in latter stages of the analysis.

### 6.2. Case study

Exploring leadership processes in interprofession-based forms of organizing, a case study was performed at one of Sweden’s largest emergency university hospitals. The case study approach was considered suitable as it allows for complexities and nuances in the continuous negotiation for influence to be assessed in detail. Eisenhardt and Graebner (2007) have described how ‘case studies emphasize the rich, in-world context in which the phenomena occur’ (p. 25). By engaging with organizational actors and their communities of practice, a comprehensive understanding of the mundane instances of interrelating could thus be achieved. Before elaborating on how this understanding was obtained – mainly through interviews and observations – it is nevertheless important to highlight how different arrangements of profession-based organizing present diverging preconditions for interprofessional interaction.

As Ackroyd et al. (2007) have stressed, the hospital’s composition of professionals working together is indeed unique. The hospital studied could, therefore, in no way be considered to be representative of professional organizations in general. Still, a similar relationship to the one between physicians (the institutionalized, established profession) and nurses (the upcoming profession) is today present also in other arrangements of interprofessional work. It is, therefore, legitimate to assume that the dynamics of leadership processes in a healthcare setting to some extent are transferable to other fields of interprofession-based organizing – where they are expected to present similar preconditions for the unfolding organizational direction. It should further be acknowledged how different healthcare settings are often characterized by local variations in interaction dynamics. For example, Nugus et al. (2010) have observed that a hierarchical power order is less articulated in community-based services than in acute hospital services. In their study, this phenomenon is tied to ‘the character of work required of community-based clinicians’ (p. 902), where community health is portrayed as a discipline that embraces the team and respects different professions’ expertise. As expressed by a
psychologist: ‘Community health is all about valuing the team.’ (p. 902). In a large university hospital, other circumstances set the preconditions for interprofessional interaction. First and foremost, a strong emphasis on research and education not only introduces parallel expectations of professional practice, but also suggests that a complex set of different power bases informs the continuous negotiation for influence. The larger hospital further employs many professions coupled to different subdisciplines of medicine and nursing. While these sub-professions are united by general professional logics, they are still differentiated by their distinct knowledge bases and values, adding complexity to the mundane instances of interrelating. Moreover, the organization is structured in such a way that a substantial amount of direct communication between physicians and nurses occurs in everyday operations. Critical medical conditions, quick decisions and complex interventions require continuous interprofessional work between these two professions, opening up for interactional instances where the complex divisions of responsibilities and knowledge bases come to a head. While different healthcare settings present contextual variations in interaction dynamics, the large university hospital should thus offer good opportunities to provide a more dynamic understanding of the leadership processes by which notions of profession-based organizing are continuously (re)constructed.

6.3. Sources of empirical material
Credible interpretations of complex sociocultural phenomena – such as relational leadership processes – presuppose a comprehensive understanding of norms and assumptions within the local setting. Endeavors to obtain a general, holistic picture of the hospital’s organizational structure and culture have, therefore, been pursued by initially approaching the empirical setting through a variety of sources (see Table 6.1). Studies of webpage and policy documents have shed light on formal organizational arrangements, whereas interviews with hospital management as well as observations of educational instances (e.g. business development workshops, Lean healthcare training sessions, patient security meetings, etc.) have provided insights into organizational priorities, communication patterns and jargon. While these initial encounters with the empirical context have not specifically focused on leadership processes, the ‘background information’ obtained has proven critical for capturing the underlying meaning behind a certain utterance or social practice in subsequent, more focused parts of the study. Although not explicitly presented in the analysis
Methodology

chapters, the more general understanding of organizational norms and assumptions thus permeates interpretations of empirical material, as will be elaborated on below.

Table 6.1: Sources of background information

<table>
<thead>
<tr>
<th>Informant/Document</th>
<th>Occasion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Webpage</td>
<td>-</td>
</tr>
<tr>
<td>Policy documents</td>
<td>-</td>
</tr>
<tr>
<td>CEO</td>
<td>• One formal interview (1.5 hours)</td>
</tr>
<tr>
<td></td>
<td>• Three business development meetings (1 hour/meeting)</td>
</tr>
<tr>
<td>Head of strategy planning</td>
<td>• One formal interview (1 hour)</td>
</tr>
<tr>
<td></td>
<td>• Three business development meetings (1 hour/meeting)</td>
</tr>
<tr>
<td>Business developers</td>
<td>• Many formal and informal interviews/chats</td>
</tr>
<tr>
<td></td>
<td>• Three business development meetings (1 hour/meeting)</td>
</tr>
<tr>
<td></td>
<td>• Two continuous improvement meetings (1.5 hours/meeting)</td>
</tr>
<tr>
<td></td>
<td>• Several educational instances (e.g. full-day Lean healthcare training sessions for different groups of physicians and nurses)</td>
</tr>
<tr>
<td>Medical directors</td>
<td>• Three formal interviews (1 hour/interview)</td>
</tr>
<tr>
<td>HR-strategist</td>
<td>• One formal interview (1 hour)</td>
</tr>
<tr>
<td>Quality strategist</td>
<td>• One formal interview (1 hour)</td>
</tr>
<tr>
<td>Business controller</td>
<td>• One formal interview (1 hour)</td>
</tr>
</tbody>
</table>
Acknowledging how language mirrors the negotiated social order by enabling and constraining articulations of professional practice, interviews are a useful starting point when more systematically addressing the dynamics of leadership processes in light of the analytical framework. Eisenhardt and Graebner (2007) have stressed how interviews indeed constitute an efficient method for gathering rich, empirical material. In the present study, interviews not only make it possible to see how different professions describe each other, but also shed light on what subjects the professional practitioners choose (consciously or unconsciously) to elaborate on as well as how utterances are framed. While a social constructionist understanding of reality implies that utterances and stories in no way could be treated as an objective truth, the interviews nevertheless provide valuable insights into power orders informing leadership processes.

Twelve semi-structured interviews were conducted with physicians and nurses from different hospital functions, including patient security, clinical pharmacology, gynecology, obstetrics, cardiology, nephrology, radiology and surgery/urology (a more detailed outline of the interviews is provided in Table 6.2). One group interview was also carried out, where chief physicians from different clinical departments discussed the aftermaths of a Lean implementation initiative in 2010. The interviews were conducted in 2014 and 2015. They ranged from 60 to 90 minutes in length and concerned three main topics (not applicable for the group interview), within which the respondents were allowed to elaborate on their own stories based on experiences and thoughts. The topics were (1.) Professional roles within the organization, (2.) Efficiency in the daily teamwork between nurses and physicians, and (3.) Organizational implications of a recent change project (the Lean implementation initiative) introduced at the hospital in 2010. The topics were highly intertwined. While professional roles and daily teamwork had a strong connection to interprofessional interaction, stories about change initiatives highlighted the constant tension between different professional groups. The three topics were thus selected to encourage a discussion of the more challenging aspects of interprofessional collaboration, particularly addressing the complex issues of responsibilities and authorities. Rather than being deductively compiled, the interview topics opened up for an inductive analysis of how dominant notions of leadership were allowed to prevail within the organizational context. Throughout the interviews, focus was maintained on how professionals within different departments perceived their own,
but also their colleagues’, role in the interprofessional (leadership) work at the hospital. General patterns beyond the individual level could in this way be captured. Interviews were audio recorded and transcribed within a week after completion.

Table 6.2: Conducted interviews

<table>
<thead>
<tr>
<th>Department</th>
<th>Interviewee</th>
<th>Duration</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administration/Hospital management</td>
<td>Nurse: Patient security</td>
<td>1 hour</td>
<td>Woman</td>
</tr>
<tr>
<td>Administration/Hospital management</td>
<td>Chief physician/Head of clinical pharmacology</td>
<td>1 hour</td>
<td>Woman</td>
</tr>
<tr>
<td>Administration/Hospital management</td>
<td>Chief physician/Head of patient security</td>
<td>1 hour</td>
<td>Woman</td>
</tr>
<tr>
<td>Gynecology</td>
<td>Chief physician</td>
<td>1 hour</td>
<td>Woman</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Resident physician</td>
<td>1 hour</td>
<td>Man</td>
</tr>
<tr>
<td>Nephrology</td>
<td>Chief physician/Head of department</td>
<td>1.5 hours</td>
<td>Man</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>Chief physician/Head of department</td>
<td>1 hour</td>
<td>Woman</td>
</tr>
<tr>
<td>Radiology</td>
<td>Chief physician</td>
<td>1.5 hours</td>
<td>Man</td>
</tr>
<tr>
<td>Surgery/Urology</td>
<td>Chief physician/Head of department</td>
<td>1.5 hours</td>
<td>Woman</td>
</tr>
<tr>
<td>Surgery/Urology</td>
<td>Chief physician</td>
<td>1 hour</td>
<td>Man</td>
</tr>
<tr>
<td>Surgery/Urology</td>
<td>Chief physician</td>
<td>1 hour</td>
<td>Man</td>
</tr>
<tr>
<td>Surgery/Urology</td>
<td>Chief physician</td>
<td>1 hour</td>
<td>Man</td>
</tr>
<tr>
<td>Group Interview – Many departments present</td>
<td>Patient security physicians</td>
<td>1.5 hours</td>
<td>Men and women</td>
</tr>
</tbody>
</table>
While interviews provide valuable insights into power orders informing leadership processes, they are limited to shedding light on the instances of negotiation that occur within each profession, separately. Although every utterance is indeed a manifestation of the prevailing social order, verbal (non)reactions to foreign professions’ utterances are difficult to grasp in an interview setting. By supplementing the interviews with nonparticipant observations of interprofessional work, a more holistic and nuanced picture of mundane interaction dynamics could, therefore, be achieved. The observations took the form of what Czarniawska (2007) refers to as shadowing, where the researcher preserves ‘an attitude of outsideness’ while gaining first-hand access to organizational practice (p. 56). As instances of interaction are productively assessed by shadowing professional practitioners in their daily work, it is important to stress that an exploration of leadership processes centers on social interaction. While individual physicians and nurses were being shadowed, the unit of analysis thus remained the direct and indirect interaction between (these two) professions. Observations provide valuable insights into the important questions outlined in Chapter 4:

- What it possible to say, and what is not?
- Who is entitled to say what?
- How do the different professions describe each other?

They further demonstrate how spaces of action are enabled and constrained for different professions in different rooms, thus adding a contextual dimension to the understanding of dominant values and assumptions. Moreover, observations enable the researcher to capture the jargon in interactions, opening up for a more comprehensive understanding of negotiation dynamics.

Six observations were initiated at different clinics within the hospital, including gynecology/childbirth, cardiology, nephrology and surgery/urology (outlined in Table 6.3). However, it should be stressed how the complex nature of hospital operations in no way delimited observations to these clinics, but rather shed light on instances of (non)interaction on different wards, with different constellations of clinicians. Some observations took place during night shifts, although the majority were performed during the day. Observations ranged from eight to twelve hours in length and included everything from meetings, rounding and standardized drug administration to different forms of surgery and critical situations in delivery rooms.
I also embraced the opportunity of talking to different people within the wards and having lunch together with nurses and physicians. In this way, it was possible to see what topics were brought up in non-clinical situations, further adding to the understanding of organizational jargon. Due to ethical reasons, observations could not be recorded, as this would go against the fundamental tenet of patient confidentiality. Instead, detailed field notes were taken.

Table 6.3: Conducted nonparticipant observations

<table>
<thead>
<tr>
<th>Department</th>
<th>Follower</th>
<th>Duration</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gynecology/Child delivery (night shift)</td>
<td>Chief physician</td>
<td>12 hours</td>
<td>Woman</td>
</tr>
<tr>
<td>Nephrology (day shift)</td>
<td>Chief nurse</td>
<td>8 hours</td>
<td>Woman</td>
</tr>
<tr>
<td>Cardiology (night shift)</td>
<td>Resident physician</td>
<td>10 hours</td>
<td>Man</td>
</tr>
<tr>
<td>Cardiology (day shift)</td>
<td>Chief nurse</td>
<td>8 hours</td>
<td>Woman</td>
</tr>
<tr>
<td>Surgery/Urology (day shift)</td>
<td>Chief physician</td>
<td>10 hours</td>
<td>Man</td>
</tr>
<tr>
<td>Surgery/Gynecology (day shift)</td>
<td>Chief physician</td>
<td>8 hours</td>
<td>Woman</td>
</tr>
</tbody>
</table>

Acknowledging the potential of leadership in every social situation, all instances of mundane interrelations were initially considered in the collection of empirical material. Coffee breaks as well as medical interventions and informal gatherings were scrutinized so as to explore how social practices manifested themselves through recurrent patterns of (non)interaction. The substantial, almost overwhelming, amount of observed healthcare operations nevertheless called for a systematic selection of material. In this first reduction process, insights from interviews as well as the more general understanding of organizational norms and assumptions made it possible to sort among the many impressions and focus on providing detailed accounts of the most critical instances of (non)relating. For example, previous understandings of a relatively stable hospital order as well as recurrent encounters with harsh comments and veiled insults during interviews made it possible to pick up on many tacit forms of sarcastic remarks, which otherwise might have become overlooked or misinterpreted.
Charniawska (2007) highlights some of the main practical challenges associated with shadowing techniques. Firstly, she describes how a researcher who does not blend in might ‘attract attention to the activity of shadowing’ (p. 57). In the present study, this never became a major issue, as I was dressed in the same kind of clothes as my followee. Rather, patients as well as clinicians often mistook me for a nurse or physician. On the other hand, I was recurrently faced with the second acknowledged challenge, namely taking notes while constantly being on the move. Although insights from interviews as well as a more general understanding of organizational norms and assumptions within the organizational context made it possible to sort among the many impressions, observations of mundane healthcare operations sometimes shed light on more critical instances of interrelating than could possibly be written down in the instant situation. In these cases, I focused on providing detailed accounts of conversations between organizational actors as they played out in practice. The setup often allowed me to write down these critical instances of interaction without being too obvious about it. In some situations, however, I had to memorize a conversation for a short time and then sneak behind a wall to document it. This typically applied to interactions during critical medical interventions, where frenetic writing in front of an exposed patient would not only have felt morally wrong, but would also have challenged my endeavors to blend in. More general accounts of how physicians and nurses verbally behaved in the interprofessional room (e.g. recurrent patterns of starting and ending conversations, possibilities to claim place, etc.) were typically documented during a coffee or lunch break. This allowed me to be present in the situation, while also basing my descriptions on more aggregated accounts of (non)interaction. Charniawska finally points to the challenge of gaining access to instances of observation. In the present study, initial access to the empirical setting was negotiated through the hospital’s business development department, where contacts had been established through previous research projects. Access to observations was then primarily obtained during individual interviews.

6.4. Methodological considerations

It should be acknowledged how interpretations from a social constructionist perspective always become ‘contaminated’ by the researcher’s own subjectivity (Alvesson & Kärreman, 2011, p. 2). In the same way as any utterance stems from a discursive context, meaning is always constructed within the realms of personal experiences and assumptions, implying that no such thing as objective knowledge
exists. As pointed out by Steedman (1991), ‘knowledge cannot be separated from the knower’ (Alvesson & Sköldberg, 2009, p. 1). Knowledge is rather understood as being produced in a close interplay with power through the practice of discourse. It is never ‘innocent’, since it cannot be cleansed from power (Alvesson & Willmott, 2003). Within the power struggles constituting discourse formation, knowledge plays a central part and is a direct source of power (Börjesson & Rehn, 2009). Power and knowledge are intertwiningly produced (Wilson, 2013), reinforcing each other through a continuous feedback process (Hörnqvist, 2012). While power sets the limits to what can be perceived as knowledge, the constructed notions of what constitutes knowledge in turn reinforce prevailing power orders. Furthermore, the discursively constructed knowledge sets the limits for what is understood as ‘the truth’. In this way, truth also becomes a discursive construction directly linked to prevailing notions of knowledge – never definitive or objective.

The conception of discursive constructions as momentary representations of underlying domination struggles can, accordingly, be related to a complex of power/knowledge, where discourses constitute the very core of ‘power execution’. The discourse is an instance where knowledge, truth and power merge together (Howarth, 2007). Building on this discussion, a discursive exploration of interaction dynamics could in no way aim to convey an objective truth about leadership processes within profession-based forms of organizing, but rather opens up for new perspectives on processes by which dominant notions of professional practice are continuously challenged or reinforced.

Acknowledging how the researcher’s own subjectivity interferes with the construction of knowledge, my personal background as a civil engineer (M.Sc.) in industrial engineering and management – with a technical specialization in clinical biotechnology, extended courses in biomedicine, immunology and pharmacology, and a moderate understanding of healthcare operations from previous research projects – has implications for the analysis. The engineering background could be considered an opportunity in the research process, as this academic degree does not infer any strong professional belonging per se. This allows me to interpret the interprofession-based environment while not being constrained by any of the major discourses that will be argued to permeate the empirical context. Although inevitably being subject to other discursive conceptions of how to understand interactions and critical negotiation situations, the engineering perspective should allow me to
identify negotiation dynamics at the hospital studied. My ambition has been to understand the medical discussions and interventions, constituting a major part of interprofessional interaction in a hospital context. While not fully grasping the risks and implications associated with a certain intervention, this limitation should not impede my ability to observe who is entitled to claim place within the interprofessional room.

While conventional research for many decades has been occupied with providing ‘true knowledge’ about an existing, objective social reality (Alvesson & Sköldberg, 2009) – mainly by confirming or rejecting hypotheses – it is important to stress how these deterministic frameworks typically make it difficult to think outside the box, and accordingly fall short in exploring phenomena from new perspectives. Many important research contributions therefore emerge in a problematization of ‘the obvious’, where empirical material used in a reflexive way provides opportunities for rethinking what appears to be ‘true knowledge’ (Alvesson & Kärreman, 2011). An illustrative example is how Weick (1993) ‘solves the mystery’ of the fatal forest fire in Mann Gulch by challenging the conventional idea that disintegration is the consequence of panic (Alvesson & Kärreman, 2011, p. 18). Contending that panic is rather the result of a disintegrated team, Weick’s conclusions go against established conceptions and turn the cause/effect-relationship around. New perspectives on processes by which dominant notions of professional practice are challenged or reinforced will similarly be able to highlight hidden but critical aspects of interactional dynamics within contemporary arrangements of interprofession-based organizing. Such insights could challenge conventional conceptions of leadership work, but also shed light on structuring processes that must be rethought so as to avoid deficient professional services.

Conducting research from a social constructionist approach within a healthcare organization has, however, interestingly presented me with the challenge of legitimizing a qualitative research approach to an audience whose own research tradition typically draws on other ontological and epistemological perspectives. This was considered particularly peculiar, as my engineering background indeed should confirm that mathematical and statistical approaches have not uncritically been overlooked in the research design. While have physicians at times demeaned my dissertation to some kind of ‘organizational check’ (e.g. when introducing me to a clinic or group of physicians), the same profession has also expressed positive
comments about how an outside perspective creates value for the organization (e.g. at the end of individual interviews). This dichotomy further strengthens the argument that different discourses indeed coexist beside each other and compete for acceptance. Still, it is interesting to note how the expression ‘outside perspective’ to some extent also reinforces the notion that there is one superior way of conducting research (which should be compared to the opening citation in the preface). The ambitions to create an extensive understanding of the empirical context should compensate for the foreign subject position inherent in an ‘outside perspective’. This being said, I take full responsibility for my interpretations.

6.5. Ethical considerations
The research project has been conducted in line with the research-ethical principles developed by The Swedish Research Council. The information requirement has been fulfilled through informing all professional practitioners in interviews and observations about the purpose of the study. Although the purpose became slightly modified as new important aspects were uncovered, the overall aim of studying leadership processes in contexts characterized by strong professional traditions is still representative of the basis on which interviews and observations were initiated. Each interview started with a presentation of me as a researcher, where the respondent also had the possibility to comment on the research design. During observations, my followee introduced me to the clinic and explained my role in the group. This was usually done during a handover meeting, at which all clinicians had the possibility to pose questions about the research. Since many critical negotiation situations between professionals arose in direct connection to medical interventions including patients (sedated as well as fully conscious), I also signed the NDA for medical interns. Personal patient information was never disclosed in the study. However, the medical condition of a patient sometimes had to be specified in order to understand the preconditions for interprofessional interaction. Regarding the consent requirement, all professionals within the study agreed to being interviewed or observed. Access to observations was mainly negotiated at the end of individual interviews. The confidentiality requirement was met by securing full anonymity of utterances and actions. In order for the analysis to show transparency, empirics nevertheless had to be presented on a sub-professional level, implying that the sub-professional belonging (and sometimes also gender and level of seniority) had to be explicit. Since the hospital studied comprises many different clinics of significant
size, this should not violate the anonymity within the research. Finally, the good use requirement was met by assuring that the findings in this study will not be used for any other purpose than the knowledge claims stated in the objectives.

6.6. Structure for analysis

Informed by a social constructionist ontology, the analysis process took its point of departure in the language observed. Guided by the analytical framework (the seven questions outlined on page 46), it was initially explored (1.) what (dominant) discourses set the preconditions for leadership processes (2.) what subject positions could be drawn upon within these discourses, respectively, and (3.) how these subject positions presented certain spaces of action.

What (dominant) discourses set the preconditions for negotiation within interprofession-based organizing?

Discourses were primarily identified from the interviews (see Figure 6.1). Scrutinizing the transcripts, utterances were initially grouped into a set of recurrent themes to understand how clinicians chose to interpret and articulate critical notions of interprofessional collaboration. Rather than applying an a priori template of codes on the material, the process was guided by an inductive approach (cf. Fereday & Muir-Cochrane, 2006). Open questions about the initial topics (professional roles within the organization, efficiency in the daily teamwork between nurses and physicians and organizational implications of a recent change project) encouraged conversations particularly regarding three themes that came to permeate interviews throughout the hospital, namely (a) formal leadership roles (b) career paths, and (c) organizational responsibilities. Discussions about formal leadership roles primarily centered on complex organizational charts, changing management structures over time and challenges derived from parallel leadership organizations. Career paths were discussed in terms of specializations and supplementary training (for nurses), whereas organizational responsibilities became addressed through thoughts on work assignments, authorities, and medical knowledge. The next step in identifying dominant discourses was to more specifically explore conflicting articulations within the three identified themes. It could be concluded that diverging notions of professional practice were informed by a sociocultural construction of medical knowledge as superior to other knowledge bases. This insight was partly guided by
the background material (where it had been noted how references to medical knowledge repeatedly allowed clinicians to change the agenda for meetings or educational instances), but also derived from inductive assessments of the interview transcripts. While fundamental conceptions about superior medical knowledge unfolded as relatively stable across different interviews, two substantially differing understandings of how ‘legitimate’ knowledge was connected to professional belonging could still be identified. Informed by strong ideologies and medical prestige, an elitist understanding portrayed medical knowledge as exclusively associated with physicians. Within a more pragmatic understanding, notions of result orientation and utilitarianism rather stressed how different professions could be ascribed medical knowledge in different forms. The two fundamentally differing understandings of professional practice presented diverging articulations about formal leadership roles, career paths and organizational responsibilities. These articulations – identified as the elitist and the pragmatic discourse, respectively – will be more comprehensively outlined in section 8.1.

| Interview topics |
| Encourage a discussion on the challenging aspects of interprofessional collaboration, particularly responsibilities and authorities. |
| • Professional roles within the organization |
| • Efficiency in the daily teamwork between nurses and physicians |
| • Organizational implications of a recent change project |

| Interview themes |
| Inductively identified. |
| • Formal leadership roles |
| • Career paths |
| • Organizational responsibilities |

| Dominant leadership discourses/articulations about leadership roles, career paths and organizational responsibilities |
| Inductively identified, notions of legitimate knowledge construct two substantially differing articulations about the three identified interview themes. |
| • The elitist discourse |
| • The pragmatic discourse |

**Figure 6.1:** Identifying dominant discourses
What subject positions are constructed within the dominant discourses?
What spaces of action are associated with the different subject positions?

Subject positions and social practices within the associated spaces of action were subsequently identified through recurrent patterns of interrelating. This part of the analysis predominantly focused on field notes from observations, although transcripts from interviews sometimes also came to illustrate critical interaction dynamics. The process was indirectly guided by the questions shedding light on how language becomes enabling and constraining:

- What is possible to say, and what is not?
- Who is entitled to say what?
- How do the different professions describe each other?

Table 6.4 exemplifies how social practices (themes) were inductively derived from field notes (and interview transcripts). In the challenging endeavor to reduce the empirical material while assuring that the original meaning of a (non)interaction situation was retained, insights from interviews as well as the more general understanding of organizational norms and assumptions became particularly guiding. It is important also to stress how the process in no way unfolded as straightforward, but rather comprised several rounds of grouping and regrouping. For example, the excerpts ‘the operator sarcastically dismisses the reported value [submitted by a surgical nurse]’ and ‘the gynecologists joke about the obstetricians’ (questionable) decisions’ were initially interpreted as ‘Criticizing other (sub)professions’, while the excerpts ‘the surgical team sarcastically devalues the caring logic’ and ‘the gynecologist and midwife joke about the patient’ were placed in the category ‘Insulting professions and patients’. As all these phenomena became associated with sarcasm and jokes – which had also been a recurrent part of interviews and educational instances – they were, however, merged into the theme ‘Making sarcastic remarks and engaging in jokes’. The phenomenon of sarcastically dismissing reported values was further grouped with other observations in the social practice ‘Drawing conclusions about professional competence’. This exemplifies how the same excerpt sometimes came to illustrate more than one theme.
### Table 6.4: Deriving social practices (themes) from field notes (and interview transcripts)

<table>
<thead>
<tr>
<th>Excerpts from field notes (interview transcripts)</th>
<th>Emerging social practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>The operator sarcastically dismisses the reported value [submitted by a surgical nurse]. The gynecologist openly declares that the nurses have taken the test, but not checked the results.</td>
<td>Drawing conclusions about professional competence</td>
</tr>
<tr>
<td>The gynecologist rolls her eyes and sarcastically encourages the nurse anesthetist to mention some theories on caring. The physician ‘humorously’ declares that she is happy as long as she doesn’t have to work with the surgeons. The surgeon sarcastically refers to Lean healthcare as sitting in groups and playing games.</td>
<td>Making sarcastic remarks and engaging in jokes</td>
</tr>
<tr>
<td>The gynecologist loudly reprimands the nurse in front of the whole surgical team. The two surgeons loudly discuss the appropriateness of the action for almost a minute. The gynecologist runs after the surgeon while loudly repeating her question, insinuating that he is shirking his responsibilities.</td>
<td>Voicing opinions and expressing emotions</td>
</tr>
<tr>
<td>The surgeon sarcastically refers to Lean healthcare as sitting in groups and playing games. The gynecologist declares that ‘caring’ is nothing but common sense. The gynecologist makes jokes about me studying leadership.</td>
<td>Demeaning initiatives not stemming from one’s own profession</td>
</tr>
<tr>
<td>The surgical nurse responds to the harsh comment by muttering something inaudible. The nurse is apparently offended but doesn’t say anything.</td>
<td>Suppressing emotions [non-interaction]</td>
</tr>
</tbody>
</table>
Rather than trying to reach the physician, the nurses passively start to complain about how he doesn’t take responsibility for the patients.

Staying quiet rather than speaking up [non-interaction]

The nurse anesthetist jokes along by asserting that she would throw up if she mentioned the caring logic.

Taking part in jokes and sarcastic conversations

The midwife and gynecologist sarcastically comment on the patient in the delivery room.

The cardiac nurse asks if it maybe would be a good idea to put in a drip before the surgery.

Making suggestions and taking part in emotional reactions

The midwife asks if the gynecologist would mind gently pressing over the pregnant woman’s belly.

The midwife confirms that the hospital really has the worst of obstetricians [as proclaimed by the gynecologist].

By more specifically looking for the emerging themes in the empirical material, it was also possible to refine the description of recurrent social practices. On a more general level, this part of the analysis thus took the form of an iterative, abductive process (see Figure 6.2).

![Figure 6.2: Identifying subject positions and spaces of action in an iterative process](image)
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Having identified the major social practices in mundane instances of interrelating, these practices were further grouped into spaces of actions. Through a similar reduction process to the one described above, social practices signaling *superiority*, *inclusion* and *submissiveness* unfolded as central in interaction patterns (see Table 6.5). The social practices associated with the three emerging themes accordingly came to define the space of action for a subject position as *superior*, a subject position as *included*, and a subject position as *submissive*.

**Table 6.5: Emerging themes of social practices, informing the typology of subject positions**

<table>
<thead>
<tr>
<th>Social practices signaling <strong>superiority:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Drawing conclusions about professional competence</td>
</tr>
<tr>
<td>• Making sarcastic remarks and engaging in jokes</td>
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<tr>
<td>• Voicing opinions and expressing emotions</td>
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<td>• Demeaning initiatives not stemming from one’s own profession</td>
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<th>Social practices signaling <strong>inclusion:</strong></th>
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<tr>
<td>• Taking part in jokes and sarcastic conversations</td>
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<td>• Making suggestions and taking part in emotional reactions</td>
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<tr>
<th>Social practices signaling <strong>submissiveness:</strong></th>
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<tr>
<td>• Suppressing emotions [non-interaction]</td>
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<td>• Staying quiet rather than speaking up [non-interaction]</td>
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The typology of spaces of action derived from the identified discourses, as conflicting notions of professional practice informed to what extent different professions were allowed to claim place within the interprofessional room. For example, professions associated with the most highly regarded knowledge bases were ascribed a *generous space of action*, whereas professions associated with less valued aspects of healthcare practice rather became restricted to a *limited space of action*. 
It is important to stress how certain (sub)professions thus already at this stage of the analysis became associated with the different subject positions/spaces of action. Still, it provided clarity to fully explore the interaction patterns before engaging in an analysis of the power mechanisms behind them. Identified subject positions and spaces of action will be more comprehensively outlined in sections 8.2 – 8.3.

**How does the interplay between discourses and power bases allow for certain professions to draw on certain subject positions (in certain contexts)?**

Adding a power dimension to the analysis, it was further being explored how the interplay between dominant discursive conceptions and power bases allowed different professions to draw on certain subject positions, and – accordingly – engage in certain social practices. Guided by empirically gained insights into how different professions verbally behaved in the interprofessional room, these mechanisms were abductively derived by connecting identified interaction patterns to how dominant discursive conceptions of professional practice enabled certain power bases to become influential, and further exploring how the same dominant discursive conceptions allowed different professions to (directly or indirectly) become associated with these influential power bases. The dynamics between power bases, discursive conceptions and possibilities to engage in social practices will be presented in section 8.4.

**How does the interplay between dominant discourses (prevailing social order) and spaces of action (enabled social practices) reinforce or challenge discursive conceptions of professional practice?**

Having established an understanding of how discursive conceptions – informed by a social order – constructed preconditions for social practice, it was further being analyzed how mundane interaction dynamics in turn came to challenge or reinforce the dominant discursive conceptions. These dynamics were abductively assessed by linking identified patterns of interrelating to previous knowledge about stabilizing and destabilizing mechanisms in organizational contexts (cf. Collinson, 1988). Particularly, organizational humor in different forms empirically unfolded as a critical aspect in the continuous negotiation for influence. These insights will be elaborated on in Chapter 9.
What images of different organizational roles are constructed in the leadership processes?

How are these images related to expectations on how interprofession-based forms of organizing should work in order to reach their goals?

Having outlined how power mechanisms enable and constrain certain directions in leadership processes (RQ1), it was further being explored how these dynamics (re)produced dominant notions of interprofession-based organizing (RQ2). Organizational roles as well as understandings of how these roles should be related to expectations on organizational goals were inductively identified by connecting dominant conceptions of legitimate knowledge bases to constructed – or reinforced – notions of leadership. The resulting conceptions of professional practice, outlined in sections 10.1 – 10.2, were also illustrated with utterances from interviews to highlight how they became manifest in leadership discourse.

Leadership processes were further taken beyond the healthcare setting by theorizing on the connection between power orders and preconditions for different forms of professionalism (section 10.3). Informed by traditional understandings of organizational culture, the dynamics of negotiation were thereafter summarized in a dominant leadership culture (section 10.4). Connecting identified interaction patterns to theoretical understandings of interactional dynamics, it was finally concluded how this dominant leadership culture is continuously reinforced through a general phenomenon of professional pride and prejudice (section 10.5).
7. Entering the empirical field

The university hospital where interviews and observations took place is located on the northern outskirts of Stockholm. Employing over 3,900 collaborators distributed over twelve organizational units and nine support functions, it forms one of the biggest acute care hospitals in Sweden, but also northern Europe’s biggest delivery hospital. During the empirical fieldwork, physicians and nurses opened the doors to different areas of the hospital.

7.1. Interviews

Interviews were mainly conducted in the respondents’ offices. The private, tranquil environment allowed for reflections upon challenging aspects of interprofessional collaboration without interruptions or disturbances from colleagues. One interview on the gynecological ward was, however, located to the staff kitchen, as the respondent was between two meetings. Interestingly, this interview also temporarily turned into an observation as the gynecologist started to interact with a surgeon who happened by. As described in Chapter 6, open questions about professional roles within the organization, efficiency in the daily teamwork between nurses and physicians, and organizational implications of a recent change project particularly encouraged conversations about formal leadership roles, career paths, and organizational responsibilities. Recurrent articulations about these three aspects of interprofessional collaboration will be further explored as dominant discourses are outlined in section 8.1.

7.2. Observations

In contrast to the interviews, observations often implied a circulation between different wards and medical functions. The remainder of the chapter will provide introductory descriptions of the different interprofessional rooms where a continuous negotiation for influence continuously played out in mundane instances of interrelating. Drawing on field notes, general patterns of (non)interaction will also be conveyed. It is important to stress that nursing work typically centered around one physical location, whereas physicians more often moved between different wards and functions.
7.2.1. Night shift on the delivery ward
The delivery ward is located in the hospital’s northern wing, closely connected to the gynecology ward, obstetrics ward and gynecological emergency ward. In the delivery rooms lining both sides of a long corridor, midwives oversee the process of childbirth, only consulting gynecologists if medical complications arise. There are also rooms allocated for the acute admission of pregnant women with complications. When not assisting women in the active phase of labor, midwives typically gather in their office in the middle of the corridor to monitor women admitted in earlier stages of labor, engage in capacity planning and take incoming phone calls from pregnant women. The office is only separated by a door from the substantially larger physician’s office, where gynecologists monitor women in labor to quickly act on deviations from the normal child delivery process. The physicians also circulate between the delivery ward, the gynecology ward and the gynecological emergency ward.

The observation was initiated during a night shift on the delivery ward. After having met up with my followee – a senior female gynecologist – in her private office, the night started with a handover meeting at the physicians’ office. Introducing me as a civil engineer studying leadership, the female gynecologist embraced the opportunity of making a joke about how the physicians had to be nice to each other. I thereafter took some time to learn more about the technology that was used to oversee childbirth. Both gynecologists and midwives kindly taught me the interpretation of cardiotocograph traces. The rest of the night was allocated to moving between offices, delivery rooms, treatment rooms, coffee rooms and the gynecological emergency ward to observe interaction patterns during medical interventions, but also to have informal chats with the professional practitioners. Most of the time, I shadowed the senior female gynecologist. However, I also had the possibility to observe midwives’ delivery work and follow a younger gynecologist on the gynecological emergency ward.

Despite full occupancy on the delivery ward, the night unfolded rather peacefully. However, some critical medical incidents engaged professions in acute interventions. Specifically, medical issues arose around a woman who against the physician’s will had insisted on being induced too early, and a baby whose curly hair complicated a vacuum extraction. It was fascinating to note how gynecologists and midwives during these dramatic interventions maintained a professional calm. They asked each
other for opinions and respectfully helped each other out in the most critical situations. It was further interesting to note how the door between gynecologists and midwives remained open throughout the whole night (literally and figuratively speaking). The gynecologists often visited the midwives’ office, where the two professions together created a cheerful ambiance by engaging in humorous conversations. Midwives also entered the physicians’ office, where jokes and sarcastic remarks unfolded towards admitted women/patients and other medical wards (particularly surgery and obstetrics). Mundane conversations about upcoming pool parties and barbeques further bore witness to private relations across professional boundaries. In a stressful and serious setting, the informal environment thus became striking. At the gynecological emergency ward, on the other hand, interprofessional relations appeared to stay strictly work-related. Nurses admitting patients hardly left their small office where they had minimal contact with physicians circulating the corridors. In contrast to the delivery ward, nurses and physicians were thus separated on a physical as well as a social level. It was interesting to note, however, how physicians also here engaged in humor. As they were often working individually, they typically addressed me when initiating jokes about patients.

7.2.2. Day shift on the nephrology ward

The nephrology ward is found in the hospital’s eastern wing, close to the surgery ward and the intensive care unit. It consists of a long corridor with treatment rooms, waiting areas, a drug storage facility and separated nurse/physician offices.

The observation took place during a day shift. Having been introduced during the morning meeting – where both physicians and nurses showed great interest in my research – I divided my time between the physicians’ offices, the nurses’ offices, treatment rooms and the drug storage facility. While primarily shadowing a chief nurse, I was also able to follow a senior physician during visits to other wards.

It was noted how a somewhat chaotic tone seemed to permeate communication not only within the ward, but also between the ward and other hospital functions. While physicians struggled with shortage of space, new patients were frequently admitted from the emergency department. Some of these patients required substantial amounts of administrative arrangements. For example, a patient with a diagnosed spinal cancer had to be referred to a different hospital, which kept both physicians
and nurses occupied for many hours. Nephrologists were further expected to assist in medical interventions and treatment decisions at other clinics. In the middle of a meeting, a physician therefore had to make an instant visit to the intensive care unit. It was also noted how an occupational therapist suddenly showed up unannounced on the nephrology ward, only to find out that the patient in need of his services had been taken to the radiology department for a CT.

The somewhat chaotic communication rubbed off on the atmosphere. It was frequently noted how nurses became upset when physicians just disappeared without announcing their whereabouts. It could also be observed how relatives to patients became annoyed when medical referrals as well as decisions about discharges were delayed, and how an assistant nurse suddenly started crying in the middle of the corridor, as she felt insulted by the nurses. While observations of relatives and assistant nurses should not be considered central to the present study, their reactions nevertheless reinforced – and also confirmed – the feeling of chaos on the nephrology ward. Under these preconditions, it was not surprising to note how communication in general, and humor in particular, became less articulated in mundane instances of interrelating. Physicians and nurses were separated both physically and socially, which typically gave rise to instances of noninteraction between these professions. While physicians circulated between different wards, nurses typically gathered in the drug storage facility to chat with each other and complain about physicians failing to take responsibility. However, nurses never voiced their opinions directly to the physicians.

7.2.3. Night shift on the cardiology ward (intermediate care unit)

The cardiac intermediate care unit is located in the western part of the hospital, close to the radiology department, the intensive care unit, and the emergency department. Many patients are admitted with life-threatening health conditions, requiring continuous monitoring by physicians. The physicians’ office is, therefore, situated in a large hall in the middle of a long corridor, where also patients with the most severe medical conditions are to be found. While nurses take part in monitoring work, they also spend a substantial amount of time in the treatment rooms lining a long corridor.

The observation took place during a night shift. I met up with my followee – a male resident physician – in his private office before taking the elevator up to the
intermediate care unit. During the night, I then spent much time in the physicians’ office where I could observe instances of interrelating connected to everything from treatment decisions and medical interventions to mundane conversations on personal matters. I also shadowed the resident physician during imaging tests at the radiology department, and followed him to the emergency department when his opinion was requested on critical medical decisions.

The night at the intermediate care unit could be summarized as the most dramatic observation during my time at the hospital. Life-threatening situations often required interventions involving different functions of the hospital. At one point, the emergency team came running with a defibrillator while several nurses and physicians were shaking a man whose heart was about to give in. In the bed beside him, another patient unceasingly screamed ‘Hello, where am I?’ as he was unable to interpret the nurse’s answer. Also, other patients were screaming from the treatment rooms. Under these circumstances, it was noted how conversations between physicians and (cardiac) nurses remained calm, methodic and respectful. However, the many serious situations made it difficult to observe interaction patterns to a fuller extent.

7.2.4. Day shift on the cardiology ward (care unit)

The cardiac care unit is located close to the intermediate care unit described above. It typically deals with less acute interventions than the intermediate care unit, and is renowned for its team offices where physicians and nurses carry out their administrative work right next to each other. During daytime, three different teams (red, blue and yellow) are responsible for ‘their own’ sets of patients. Similar to the nephrology ward, the cardiac care unit also comprises treatment rooms, waiting areas, and a drug storage facility. At the end of the long corridor, a balcony allows patients to eat and chat in the fresh air.

The observation started early in the morning. Having changed into my nursing outfit in the drug storage facility, I was introduced during a handover meeting at the red team office. While predominantly shadowing a chief cardiac nurse, the shared team office made it possible to observe most instances of interaction between physicians and nurses. My observations included everything from ward rounds and drug administration to diagnostic dilemmas and continuous improvement-meetings. I also shadowed a chief cardiologist during electroshock therapy on the surgery ward.
It was instantly noted how less acute interventions in no way implied non-severe medical situations. Many patients were facing life-threatening conditions and some rooms were even allocated for the late stages of palliative care. Still, the atmosphere was perceived as laidback and cheerful. I directly felt included in the red team where my nurse followee was placed for the day. At the team office, both physicians and nurses eagerly taught me everything about journal systems and electrocardiogram interpretation while assessing the medical status of their patients. This was often done in humorous ways. For example, a physician loudly joked about how she succeeded in curing a man from his chronic Crohn’s disease by simply deleting the diagnosis that by mistake had been registered for the wrong patient in the journal system. The laidback attitude was further observed in interactions between cardiologists and cardiac nurses. The professional practitioners repeatedly helped each other across team boundaries, had coffee breaks together and laughed about visiting physicians who did not like the team offices – because there was too much laughter. Still, the environment stayed less informal than on the delivery ward.

7.2.5. Day shift on the surgery ward (shadowing a surgeon)

The surgery ward is located at the heart of the hospital, bringing together professional practitioners from many different subdisciplines of nursing and medicine. In a long corridor lined by transparent windows, operating theatres are systematically divided between standardized procedures (e.g. cholecystectomies and gastric bypass) and more complicated interventions (e.g. removal of colorectal tumors). Patients can be admitted directly from the emergency department, but are more often scheduled for their surgeries.

The observation was performed during daytime, when scheduled operations take place. Having met up with my followee – a senior male surgeon – I was invited to watch a surgical intervention where a new, advanced technique was showcased by a visiting physician. After this educational instance – where also medical students took part – my followee introduced me to his physician colleagues on the ward, making it possible for me to move between different surgical interventions during the day. Predominantly being located at the back of an operating theatre did not impede my possibilities to observe (non)interactional patterns between operator, assistant operator, surgical nurse and nurse anesthetist. I even took part in conversations and posed questions. At one point, I was also asked to assist the surgical nurse in her preparations. When not observing interaction patterns in operating theatres, I
circulated the long corridor, but also had lunch and coffee breaks together with the surgeons.

In general, it could be noted how the teamwork on the ward played out well. During surgical interventions, the (male) surgeons showed great respect for the (female) surgical nurses, who were allowed to professionally carry out their tasks without interference. Despite real-time flowcharts through which the termination of different stages could be estimated (preparation of the patient, anesthesia, onset of surgery, termination of surgery, etc.), it was, however, frequently noted how surgical procedures became delayed in one way or another. Anesthesia sometimes became complicated by somatic causes, but was also hindered when anesthetists did not show up on time. It was further noted how unclarities arose when a surgeon – without prior notice – had suddenly been replaced by the visiting physician in an operating theatre. Sometimes complications were also encountered during the medical intervention itself. Delays typically created frustration among surgeons who were waiting to take charge of a proceeding intervention. Still, it could be noted how the ambiance mainly remained cheerful. Humor and laughs became a recurrent part of conversations, both in the operating theatre and during breaks.

7.2.6. Day shift on the surgery ward (shadowing a gynecologist)

Another observation was performed at the very same surgery ward, following the senior female gynecologist introduced in section 7.2.1. While most of the day was spent in operating theatres, delayed onsets of surgical procedures also allowed me to observe interaction patterns between gynecologists, anesthetists and nurses in the care units where patients were prepared. Also this time, I embraced the possibility of having coffee and lunch together with the clinicians.

Observing the ward from a gynecological perspective, many surgical procedures centered on the removal of cervical cysts. During these medical interventions, it became particularly prominent how the gynecologists (operator and assistant operator) vividly engaged in conversations about anything and everything. Anesthetists and nurse anesthetists sometimes took part in these conversations, while surgical nurses more often stayed quiet and focused on providing the right instrument in the right time. It could, however, be noted how the gynecologists were annoyed when a surgical nurse ran out of a certain component (e.g. absorbent pads) or misinterpreted a medical task. While the gynecologists openly expressed this
irritation – and sometimes even told off a nurse in front of the whole team – surgical nurses typically responded to these reactions by repressing their emotions and silently moving to another part of the room. Sometimes it could also be noted how they muttered something inaudible. In comparison to the delivery ward, where gynecologists and midwives had been observed to respect each other and engage in informal chats, the relationship between gynecologists and surgical nurses thus unfolded as more tense. In conversations between gynecologists and nurse anesthetists, it was further noted how nursing work sometimes became portrayed in less favorable ways. Having observed these social walls, it was not surprising to note how the different professions spent their breaks apart from each other. Within the gynecologists’ coffee room, however, the atmosphere remained cheerful as sarcastic remarks unfolded regarding patients, surgeons and obstetricians.

Having summarized the essence of mundane interrelating on the surgical ward, but also on other wards within the hospital, the exploration of leadership processes will in the following chapter take its point of departure in empirical material obtained during interviews. The observations will be returned to in sections 8.2-8.3, where more detailed accounts of (non)interaction patterns lay the foundation for an analysis of subject positions and spaces of action.
8. Naaw, aren’t they too funny: Professions negotiating for influence

Drawing on insights from the empirical study, this first analysis chapter explores how interaction dynamics become informed by dominant conceptions of professional practice. Initially, two main discourses are identified as setting the general preconditions for leadership processes. Subject positions within these discourses are subsequently introduced and discussed in connection to their associated spaces of action. Interactions between dominant discursive conceptions and power bases are finally assessed in exploring how the two professions studied are enabled to draw on certain subject positions, respectively.

8.1. Dominant discourses

Recurrent articulations about formal leadership roles, career paths and organizational responsibilities not only reflect how certain cultural values and assumptions are allowed to flourish within the interprofessional room, but also come to inform the dynamics of interaction. The two major discourses setting preconditions for leadership processes within the hospital studied could be referred to as the elitist discourse and the pragmatic discourse. Outlining their diverging understandings of professional practice, it is important to stress that no professional group or individual is understood as ‘belonging’ to a certain discourse, and that no discourse is perceived as being more productive than another. Rather, the identified discourses construct (in a continuous interplay with power bases) both possibilities and limitations for each profession in the continuous negotiation for influence. Still, discourses could unfold as more or less pronounced in different social rooms. While the elitist discourse became particularly prominent during interviews on the surgical ward, notions of a more pragmatic discourse were articulated throughout most clinics at the hospital. As argued at the beginning of the dissertation, different discursive conceptions of professional practice are understood as always co-existing beside each other and competing for acceptance. This competition became evident during interviews and observations, where the same individual (physician or nurse) sometimes came to draw on elements from different discourses in the same discussion or situation. Utterances cited in the exploration of dominant discourses
should be considered the most illustrative examples of conceptions that were recurrently pronounced in interviews.

8.1.1. The elitist discourse

Within the elitist discourse, strong ideologies and medical prestige set the boundaries for notions of formal leadership roles, career paths and organizational responsibilities. Traditional conceptions of medical knowledge as the highest valued asset of healthcare operations are manifested in a multitude of ways, thus articulating a clear distinction between more and less important aspects of organizational practice.

Portraying medicine as superior to other knowledge bases, the elitist discourse fosters conceptions that a professional career within healthcare should be restricted to the doctoral workforce. Even if nurses indeed are depicted as professionals ('I really don’t mean that they [the nurses] aren’t professional, because they are' - male surgeon) and have all the possibilities to take on more responsibilities in their working lives, it is described how this typically happens outside the hospital:

‘We have a midwife who has embarked on further training and started her own practice here. At our clinic it has been well received, but at other clinics they think that it shouldn’t work like this […].’

- Female gynecologist

‘You [the nurses] have a three-year long education that lacks medical scope but incorporates a substantial amount of leadership training. Two years after graduation, 30% of all nurses are gone. […] They are trained to become managers; they take many jobs in our society that previously were occupied by the military. Many [nurses] work in IT or consultancy firms and sort of organize things together.’

- Male surgeon

From a physician’s point of view, nurses are thus recognized for their administrative leadership competencies. Within the elitist discourse, however, administrative leadership is considered subordinate to the prestigious field of medical knowledge, which becomes a natural explanation for why nurses make career outside the hospital’s walls. The conception of administrative leadership as less important is further manifested in an utterance about physicians taking on the role as department director:
'As a physician you deviate from healthcare practice [when you become department director] and of course it’s possible to become reintroduced as a physician … but in many cases you quit completely as a physician and become a paper pusher.’
- Male surgeon

The position as department director is here being described as undesirable for a medical doctor to take on, since it brings about a transformation to ‘paper pusher’ and reduces their credibility among doctoral colleagues. This observation is in line with how Cregård and Eriksson (2015) have contended that physicians who embark on a managerial career typically reduce their credibility as professionals rather than increase the standing for management within the medical profession. While administrative leadership is portrayed as less valued within the healthcare context, leadership in the form of medical responsibility is, on the other hand, considered a vital part of organizational practice:

‘It [the leadership practiced by physicians] lies in treating the patient. […] I mean, you should dictate medical reports, you should prescribe drugs, you should maybe operate, you should talk to the patient, you should talk to the relatives, you should sign the medical record; it’s sort of a lot, but it’s about treating the patient so to speak. Then we have this… administrative other work like financial reporting and other administrative tasks and, I mean there are some physicians who are involved in these tasks too so to speak, or actually many physicians, and many physicians are managers over other physicians and there are those who have managerial responsibilities for a ward but the primary task for a physician must be to treat the patient, right?’
- Male surgeon

‘I mean as a physician you are in a way a leader all the time so to speak. So, leadership becomes inherent in your job where you are in charge of the rounds or you are in charge of this or that. Then it’s important, I think, that you take the other professions’ competencies into consideration and you have to embrace what they can do and know but when it all comes around, the physician decides […]. And being crass, who do the patients come to the hospital to meet? It’s the physician.’
- Male surgeon

Interestingly, leadership here seems to be synonymous with mundane instances of the physicians’ daily work. The disparity between this important medical leadership
and the other, non-important administrative leadership is only one example of how the elitist discourse makes a distinction between highly valued and less valued knowledge bases. Also, organizational change initiatives stemming from non-medical discourses are considered overvalued within the healthcare context. In the following statement, seeking to explain why Lean production exists and was introduced at the hospital in the first place, the elitist discourse basically depicts not only operations management, but all foreign knowledge bases, as subordinate to the prestigious field of medicine:

‘People who don’t want to be in healthcare want something to work with.’
- Male surgeon

Conceptions of medical superiority are also manifested in formal practices (encountered during observations), further illustrating the strong organizational hierarchy. On the surgery ward, clinicians always present themselves in the following well-established order during timeout: (1) Physician/operator, (2) Physician/assistant operator, (3) Medical student(s), (4) Surgical nurse, (5) Assistant nurse, (6) Nurse anesthetist. It is interesting to note how medical students without professional status qualifications get to present themselves before the more experienced specialist nurses. While this established order provides clarity in a critical setting, it nevertheless is also a sign of how medicine stands over nursing within the hospital’s social order.

As can be noted, notions of an elitist discourse outline strong barriers within the healthcare organization. There are clear distinctions between what should be considered highly valued (medical knowledge and medical responsibility) and what could be understood as less important (‘everything else’). Ideologies and medical prestige thus inform notions of organizational responsibilities, career paths and formal leadership roles. Portraying medicine as the highest valued vocation in society, preconceptions about the competences of different professions’ and their suitability for certain job assignments further construct considerable power imbalances that affect the possibilities to exert organizational influence. This will be elaborated on in subsequent sections.

8.1.2. The pragmatic discourse

Within the pragmatic discourse, result orientation and utilitarianism should be considered key drivers. While medicine also here is being portrayed as superior to
other knowledge bases, different professions are still recognized for their medical knowledge in different forms. A strategy to maximize the value of each profession’s competence thus permeates discussions and decisions, where it is more important that things get done in an orderly way than by the ‘right’ profession. Laws and regulations, rather than ideologies and medical prestige, set the boundaries for formal leadership roles, career paths and organizational responsibilities.

Fundamentally, the pragmatic discourse stresses the importance of making efficient use of resources. As an example, the person with most competence within a certain field should be responsible for carrying out medical examinations and teaching others, regardless of professional belonging. On the surgery/urology ward, the female department director describes how the entry of practicing endoscopy nurses not only reduces the workload for physicians, but also adds valuable knowledge to the clinic. However, she also signals that prestige problems prevail at the hospital, thus indirectly confirming the existence of a competing elitist discourse:

‘Everyone is really happy. They [the endoscopy nurses] think it’s fun, they do a really great job; they are highly respected by the physicians. Actually, I should say that many of our younger physicians currently are being trained by the nurses who have been here for the longest period of time. […] Here at the clinic, it hasn’t been a problem but I think it depends on how you look at it and whether you’re afraid of the competition, if you feel… I mean, does it come down to prestige or not. For us, it apparently doesn’t because it really has turned out well. This is not a risk. This is not a problem. Rather, we get a lot done at a lower cost… in a really good way. But I know that we had a patient who wrote a letter and told us that he was disappointed because… in the referral letter it was specified that he should see a physician and then he got to see a nurse, I mean you can’t expect him to understand that seeing a nurse actually was better than seeing a physician, but the fact is that it really was, they [the nurses] are very skilled.’
- Female anesthesiologist

In a similar way, the male department director on the nephrology ward recognizes nursing’s medical competence by articulating how this profession could productively be responsible for more advanced medical examinations. However, also here it becomes interesting to note how prestige problems are acknowledged to prevail at the hospital:
‘I mean, a highly educated nurse specialized in one task probably does it much better than a physician who doesn’t do it very often […], so I don’t see a prestige problem there. I think it’s good. I believe it is more fun for everyone if you can work with more complex things […]. It’s better that they [the nurses] use their education and competence for the more difficult tasks. […]. If you could allow the assistant nurses to administer insulin and that kind of stuff that they aren’t allowed to do today, or place needles or connect IV and stuff like that, then we would become much more efficient. […] For example, why should nurses go around and measure or calculate how many have this or that, I mean an untrained administrator could carry out those [tasks] so that the nurse can work with what she is good at.’

- Male nephrologist

Recognizing how nurses contribute valuable medical competence, dominant conceptions within the pragmatic discourse accordingly allow the nursing profession to take on more responsibilities in healthcare practice:

‘I think that the nurses take over many tasks in healthcare and, at least at this clinic, I don’t see that it meets any resistance.’

- Female anesthesiologist

Nurses are even encouraged to take on more qualifying medical assignments in their professional role:

‘Now I think that this education [endoscopist] is good because you need more career opportunities for nurses.’

- Male surgeon

These conceptions should be compared to how strong ideologies within the elitist discourse seemed to create a barrier to nurses making a career within the healthcare context.

Notions of formal leadership roles within the pragmatic discourse also differ significantly from the ideological understanding described earlier. Whereas the elitist discourse constructed administrative leadership as incompatible with the medical profession, the expression ‘to remain an administrator for the rest of my life as a physician’ in the statement below illustrates how the pragmatic discourse indeed acknowledges administrative leadership as a part of the medical profession’s identity:
'This [being a department director] is actually more than a full-time job so I don’t really have the time to maintain my clinical skills at the anesthetic department. I mean I could have done that, standby duty and stuff like that, but you’re quite happy when you get a weekend off. [...]. I could either go back practicing as an anesthesiologist, [...] then I would need to train for six months maybe and then I’m back. Or I could remain an administrator for the rest of my life as a physician.’

- Female anesthesiologist, department director

The phenomenon of nurses taking on the role as department director is, however, understood as rather problematic also within the pragmatic discourse. Still, the rationale for this understanding differs from the ideological and prestigious conceptions described above. Within the more result-oriented discourse, laws and regulations are considered a major constraint for an efficient division of organizational responsibilities:

‘There are lots of nurses who are really skilled, who have worked for a long time and have lots of knowledge and you need to acknowledge that and listen to them, but that’s not the leadership so to speak. [...]. I mean it’s stated in the legal documents that nurses aren’t allowed to claim medical responsibility.’

- Male surgeon

‘Working with nurses without specialist training is never a problem. But nurses with specialist training … I mean they are specialists in their fields and can have [much more] experience than you. And then you need to show humility while at the same time being very clear about the fact that the person with the [medical] responsibility also has to be the one who makes the decision.’

- Female gynecologist

It is interesting to note how leadership also here becomes synonymous with the physicians’ work, although in the more specified form of ‘medical responsibility’. Referring to leadership as medical responsibility, the pragmatic discourse further stresses how formal structures complicate distributed forms of leadership:

‘Now I’ve never had a nurse as manager, but I know other people [physicians] who have and they haven’t been too satisfied with it because often you need parallel leadership organizations. [...]. Then there are lots of chief nurses in formal management positions who perform excellently. [...]. But, if you are to manage larger organizations, you might sometimes risk the leadership becoming unclear, where you have the nurse as a manager and
then you have the physician with the medical management responsibilities and then the physician might become the informal leader to whom the other physicians turn, so to speak, and then the leadership is unclear.’

- Male surgeon

While the pragmatic discourse – in line with the elitist discourse – comes to depict medicine as superior to other organizational functions (such as administration and leadership), it is important to acknowledge how different professions are still recognized for their medical competence. This has implications for how conceptions of formal leadership roles, career paths and organizational responsibilities unfold. In contrast to how notions of competence within the elitist discourse typically restrict the nursing profession to career possibilities outside the hospital, the pragmatic discourse encourages nurses to incorporate more advanced medical assignments into their professional identities. Further, while regulations and formal structures are acknowledged to complicate distributed forms of leadership, the pragmatic discourse still advocates more organizational responsibilities for the nursing profession. Articulating substantially differing notions of professional practice, the elitist and pragmatic discourses continuously compete for acceptance within the healthcare context, setting preconditions for negotiation (Figure 8.1). Guided by the analytical framework, the next step in assessing power mechanisms within leadership processes is to explore how certain subject positions and associated spaces of action are constructed within these discourses, respectively.

*Figure 8.1: Discourses setting preconditions for negotiation*
8.2. Subject positions within the elitist discourse

It has been recognized how the elitist discourse advocates a dichotomy between important and less important aspects of organizational practice. These hierarchical notions construct a power imbalance, where professions strongly associated with the more valued aspects of organizational practice come to enjoy a substantial space of action, while professions associated with the less valued aspects rather face a plethora of constraints. The diverging possibilities for engaging in social practices within the interprofessional room can be understood in terms of a subject position as superior and a subject position as submissive. Noting how many utterances in the following section tend to uncover the superior position as exclusive for the medical profession (and some domains of nursing) to draw on, it seems appropriate to point out how this part of the chapter maintains its focus on providing illustrations of the spaces of action associated with certain subject positions. How the interplay between dominant discursive conceptions and power bases enables professions to draw on these subject positions, respectively, will be assessed further on. Presented accounts of (non)interaction observed at clinics throughout the hospital should be considered the most illustrative examples of identified social practices within the different spaces of action.

8.2.1. The superior

The subject position as superior comes with a generous space of action, where it becomes possible to engage in a wide range of social practices – including everything from judging others to making sarcastic jokes and devaluing foreign aspects of organizational operations.

Superior: With a license to draw conclusions about professional competence

A profession drawing on the subject position as superior (also referred to as ‘the superior’) first and foremost possesses the right to draw conclusions about professional competence. This practice is frequently manifested on different wards within the hospital. In the following example, a female gynecologist who has been conducting cervical surgery slips into a small room close to the operating theatre to dictate. The final stage of the surgery was slightly prolonged as the patient started to bleed more than expected, and the surgical team ran out of absorbent napkins. Scrutinizing the blood loss report, which has been compiled by the responsible female surgical nurse, the superior gynecologist puts down the microphone and comments on the value at hand:
'Naaw, aren’t they too funny? Bleeding 600 [ml], yeah right. That sounds like a lot... (nods her head and laughs).'

From the perspective of an observer, it is impossible to determine whether the registered value is too high – as indicated by the physician – or not. Regardless of which, it nevertheless seems critical to note how the gynecologist finds it natural to openly imply that the nurse has made a mistake. The sarcasm embedded in the utterance further suggests that information provided by nurses has been questioned by physicians on the ward before, and probably will be again.

A similar situation of drawing conclusions about professional competence is indeed observed on the same surgery ward later that day. Waiting for an operation to be initiated, a female gynecologist (operator) and a male anesthetist are obviously irritated at the fact that the patient has not shown up on time. Eventually, the two physicians decide to walk over to the adjacent anesthetic department to consult the nurse anesthetists about the cause of delay. It turns out that a low hemoglobin value hinders anesthetization, and – further – that this unsatisfying Hb-value already yesterday was identified in the patient’s test results on a nursing ward. On the way back to the operating theatre, the gynecologist comments on the situation:

‘Yesterday, when it [the Hb-value] was down at 69, they [the responsible nurses at the nursing ward] should have made a call... but of course they have just taken the test and not checked the result...’

Instead of contemplating different explanations for the dissatisfactory Hb-value, inadequate responses to test results are here taken for granted. Implying that nurses perform poorly in their professional role, this example thus further indicates a tendency of sarcastically judging other professions’ work. Interestingly, the subject position as superior also enables clinicians to make judgments about competences within their own profession. During a night shift on the delivery ward, two gynecologists (a young man and a more senior woman) are supervising the patient monitors while discussing their colleagues at the obstetric ward. Apparently, the gynecologists are all but satisfied with the obstetricians’ decision to schedule a C-section for a patient. Indicating that some obstetricians make suboptimal decisions, while others lack the courage to challenge these, the gynecologists readily refer to their physician colleagues on the obstetric ward as misfits and hostages:
Ashley (gynecologist): There are really a lot of misfits here [at the hospital] (laugh)!
Jonathan (gynecologist): Hostages too!
Ashley (gynecologist): Haha yes misfits and hostages working here!
(Both physicians are laughing.)

The dialogue clearly indicates sarcasm as well as skepticism towards competence within other disciplines of the medical profession.

**Superior: With a license to make sarcastic remarks and engage in jokes**

Having noted how the subject position as superior enables professions to make judgments about professional competence, it is interesting to note how the space of action further comprises a possibility to make sarcastic remarks and engage in jokes. Sarcasm directed towards other professions has already been indirectly described, as in the case with the gynecologist uncritically assessing the inadequate work of nurses. Sarcasm directed towards one’s own profession has also been described, as in the case with gynecologists referring to obstetricians as misfits and hostages. A similar situation is noted during a coffee break on the surgery ward, where a female gynecologist tells her colleague (also a female gynecologist) about how she had to save a patient from the obstetricians’ questionable decisions.

Ashley (gynecologist): Well guess what decision I had to make this morning (laugh) […] they [the obstetricians] had decided to induce her (rolls her eyes).
(Both physicians are laughing.)
Bella (gynecologist): But you gave her a C-section, right?
Ashley (gynecologist): Of course I did!

Surgeons are similarly subjected to the gynecologists’ sarcasm. During an interview, the respondent (another female gynecologist) explains why surgeons probably would find it difficult to work with midwives:

‘Many surgeons would have a hard time communicating with our midwives (laugh). Oh my, now it sounds like I’m tarring everyone with the same brush, but maybe it just does not characterize surgeons as being good listeners and team-players (laugh)…’

Also within other subdisciplines of medicine, humor plays a natural part in mundane instances of interrelating. On the surgery ward, sarcasm and jokes are repeatedly directed at one’s own profession. While surgeons typically engage in sarcastic remarks about the more medically oriented fields of medicine (the ‘desk
physicians’), they also joke about their own colleagues, as illustrated in the example below:

Victor (surgeon): Did you hear that Alex pricked herself with a [Hepatitis C-needle] this morning?
Sebastian (surgeon): Really? Oh shit!
Gabriel (surgeon): Poor Alex, it will be very interesting to see what happens to her.
(Everyone is laughing.)

In an interview setting, a male radiologist further makes a sarcastic comment about the medical profession in general by pointing to the challenges associated with managing physicians:

‘Managing physicians is like herding cats. Everyone runs in different directions. We are kind of maverick. It’s a little hard to make us march in step (laugh).’

This statement could productively be compared to the opening quote in the preface, where a medical student walks the fine line between awareness and superiority. Interestingly, sarcastic remarks also unfold towards the patient every now and then. In the following example, an interprofessional team at the surgery ward is gathered around a middle-aged woman on the operating table while engaging in a heated discussion of cervix cancer. Putting an abrupt end to the conversation, the responsible operator (a senior female gynecologist) summarizes the patient risks associated with not following the recommended track for cervical screening tests:

‘Then they don’t go to their cervical screening tests and then they get cervix cancer and well that sucks.’

While putting the raw truth on the table, the sarcastic undertone in the utterance becomes striking. Sarcasm directed at patients can further be noted during a stressful night shift on the gynecological emergency ward, where a female gynecologist prepares to meet a woman with stomach pain. Approaching the examination room, the young physician glances through the admission form and comments on the patient’s earlier contacts with healthcare:

‘You read here that she’s been in contact with pain rehab. And already there you know that it’s gonna be an annoying patient (rolls her eyes)...’
True or not, the statement clearly illustrates how sarcastic remarks about patients flourish on the ward.

**Superior: With a license to voice opinions and express emotions**

Professions drawing on the subject position as superior further enjoy the possibility of voicing opinions and expressing emotions in interactions. This includes making suggestions on medical interventions, but also strongly reacting to actions undertaken by others. Strong reactions are observed during the day shift on the surgery ward. Upon completion of a cervical operation where a number of cysts have been removed, the surgical nurse is standing in the middle of the room with the compound bucket (the bucket with the removed cysts) in her hand, trying hard to separate the blood from the rest of the contents. This is noted by the superior gynecologist, who does not hesitate to intervene:

*Ashley (gynecologist):* What are you doing?
*Kate (surgical nurse):* We’re separating the blood from the cysts in order to measure how much blood there is.
*Ashley: But you shouldn’t include that.*
*Kate: Exactly, so we’re taking away the cysts.*
*Ashley: But compound bleeding is not included in total bleeding, I’m telling you! You cannot include that!*

Loudly criticizing the nurse in front of the whole team is an example of how strong reactions play out in practice. It becomes interesting to note how powerful reactions can also be directed at one’s own profession. Below, a male surgeon and a male assistant surgeon have reached a critical point in the final stage of a gastric bypass surgery. They now have to make sure that the blood loss stays minimal while they remove their instruments and fuse a blood vessel. The assistant surgeon thinks that the surgeon lets go of an instrument too soon, while the surgeon has another opinion:

*Gabriel (assistant surgeon):* Don’t let go!
*Sebastian (surgeon):* But I’ve reached the other side, then I have to let go!

Loudly discussing the appropriateness of this action for almost a minute, the surgeons both voice opinions and express emotions in the interprofessional room. Emotional reactions are further manifested as the interview on the gynecological ward is interrupted by a heated discussion. At the beginning of the interview, the
respondent (a female gynecologist) has excused herself to take the supervisor phone. She has explained how she is covering for a surgeon who had to take care of an acute medical intervention, but should have been done a long time ago. When this surgeon now appears in the room where the interview takes place – apparently not planning on taking back the phone – the gynecologist stops herself in the middle of a sentence to yell after her male colleague, who just responds dismissively:

Bella (gynecologist): Hello my friend, how did it go? Are you done? (snappish, almost aggressive tone of voice – insinuating that the surgeon has been done for a long time and is now shirking his responsibilities)
Chris (surgeon): No, I’m about to… (continues to move towards another door without looking at the gynecologist)
Bella: Do you want the supervisor phone? ... Do you want the supervisor phone?!

The door slams shut after the disappearing surgeon and the gynecologist quickly follows while loudly repeating her last question. Half a minute later, she returns, nodding her head and sarcastically quoting the eventual encounter:

‘Strange, no one has paged me (sarcastic voice). No, that’s because I’ve covered for you. How amazing (sarcastic voice).’

The situation not only manifests the social practice of expressing emotions, but also further illustrates how sarcastic remarks unfold towards one’s own profession.

**Superior: With a license to demean initiatives not stemming from one’s own profession**

Also inherent in the subject position as superior is the right to demean initiatives not stemming from one’s own profession. In the following utterance from an interview, a male surgeon seeks to explain why nurses have embraced the ideas of Lean healthcare to a fuller extent than physicians:

‘The nurses have embraced Lean to a fuller extent. Being crass, it gives them something to do during the day other than their ordinary work. Maybe not career possibilities, but you can leave your job and sit in a room and talk and do that kind of stuff. […] Maybe you don’t have as fully varying work tasks as a physician. Then it might be a way to escape reality and get to sit and play Lean-games and sort of talk and group, sort of…’
Sarcastically referring to Lean healthcare as ‘sort of sitting in rooms, playing games and talking in groups’ reflects a condescending attitude to managerial initiatives, which similarly was articulated in most interviews throughout the hospital. The utterance further portrays the nursing profession in a rather derogatory manner. A similar attitude to the ‘caring logic’ will be conveyed as the subject position as included is outlined below. These observations are well in line with the hierarchical view of knowledge bases within the elitist discourse, where certain academic areas are constructed as valued more highly than others.

To conclude, the subject position as superior presents a generous space of action – or a right to take substantial place in the interprofessional room. By drawing conclusions about professional competence, making sarcastic remarks, engaging in jokes, voicing opinions, expressing emotions, and demeaning initiatives not stemming from one’s own profession, the subject position also infers a significant level of organizational influence, which will be addressed later on.

8.2.2. The submissive

If the subject position as superior was associated with a generous space of action, the subject position as submissive is rather characterized by a plethora of constraints. Professions drawing on a subject position as submissive (also referred to as ‘the submissive’) are typically excluded from all forms of social practices described above. However, they are still subject to demeaning and sarcastic remarks. While the superior is allowed to voice opinions and express emotions in the presence of other professions, professions drawing on a subject position as submissive can only voice opinions between each other. This became particularly evident during the day shift on the nephrology ward, where two nurses drawing on the subject position as submissive were waiting for medical approval to administer drugs to a patient. The physician who should have authorized the action was nowhere to be seen, and the nurses had no idea where to find him. He was ‘out running somewhere’. Instead of trying to reach the physician, the nurses adopted a passive attitude and started to complain about his lack of responsibility. Drawing on the subject position as submissive, it was impossible to take up the phone and make a call.

Submissiveness was further manifested during the gynecological procedure on the surgery ward where an unexpected bleeding delayed the process and resulted in a shortage of absorbent napkins. As it became clear that also the storage was out of
napkins, the operator (a female gynecologist) did not hesitate to give the female surgical nurse a roasting. While the nurse got tears in her eyes and seemed to feel very offended by this attack, she still repressed her emotions and just muttered something inaudible while moving to another part of the room. Drawing on a subject position as submissive, it was impossible to voice opinions in the presence of other professions. Acknowledging how the elitist discourse infers major differences in interaction preconditions for the superior and the submissive, it should be stressed how these subject positions are associated with substantially differing spaces of action in the continuous negotiation for influence.

8.3 Subject positions within the pragmatic discourse

Within the pragmatic discourse, different professions become recognized for their medical knowledge, and are accordingly allowed to incorporate more qualifying job assignments into their identities. While these mechanisms construct a more inclusive environment, the inclusion takes place within a still hierarchical context where medical knowledge is portrayed as the most valuable asset of healthcare practice. This allows for the subject positions as superior and included to dominate the pragmatic discourse.

8.3.1. The superior

The subject position as superior has already been associated with a generous space of action, where it is possible to engage in a wide range of social practices within the interprofessional room. The same subject position is also constructed within the pragmatic discourse, where understandings of laws, regulations and formal responsibilities establish power imbalances between different professions. Enabling professions to draw conclusions about professional competence, to make sarcastic remarks and engage in jokes, to voice opinions and express emotions, and to demean initiatives not stemming from one’s own profession, the generous space of action associated with a superior subject position plays a critical part also within the pragmatic discourse.

8.3.2. The included

Professions drawing on the subject position as included (also referred to as ‘the included’) are offered a set of social practices resembling those within the superior’s space of action. The most illustrative manifestations of these social practices will be demonstrated below. Important to note is how the extent to which inclusion takes
place seems to vary between sociocultural contexts. Sometimes, the inclusion appears to be partial (or superficial), while other situations suggest a more ‘total inclusion’. These variations, and their implications for the continuous negotiation, will be elaborated on in subsequent chapters.

**Included: With a license to take part in jokes and sarcastic conversations**

The position as included enables a profession to take part in jokes and sarcastic conversations. In line with the similar practice inherent to a superior position, sarcasm can be directed at one’s own profession, other professions, or a patient. In the following example from the surgical ward, an interprofessional team is in the middle of a medical procedure, combining clinical work with discussions of private matters. The responsible surgeon has already during time-out set the humorous tone by loudly declaring that the assisting surgeon will be responsible if anything goes wrong. Still loud and lively, the conversation has now slipped into the nursing logic of caring, and – more specifically – the actual meaning of the concept. The superior responsible surgeon amusingly turns to the included nurse anesthetist to ask about her opinion on the matter:

*Angela (surgeon): Well, Jenny, could you mention some theories on ‘caring’ (sarcastic laugh)?*  
*Jenny (nurse anesthetist): No way, then I would throw up. We aren’t that into ‘caring’ here. (Everyone is laughing.)*  
*Angela: If you are a normal person, you don’t need it. […] Caring is common sense.*

It is interesting to note how the nurse anesthetist does not hesitate to ridicule other domains of her own profession, which are more involved in direct patient care. This suggests that the subject position as included opens up for a demeaning of initiatives stemming from one’s own profession, which could be compared to how the superior is enabled to demean initiatives stemming from other professions.

The social practice of taking part in jokes and sarcastic conversations can further be observed after a continuous-improvements-meeting on the cardiology ward. A female cardiologist – drawing on the subject position as superior – and a female cardiac nurse – drawing on the subject position as included – are having coffee together in the conference room, discussing diverging opinions about the ward’s team offices where physicians and nurses are carrying out their administrative work next to each other. While both the cardiologist and the cardiac nurse fully support
the idea of facilitating interprofessional communication through a shared working space, they declare that visiting physicians are disturbed by the increased levels of conversation that impede efficient dictation. They further joke about how to handle the situation with visiting physicians, who do not seem to fully embrace the value of laughing at work:

Meghan (cardiologist): It’s problematic, where are we supposed to laugh then?! I mean, you’re not allowed to go behind the door and laugh.
Lisa (cardiac nurse): We have to come here [to the conference room] to laugh!
Meghan: (Laugh). No, you and me have to go outside [to the balcony] and laugh.
Lisa: Yes! The next step will be to install infrared heaters so that we can go out and laugh in the winter (laugh).
Meghan: It’s gonna get cold for us (laugh).

While the included is often invited to jokes and sarcastic conversations by the superior, it should also be acknowledged how the included sometimes takes the initiative in making a humorous or sarcastic remark. In the following example, a female midwife – drawing on the subject position as included – and a female gynecologist – drawing on the subject position as superior – are having a good time commenting on the drama in delivery room 4. Earlier in the evening, the patient has claimed to experience severe pain and repeatedly begged to be induced. While both midwife and gynecologist strongly have spoken against this intervention numerous times, the patient has eventually succeeded in imposing her will. Monitoring the progress in the room, the midwife now notes how the CTG witnesses about increased contractions – however not strong enough to deliver the baby:

Jane (midwife): Oops, now there is some real piece of action in number 4 (laugh)!
Ashley (gynecologist): Yeah, really unexpected (laugh).
Jane: Yep, she can lie there and bear down. Won’t help a bit (laugh).

The midwife walks away to check on the patient and returns a couple of minutes later:

Jane: Now she wants morphine as well (laugh).
Ashley: Haha, but she can forget about that. I told her several times that inducing the delivery was a really stupid idea. This is what happens next. We are heading for a C-section now (laugh).
Included: With a license to make suggestions and take part in emotional reactions

The included profession is further, in a similar manner to the superior, allowed to make suggestions and take part in emotional reactions. During the night shift on the delivery ward, a female midwife – drawing on the subject position as included – wants a female gynecologist – drawing on the subject position as superior – to assist a mother-to-be in labor. The situation has turned critical and there has been a decision to go for a vacuum extraction. However, this intervention requires that the baby first makes its way further down the birth canal:

Lily (midwife): I know I’m not allowed to ask this, but would you mind...?
Ashley (gynecologist): Absolutely! (presses gently over the woman’s belly)

A similar situation is noted in the team office on the cardiology ward, where a cardiac nurse – drawing on the subject position as included – suggests an intravenous drip before a gastroscopy:

Mary (cardiac nurse): Should we maybe put in a drip?
Jonna (cardiologist): Absolutely, a drip sounds good!

Both these examples clearly illustrate how the included profession is able to make suggestions in the interprofessional room. Taking part in emotional reactions, the included is often engaging in sarcastic conversations with the superior, further illustrating how different social practices interfere with each other. The following dialogue between a midwife – drawing on the subject position as included – and a gynecologist – drawing on the subject position as superior – centers on a woman who has just been admitted to the delivery ward for her planned C-section:

Ashley (gynecologist): But why should she be cut (upset)?
Jane (midwife): Because apparently the obstetricians have promised her... (rolls her eyes).
Ashley: We really have the worst of obstetricians here. How can they make decisions like that?!
Jane: I know!!

In some interprofessional rooms, the included is even allowed to initiate the emotional reactions, which could almost be equated with how the superior is allowed to ‘express emotions’. This kind of situation is manifested during the night shift on the delivery ward, where an already complicated birth has suddenly turned even more critical. Eager to help the child, the gynecologist – drawing on the subject
position as superior – takes a medical initiative by pressing downwards over the pregnant woman’s belly. The midwife – drawing on a subject position as included – loudly raises an objection to this intervention:

Kate (midwife): No! You can’t do it like that!
Sarah (gynecologist): Ok.

While the generous space of action associated with the subject position as superior enables professions to express thoughts and emotions in a multitude of ways, it should be noted how the included profession’s space of action often presents more restrictions in terms of how and when utterances unfold. When it comes to making suggestions on medical interventions, these suggestions are typically framed in a subtle way:

‘I know I’m not allowed to ask this, but would you mind...?’

‘Should we maybe put in a drip?’

These insights should be compared to historical notions of the doctor-nurse game (Stein, 1967), where nurses who wished to give recommendations on medical treatments had to phrase their ideas in a well-established subtle manner. In line with how the nurses in this way safeguarded the honor of the medical profession, it could be argued that included professions who ‘disguise’ medical recommendations by incorporating phrases such as ‘I know I’m not allowed to ask’ or ‘maybe’ actually are safeguarding the honor of the superior profession. This suggests that a similar social game as the one described by Stein (1967) still permeates the healthcare context, where it informs the continuous negotiation for influence.

When it comes to taking part in emotional reactions and sarcastic conversations, it further appears that the included profession is invited to these instances of interaction by the superior profession. Thus, the subject position as included is often constrained by more limitations than the subject position as superior, rendering social practices more restricted for professions drawing on the former subject position. However, there are also situations where the inclusion could be interpreted as more ‘total’. In these cases, it might even be productive to consider the total inclusion as reflecting two different professions in the same superior subject position, interacting in an interprofessional space of action.
Acknowledging how the pragmatic discourse constructs the superior and included subject positions’ spaces of action as seemingly close to each other, it is also important to stress how the included profession’s perceived sense of belonging often remains merely superficial. By accepting the invitation to a limited part of the superior’s space of action, the included profession tends to undermine its own organizational standing, as will be concluded further on. Figure 8.2. summarizes how different subject positions are constructed in the continuous negotiation for influence, in turn inferring possibilities to act in the interprofessional room.

Figure 8.2: Linking dominant discourses to subject positions and spaces of action

8.4. Subject positioning: When power bases come into play
Dynamics within the continuous negotiation for influence are strongly informed by power bases, which – based on dominant discursive conceptions – construct preconditions for drawing on certain subject positions in interaction. It is important to explore, therefore, how the interplay between discourses and power bases allows for certain professions to draw on certain subject positions, but also how these possibilities are informed by the local context. Observing mundane instances of interrelating, it was possible to discern how subject positions were constructed for different professions within the interprofessional room.

As both the elitist and pragmatic discourse come to portray medical knowledge as the most valuable asset of healthcare practice, this fundamental conception sets the
major boundaries for negotiation. Professions associated with power bases that can be connected to medical knowledge are able to draw on influential subject positions, while other professions are restricted to more limited subject positions. Within the elitist discourse, medical knowledge is perceived as being exclusively connected to medical education. Historical conceptions of prestige therefore enable groups that have traditionally been associated with professional certifications within medicine to draw on subject positions inferring the most generous spaces of action. Within the pragmatic discourse, also other power bases are recognized for their connection to medical knowledge. However, as these ‘pragmatic notions’ compete with more institutionalized understandings of medicine, professional groups that can indirectly – through other power bases – be recognized for their medical knowledge are restricted to somewhat more limited subject positions. Professional groups that find it difficult to draw on power bases to claim medical knowledge become constrained to the least influential subject positions.

As traditional guardians of medical knowledge, physicians are naturally invited to draw on the subject position as superior. At the hospital, this was manifested in how the medical profession readily drew conclusions about professional competence, made sarcastic remarks, engaged in jokes, voiced opinions, expressed emotions, and demeaned initiatives not stemming from their own profession. Nursing disciplines associated with medical knowledge through specialist education were able to draw on the subject position as included. It was observed how both cardiac nurses and nurse anesthetists engaged in jokes and took part in emotional reactions together with physicians. However, as interaction was often initiated by the physicians – and sometimes also incorporated loyalty tests in different forms – it could be argued that inclusion in these cases remained just superficial. It is interesting to note how midwives, on the other hand, seemed to be more totally included in their interaction with gynecologists. On the delivery ward, physicians and nurses interacted under similar conditions. They showed great respect for each other’s knowledge bases and asked each other for medical opinions. It was further possible for midwives to initiate jokes, a possibility that otherwise seemed restricted to physicians.

Like other disciplines of nursing, midwives have a solid specialist education that, through pragmatic notions, can be connected to medical knowledge. However, midwifery also deviates from other subdisciplines of nursing in some respects that are critical for its possibility to claim a more substantial place within the
interprofessional room. A fundamental difference between midwives and other specialties of nursing is the traditional understanding of midwifery as something extraordinary. Gleisner (2013) describes how midwives depict themselves as a separate profession – distinct from other disciplines of nursing:

‘They [the midwives] emphasized that midwifery is another profession, not a specialization within nursing, unlike an anesthesiology nurse or a district nurse.’

– Gleisner, 2013, p. 16

Whether arguing that midwifery constitutes a profession in its own right or not – this extraordinary field of nursing indeed comprises aspects of clinical practice suggesting that midwives share more similarities with physicians than do other disciplines of nursing. An important aspect is the medical responsibility, where midwives are expected to draw on their esoteric knowledge bases of pregnancy and child delivery to make critical decisions about whether a person/patient should be treated or not:

‘The distinction between normal and abnormal pregnancy and childbirth, and the assumption that the distinction can be made [is] one of the central activities in medicine. It involves a decision about whether the person/patient should be treated or not. The distinction between normal and complicated birth determines who is in control. When a midwife defines a pregnancy or delivery as abnormal doctors will take over the responsibility of the patient (in cooperation with midwives).’

– Gleisner, 2013, p. 15

Midwives thus recurrently face decisions that might have devastating medical consequences. Accordingly, their view of life and death also comes more into line with a medical than a caring logic. Gleisner (2013) describes how midwives during specialist education learn to ‘understand death in the midwifery context and how it [differs] from how death [is] perceived in other caring professions, most notably in their previous roles as nurses’ (p. 154). While associations with specialist training enable most sub-disciplines of nursing to claim medical knowledge in the negotiation for influence, midwives thus stand out through their medical responsibility and their ‘physician-like’ understanding of life and death, where they still possess unique knowledge distinct from the medical knowledge base. This should explain why midwives seem to find it easier than (other) nurses to be (fully) included in the
negotiation for influence. It also links back to how Liff and Wikström (2015) have described midwives as ‘skilful in highlighting their special expertise that physicians are less likely to be familiar with’.

Nurses who find it difficult to claim medical knowledge are typically restricted to a subject position as submissive. They go quiet in interactions and have to repress their emotional reactions in front of other professions. These phenomena were particularly noted on the nephrology ward, where nurses silently waited for physicians to appear and authorize drug administration, but also on the surgical ward, where nurses responded to physicians’ judgmental comments by silently moving to another part of the room. Interestingly, however, it could be noted how surgical nurses seemed to cooperate better with male surgeons than with female gynecologists. While the gynecologists repeatedly held the nurses responsible for practical incidents and openly judged their competence, the male surgeons (with few exceptions) encouraged the nurses to professionally carry out their working tasks without interference. These diverging patterns of (non)interaction could partly be understood in the light of the traditional doctor nurse game (Stein, 1967). In an era where the social hierarchy between physicians and nurses has not only been challenged by overlapping responsibilities, but also by a feminization of the medical profession (Riska, 2008; Adams, 2010), interaction patterns between female nurses and female physicians become particularly open for contestation. Within the continuous negotiation for influence, female physicians can therefore not rely on established interaction patterns between the professions, but must more actively engage in social practices through which their superior position is consolidated. Still, the problematic aspects of teamwork between female nurses and male physicians on the nephrology ward emphasizes how a gendered power order in no way explains all these complexities in interaction inequalities, but rather stands in close proximity to structuring processes informed by other power bases (e.g. seniority and sub-professional belonging). The observation that different subdisciplines of nursing experience diverging possibilities to engage in social practices within the interprofessional room could further be understood in the light of how the nursing profession seeks to team up with physicians in its quest for organizational influence. As concluded by Lindgren (1992), nurses’ strategic undertakings can only be accomplished if the physicians simultaneously benefit from an interprofessional cooperation. Building on the discussion above, it seems reasonable to assume that physicians see benefits in cooperating with subdisciplines of nursing that can be
associated with medical knowledge through power bases, while still possessing unique knowledge allowing them to contribute valuable input in medical decisions.

It is important to stress also how obstetrics as a medical subdiscipline seems to struggle for recognition. It has been noted how gynecologists and midwives refer to this group of physicians as ‘misfits and hostages’, openly complain about ‘having the worst of obstetricians’, and make jokes about how they have to save patients from questionable decisions. These intraprofessional tensions were further manifested during the interview on the obstetrics ward, where a female physician despondently described how her clinic had little say in the hospital’s management group and how resources for continuous improvements would be a waste of both money and time as the cooperation with other departments ‘would still be deemed to fail’. While the present work (with few exceptions) has treated physicians as an umbrella term, these insights stress how also medicine seems to be fragmented by its different subdisciplines. Still, in line with Lindgren’s (1992) observations, the medical profession appears to be more homogenous than nursing in terms of organizational influence.

The observed interaction inequalities highlight the power dimension of negotiation, stressing how leadership processes indeed construct different possibilities, potentials, opportunities and limitations for different professions (cf. Lindgren & Packendorff, 2011). The dynamics between discursive conceptions, power bases and subject positions are summarized in Figure 8.3. While the elitist discourse tends to equate medical knowledge with professional qualifications obtained through medical education (and possibly also with midwives’ medical responsibility), the pragmatic discourse acknowledges how also other forms of specialist nursing education can be connected to medical knowledge. While these values and assumptions typically allow physicians (with few exceptions) to draw on a subject position as superior, specialist nurses are often invited to the subject position as included. Still, specialist nurses who find it difficult to draw on power bases to claim medical knowledge are restricted to a subject position as submissive. On an individual level, it has further been noted how gender interferes with other power orders to inform relations between nurses and physicians. While seniority has not explicitly been addressed in the present study, previous accounts of its central role in the social ordering of interaction (Cohen & Zhou, 1991; Lindgren, 1992) suggest that it indirectly informs leadership processes through associations with medical
knowledge. Formal management roles, however, seem to hinder rather than help in the continuous negotiation for influence, which could be expected in a sociocultural context where leadership has traditionally been considered superfluous rather than extraordinary and fancy.

Figure 8.3: The dynamics between discursive conceptions, power bases and subject positions

Acknowledging how possibilities to claim medical knowledge – and accordingly draw on influential subject positions – are strongly informed by sub-professional belonging, it might be productive to think of sub-profession as an aggregated power base incorporating elements of other power bases. This has implications for interprofessional interaction dynamics, since not only adjacent professions, but also subdisciplines within the same profession, negotiate for organizational influence. While it might provide conceptual clarity still to distinguish between ‘physicians’ and ‘nurses’ on a general level, it should thus be acknowledged how studies of organizational dynamics call for an increased problematization of sub-professional boundaries.

Having outlined how the interplay between dominant discourses and power bases present diverging preconditions for professions – but also for subdisciplines within the same profession – to draw on subject positions and engage in social practices within the interprofessional room, the next step in assessing power mechanisms within leadership processes is to explore how the recurrent social practices in turn
come to inform dominant conceptions of professional practice. Scrutinizing mundane instances of interrelating, the widespread use of humor becomes striking. Many utterances incorporate some kind of joke, sarcastic or non-sarcastic, while the jargon in most clinics is characterized by (sarcastic) laughter, implied opinions and veiled insults. Advancing the understanding of how social practices inform notions of professional practice, it will, therefore, in the following be elaborated on how the interplay between dominant discourses (prevailing social order) and spaces of action (enabled social practices) effectively reinforces discursive conceptions of professional practice through different mechanisms of humor.
9. Scrutinizing organizational humor

Humor has empirically unfolded as a central aspect in the continuous negotiation for influence. While these insights came across as being somewhat unexpected, they still resonate well with how Reeves et al. (2009) have depicted joking as a recurrent theme in interactions between physicians (and sometimes also in interactions between physicians and other healthcare workers). Informed by an abductive research approach, the present chapter will elaborate on how humor seems to limit and normalize certain ways of thinking and speaking in organizations (with a particular focus on the healthcare context). Initially, previous research on this phenomenon will make important contributions to the analytical framework. Insights from the additional literature review will subsequently lay the foundation for a further analysis of the social practices outlined in Chapter 8, emphasizing how humor reinforces discursive conceptions of professional practice through different stabilizing mechanisms.

9.1. An introduction to humor in organizations

The relation between humor and organizational realities has received considerable attention in the literature, where it has been acknowledged how humor as practice interferes with structuring processes within organizations (Hatch, 1997; Johansson & Woodilla, 2005). It has specifically been stressed how humor ‘not only [becomes a] short-term individualistic strategy that makes employees feel good but also an interactional process that serves to select, maintain, reproduce, and reify preferred interpretations of work’ (Tracy et al., 2006, p. 285). Humor has accordingly been described as a both preservative and destabilizing device, able to pull an organization in different directions depending on the nature of its use. While the oppressive side of humor might serve as a strategic tool for power elites wanting to preserve current values and distance themselves from new organizational or social movements, its more complex side can be embraced by less influential working groups in their endeavors to test, challenge, and potentially change, institutionalized boundaries (Johansson & Woodilla, 2005). An analysis of organizational humor thus adds to the understanding of how flows of influence emerge in interprofessional work relations – in turn reinforcing or challenging dominant notions of professional practice. While studies have discussed the distinction between humor, sarcasm, jokes
and irony (see Hatch, 1997; Johansson & Woodilla, 2005), humor is here recognized for its ambiguous nature and ability to fulfill different purposes within an organization. The concept will thus be treated as an umbrella term, encompassing the practices of sarcasm, jokes and irony.

9.1.1. Humor as stabilizing: Resistance, conformity and control

Humor often interferes with structuring processes by stabilizing power relations between different organizational actors. This phenomenon is manifested in direct interaction between professions, but also in other practices where a profession consolidates its position within the social order. Collinson (1988) – in his study of the joking culture among engineers at a lorry production company – suggests that humor can serve at least three different purposes within an organization, all constructing stability in one way or another.

Firstly, humor can be used as an expression of resistance. At the lorry production company, it was noted how a harsh humorous climate permeating the shop floor allowed for engineers to deal with tightly controlled repetitious work tasks and strongly hierarchical social structures within the company. ‘The spontaneous and cutting creativity of shop-floor banter was indeed conditioned by a desire to make the best of the situation and to enjoy the company of others’ (Collinson, 1988, pp. 184–185). In this way, a strong culture of masculinity and toughness was created; ‘the men were concerned to show that they were ‘big enough’ to laugh at themselves’ (Collinson, 1988, p. 185). The strongly institutionalized joking culture further operated as a mechanism of self-differentiation, where the unique jargon allowed shop floor workers to distance themselves from the company’s management function. This defensive stance was considered important in the endeavors to preserve engineering dignity, as the shop floor workers experienced a situation with less favorable working conditions. The distance from white-collar workers was safeguarded by consciously keeping managers out of engineering jokes. Interestingly, management, on the other hand, often tried to engage in jokes with shop floor workers in their strategic attempts to ‘obscure conflict behind personalized relations, which tried to deny the hierarchical structure of status and power’ (p. 186). While Collinson describes how engineering workers on the shop floor embraced a humorous culture to ‘make the best of the situation and to enjoy the company of others’, a similar situation has been recognized within the healthcare context, where humor is practiced by medical professionals as a means of reducing
stress (Bennett, 2003) and coping with death in an environment where emotion management is often taboo (Smith & Kleinman, 1989). An institutionalized joking culture among physicians typically makes fun of other professional workers as well as patients (Tariq et al., 2016; Wear et al., 2006). For example, the hierarchical structure within the medical profession allows residents to criticize students for being stupid (Tariq et al., 2016). The derogatory culture also permeates interactions between professional disciplines. Tariq et al. (2016) note how consultations among medical specialties often become characterized by a disrespectful attitude, where physicians talk about foreign fields of medicine in sarcastic ways. For example, the physicians can portray emergency medicine as ‘guys that don’t know what they’re doing’ and refer to radiology as ‘the shadow science’. Within the medical profession, as in the case with engineers on the shop floor, a harsh culture is thus created. Wear et al. (2006) describe how medical students who are introduced to this reality typically perceive humor as a ‘coping mechanism or an ‘outlet’ to deal with frustrating or depressing situations, particularly when patients do not take care of themselves in spite of the time, care, and resources spent on them’ (p. 459). The institutionalized joking culture should be compared to how humor, in the face of trying job duties, has been described as ‘[serving] employee identity needs through differentiation, superiority, role distance, and relief’ (Tracy et al., 2006, p. 283).

Besides allowing employees to express resistance, humor has further been acknowledged as a means of constructing conformity (Collinson, 1988). Within the lorry production company, a masculine engineering culture was sustained through initiation rituals, where new shop floor workers had to perform humiliating acts to prove their loyalty and eventually become accepted by the group. ‘Exposure to the joking culture not only instructed members on how to act and react, but also constituted a test of willingness of initiates to be part of the male group and accept its rules’ (Collinson, 1988, p. 188). While not everyone was ready to embrace the initiation procedures, most workers were afraid of facing social exclusion – which often became a reality if one did not conform to the established culture. Thus, ‘social survival of the fittest was the underlying principle behind the pressure to be able to give and take a joke, to laugh at oneself and expect others to respond likewise to cutting remarks’ (Collinson, 1988, p. 187). Interestingly, Collinson also describes how he himself was subjected to initiation rituals when starting off his studies of workshop culture at the company. In addition to the many nicknames and practical jokes that were thrown at him during the first weeks of interviews and observations,
he further noted how the engineering workers positioned their practically oriented shop floor work and technical expertise in a superior position to his own research tradition within the social sciences:

*‘The comments that followed my initiation tended to be directed at the issues which seemed to differentiate them from me, often concentrating on undermining what was assumed to be important to me. […] It is important to recognize that despite the overtly humorous exterior of these comments, another more serious meaning lurked beneath the surface. Workers retained a masculine pride in their, manual, productive skills and practical experience, remaining suspicious of purely theoretical ideas that were seen as inferior to ‘commonsense’.’*

– Collinson, 1988, p. 190

In this way, humor not only fostered conformity in terms of behavior, but also reinforced the perception of what should be understood as legitimate knowledge within the work unit. In turn, this created a distance from those constructed as ‘further down the hierarchy’, as opposed to the distancing from more powerful organizational functions described above. While Collinson (1988) describes initiation rituals on the shop floor as humiliating procedures where apprentices are sometimes stripped and locked into restrooms, loyalty tests within the healthcare context typically take other forms. For physicians, the socialization into a harsh, humorous culture starts already during medical training. Bennett (2003) describes how ‘students respond to the stress of their education by making fun of their courses, their professors, and the process of becoming a physician’. The students also learn how ‘mocking the established social order always has been a part of group life’ (p. 1258). During clerkships, the medical apprentices are further introduced to the derogatory jargon (Tariq et al., 2016; Wear et al., 2006). Tariq et al. (2016) note how young physicians hold diverging attitudes towards this experience:

*‘Some students felt flattered when they were privy to the derogatory ‘off-stage’ remarks because they believed this made them more a part of the ‘club’. Other students considered this type of behavior as inappropriate, even if the patient was under anesthesia or out of ‘earshot’ when such comments were made.’*

– Tariq et al., 2016, online

Whether feeling flattered or uncomfortable, apprentices are nevertheless expected to join and respect the harsh culture:
'When someone at a higher rank uses derogatory humor, those of lower ranks, including medical students, may not always appreciate or find the humor to be funny, but in some settings they are still expected to laugh or at least not object.'

– Wear et al., 2006, p. 458

This phenomenon could thus be understood as the ‘social survival of the fittest’ described by Collinson (1988), where individuals conform to a distinct culture in order not to face social exclusion: ‘exposure to the joking culture not only instructs members on how to act and react, but also constitutes a test of willingness of initiates to be part of the group and accept its rules’. By conforming to the derogative jargon, a strong joking culture is thus reinforced within the medical profession, constructing conformity in terms of how to behave.

Finally, Collinson (1988) contends that humor can also function as a form of social control, where ‘the pressure to conform to routine shop-floor values and practices [is] transformed into worker strategies of mutual control and discipline’ (p. 194). On the shop floor, it could be noted how workers became insulted by their colleagues if they did not live up to the expected levels of ‘masculine work performance’. Accordingly, many sarcastic remarks centered on laziness and ‘non-masculinity’.

9.1.2. Humor as destabilizing: Testing the limits

While humor has primarily been described as a stabilizing device, it is important to stress how the complexity of meanings attached to a joke or sarcastic remark can also have destabilizing effects. Humor can be used to test – and possibly also change – organizational limits:

‘Irony as a destabilizing device builds upon the complexity of meanings attached to the ironic tale, where the ironic tale-maker uses this complexity to check which way the interpretation will go, always leaving open the option to ignore the underlying meaning and return to a simple description. The ironist hints at possible alternate realities; then, when confronted, may either confirm or deny her intentions, depending on her interpretation of the confrontation. Irony, therefore, can have a destabilizing function, testing the actual limits and possibilities of moving them either direction.’

– Johansson & Woodilla, 2005, p. 44
9.2. Exploring humor in leadership processes

The present study suggests that processes of humor reinforce dominant conceptions of professional practice by functioning as a stabilizing device (even if tendencies of destabilizing efforts could also be noted at the hospital studied). During interviews and observations at different clinics, humor was recognized as a means of dealing with working conditions, especially within the medical profession. Procedures resembling initiation rituals, as well as other forms of ‘conformity-constructing practices’, could further be noted in interactions between physicians and nurses.

9.2.1. Humor as resistance: Coping with annoying people

The institutionalized medical joking jargon, described by Tariq et al. (2016) and Wear et al. (2006), became evident also in the present study. During interviews and observations, it was noted how disrespectful comments unfolded towards annoying physicians, whose decisions were understood as disputable:

‘There are really a lot of misfits here [at the hospital] (laugh)!’
‘Hostages too!’
‘Haha yes misfits and hostages working here!’

Also, annoying nurses – whose job performance through the practice of ‘drawing conclusions about professional competence’ was understood as being deficient – became subject to the sarcasm:

‘Naaw, aren’t they too funny? Bleeding 600 [ml], yeah right. That sounds like a lot…’
‘… of course, they have just taken the test and not checked the results…’

Sarcastic remarks further unfolded towards annoying patients, who did not take care of themselves in spite of the time, care, and resources spent on them:

‘Then they don’t go to their cervical screening tests and then they get cervix cancer and well that sucks.’
‘You read here that she’s been in contact with pain rehab. And already there you know that it’s gonna be an annoying patient…’
‘Now she wants morphine as well (laugh).’
‘Haha, but she can forget about that. I told her several times that starting up the delivery was a really stupid idea. This is what happens next. We are heading for a C-section now (laugh).’
Joking about patients could be interpreted as a coping mechanism for dealing with frustration, as concluded by Wear et al. (2006). In a stressful situation, the professional workers are also ‘concerned to show that they are ‘big enough’ to laugh at themselves’, as described by Collinson (1988). The joking culture that is sustained through the practice of coping with annoying people reinforces a distance between physicians/(midwives) and other healthcare professionals, strengthening the feeling of ‘us and them’.

9.2.2. Humor as conformity: Fostering ‘appropriate’ behavior
While previous research has described how physicians are initiated into a harsh joking jargon already during medical training, the present study suggests that also other professions (superficially) can be initiated into the medical profession’s closed joking community. At the surgical ward, it was noted how the nurse anesthetist became subject to a humorous initiation ritual:

*Angela (surgeon): Well, Jenny, could you mention some theories on ‘caring’ (sarcastic laugh)?*
*Jenny (nurse anesthetist): No way, then I would throw up. We aren’t that into ‘caring’ here. (Everyone is laughing.)*

As concluded by Collinson (1988), exposure to the joking jargon not only instructs members on how to act and react, but also constitutes a test of willingness of initiates to be part of the group and accept its rules. In this way, appropriate behavior (making sarcastic remarks and joking about others) is protected from outside scrutiny.

9.2.3. Humor as conformity: Fostering ‘appropriate’ thinking
The initiation of the nurse anesthetist could also be interpreted in terms of a loyalty test, as described by Kanter (1977). Through processes of contrast, the majority (the medical profession) reacts to the minority (a subdiscipline of nursing associated with medical knowledge) by further reinforcing the ‘humorous’ culture. As concluded by Kanter, the token minority often seeks social invisibility by adapting to the majority’s culture. Feeling included, the token also tends to distance themself from the minority and embrace the role as exception. The nurse anesthetist who makes sarcastic remarks about ‘caring’ distances herself from nursing practice and embraces the role as exception. She thereby confirms her loyalty to the medical profession through an
informal test. Seeking immediate influence (a possibility to interact on the same terms as physicians – to enjoy a similar space of action), the nurse anesthetist nevertheless undermines foreign aspects of nursing practice. While partaking in the superior’s ways of joking gives instant recognition to professions drawing on the subject position as included, these professions (often sub-disciplines of nursing) thus tend to devalue their own profession in the process of becoming initiated in the superior’s (often physicians’) harsh joking jargon. This observation is not only in line with Lindgren’s (1992) description of nursing as a fragmented profession with smaller communities competing against each other in the striving for organizational legitimacy, but also links back to previous insights about how nursing success depends on quickly adapting the behavior to expectations from the more influential physicians.

It is interesting to note how my own role as a researcher within the leadership domain was also subject to loyalty tests – similar to how Collinson (1988) experienced his initiation into the masculine engineering culture on the shop floor. During the night shift on the delivery ward, my study was humorously introduced in a rather derogatory manner:

‘This is Erika and she is studying leadership so now we have to be good to each other (the physicians are laughing).’

Seeking to maintain a good relation to my informants, I laughed along with the physicians and consolidated medical superiority within the organization – not only by conforming to dominant conceptions of superior knowledge, but also by behaving in the ‘right way’. Loyalty tests disguised as humor foster appropriate thinking in terms of what should be understood as legitimate knowledge within healthcare practice. In these processes, the superiority of medical knowledge typically becomes stabilized whereas other knowledge bases (e.g. caring and leadership) are constructed as being less important.

9.2.4. Humor as strategic endeavor: Testing limits or proving loyalty?

As was concluded in the discussion on subject positioning, midwives on the delivery ward are able to initiate jokes – as opposed to (other) sub-disciplines of the nursing profession. It was, therefore, suggested that midwives are invited to a subject position as fully included. When the fully included midwife initiates a sarcastic remark about the patient who has been induced too early (‘Oops, now there is some real
piece of action in number 4’), this could be interpreted as an endeavor to test the limits of her space of action, and – possibly – also encroach upon the subject position as superior. When the gynecologist laughs along and answers with a sarcastic remark (Yeah, really unexpected) this sends signals to the midwife that she is allowed to proceed with her strategic undertaking. Accordingly, she confirms her initial intention and engages in a sarcastic conversation (Yep, she can lie there and bear down. Won’t help a bit.). However, if the gynecologist had confronted the midwife’s strategic endeavor, there would have been a possibility to ‘ignore the underlying meaning and return to a simple description’, as explained by Johansson & Woodilla (2005). For example, the midwife could have adopted a more serious tone and suggested medical assistance.

The situation above can be further analyzed in terms of an institutionalized humor order. Wear et al. (2006) describe ‘a ‘secret code’ for how [medical] students learn the acceptable and unacceptable circumstances for expressing derogatory and cynical humor in clinical settings’ (p. 458). Once ‘the ice has been broken by someone of a higher level’, medical students are allowed to express their sarcastic remarks. It could be argued that the midwife on the delivery ward challenges the same kind of hierarchical order for using derogatory humor and sarcasm, namely that someone further up in the hierarchy (the superior) has to break the ice. The possibility of drawing on a subject position as fully included seems to be a precondition for engaging in this kind of strategic endeavor. If the midwife succeeds in challenging the secret code, she gets to interact with the superior on more equal terms – inferring increased organizational recognition and immediate influence.

However, the situation could also be interpreted as an expression of loyalty, where the midwife (drawing on the subject position as fully included) confirms medical superiority by adhering to the physicians’ (the superior’s) derogatory jargon. Also this endeavor gives instant recognition and influence in the immediate situation. Whether testing limits or proving loyalty, adhering to the derogatory jargon stabilizes medical superiority within the healthcare organization. While the (fully) included midwives are associated with a sheer amount of organizational influence, this influence is obtained by conforming to the physicians’ ways of interacting – thereby reinforcing a hierarchical social order. These insights link back to how Liff and Wikström (2015) have described that nurses only succeed in defending their
professional jurisdictions if they avoid challenging knowledge within the established field of medicine when developing and practicing their knowledge base.

9.2.5. Reinforcing medical superiority

Scrutinizing professional humor, it is possible to see how notions of medical superiority are reinforced within the organization. The subject position as superior (typically occupied by physicians) comes with an initially generous space of action, where professions are enabled to initiate jokes, humorously demean initiatives not stemming from the own profession, and test the loyalty of other professions through initiation rituals. In contrast, professions drawing on the subject position as submissive face a more restricted social space, where they are excluded from the ‘humorous’ social practices. Professions drawing on the subject position as included enjoy similar interaction possibilities to the superior. Even if the preconditions for talking and acting often unfold as more restricted for the former group, a perceived sense of belonging nevertheless opens up for interactions where (sarcastic) jokes unite professions in an interprofessional space of action. When engaging in these social practices, however, an initial power imbalance between the different professions is typically sustained. By reproducing the harsh joking climate through loyalty tests as well as mundane interaction, dominant conceptions of ‘appropriate behavior’ and ‘appropriate thinking’ are consolidated within the organization. These notions are further safeguarded through mechanisms of humorous resistance, where the harsh joking climate is reinforced. Accordingly, the barrier between influential and less influential knowledge bases is maintained, allowing notions of medical superiority to set the preconditions for negotiation. These dynamics should be understood in the light of how interdependencies are organized in ways that promote the values and interests of the social order, as explained by Uhl-Bien (2006). The reasoning is also in line with how Lindgren (1992) has described healthcare professionals as ‘actors performing on a stage’, where they together seek to maintain an established hierarchy in order not to violate dominant conceptions of interprofessional practice. In an era of interprofession-based organizing, it is important to stress how humor constitutes a critical element in establishing this hierarchy. The medical dominance described by Reeves et al. (2009), Nugus et al. (2010) and Liff and Wikström (2015) is accordingly largely sustained through different mechanisms of humor. When a discursive antagonism has opened up for conflicting interpretations of legitimate knowledge – making it difficult to draw on educational credentials in claiming organizational influence – it should be
acknowledged how the tactics for safeguarding authority and control thus seem to take new, more tacit forms. *Figure 9.1.* illustrates how humor connects social practice to social order within the continuous negotiation for influence. It is important to stress how reinforced notions of medical superiority not only allow for physicians – but also for other (sub)professions associated with power bases connected to medical knowledge – to enjoy influence within the organization. However, by conforming to the superior’s notions of appropriate behavior and thinking, the prevailing social order is reinforced. While different professions are enabled to exert influence in the immediate situation, the superior thus maintains the interpretative prerogative in organizational development.

*Figure 9.1:* Linking social practice to social order through ‘humorous’ stabilizing mechanisms
10. Exploring the consequences of leadership dynamics

In Chapter 8, it was noted how an elitist and a pragmatic discourse set boundaries for negotiation within the healthcare context, portraying medical knowledge as the highest valued asset of healthcare practice. Accordingly, the interplay between discourses and power bases enabled professions to draw on certain subject positions based on their association with power bases that could (directly or indirectly) be connected to medical knowledge. Restricted to subject positions as superior, submissive and included, (sub)professions collectively engaged in social practices within a generous, limited, or superficially generous space of action. Looking further into these social practices, it was in Chapter 9 noted how humor became a recurrent theme in interaction, reinforcing dominant discursive conceptions of professional practice through stabilizing mechanisms. Having described how these dynamics enable and constrain certain directions in leadership processes within contemporary arrangements of interprofession-based organizing (RQ1), the present chapter draws attention to the dominant notions of interprofession-based organizing that are (re)constructed when power mechanisms play out in practice (RQ2).

10.1. Constructing images of organizational roles

In the healthcare context, assumptions about medical superiority are continuously reinforced through leadership processes. Dominant discursive conceptions construct the medical knowledge base as superior, and social practices further stabilize a hierarchical social order where professions associated with power bases connected to the medical knowledge base are enabled to draw on the most influential subject positions. These dynamics strongly inform how images of organizational roles are constructed. In the following sections, descriptions of constructed roles will be supplemented with utterances from interviews to highlight how dominant values and assumptions are reflected in leadership discourse. As will be noted, the constructed organizational roles are strongly connected to dominant perceptions within the elitist discourse outlined in Chapter 8.1.1, suggesting that power mechanisms in leadership processes restrict more pragmatic understandings of professional practice (see Chapter 8.1.2) from becoming dominant. This links back to how alternative interpretations – which on the basis of current social norms have not
been allowed to establish themselves as obvious (Howarth, 2007) – constitute a
discursive field in relation to which the dominating discourse is always being shaped
and re-shaped (Jorgensen & Phillips, 2000). While different discursive conceptions of
professional practice (particularly conflicting understandings of medical knowledge)
prevail in the healthcare context, the constructed organizational roles thus shed light
on how power mechanisms within leadership process enable some of these
conceptions to reinforce hierarchical understandings of authority and influence.

10.1.1. Physicians: Natural leaders dissociated from leadership
A continuous reproduction of medical superiority ascribes the medical profession
(drawing on a subject position as superior) an interpretative prerogative in
organizational development. Unrestricted association with power bases connected to
the esoteric medical knowledge base not only infers influence over strategic
decisions, but also invokes possibilities of demeaning foreign concepts in mundane
instances of interrelating, particularly through the use of humor. In the healthcare
context, leadership thus becomes constructed as overvalued:

‘Well we have a very strange leadership here because we are very anti-leaders (laugh).’

‘Generally, I think that there are too many people who run around being leaders. It gives us
less time to work with the patients.’

These understandings should be compared to how leadership is often romanticized
and idealized in other organizational contexts (Calás & Smircich, 1991; Alvesson &
Sveningsson, 2003). Having acknowledged how humor might serve as a strategic
tool for power elites wanting to preserve current values and distance themselves
from new organizational or social movements (Johansson & Woodilla, 2005), a
possible interpretation would be that the medical profession consciously demeans
the leadership concept in order to maintain control over the subject position as
superior, and – accordingly – safeguard traditional, hierarchical notions of healthcare
practice. Previous research has stressed how many established professions in the
complex era of interprofession-based organizing engage in different endeavors to
preserve organizational influence. In the tacit, indirect negotiation, humor becomes a
strategic tool for depicting competing assumptions and values (e.g. leadership) in
less favorable ways by using statements that would have been impossible to utter in
the absence of irony. Humor thus becomes an oppressive device, as explained by
Johansson & Woodilla (2005), protecting the institutionalized social order from new
ideas (e.g. that nurses or non-medical managers should exert influence over healthcare practice).

Even if leadership is constructed as an overvalued concept in the healthcare context, it is interesting to note how formal leader positions are still strongly associated with the medical profession. Regardless of underlying agenda, leadership processes reproduce the idea that leadership should be synonymous with medical knowledge and medical responsibility. Accordingly, the leader role also presupposes medical competence:

‘You gotta say like this: I’m sorry, I respect your opinion, but it’s my responsibility and I have to do what I think is right. […] I mean we bring up physicians here every day to become leaders and point things out forcefully and talk in a clear way so that confusion is avoided when you communicate what you want.’

‘There are lots of nurses who are really skilled, who have worked for a long time and have lots of knowledge, and you need to acknowledge that and listen to them but that’s not the leadership so to speak. […] I mean it’s stated in the legal documents that nurses aren’t allowed to claim medical responsibility.’

‘I mean as a physician you are in a way leader all the time so to speak. So, leadership becomes inherent in your job where you are in charge of the rounds or you are in charge of this or that…’

As notions of medical superiority are reinforced while leadership is constructed as overvalued, physicians are assigned the peculiar role as natural leaders dissociated from leadership. By equating leadership with medical knowledge and medical responsibility, the medical profession can control healthcare operations without having to meddle in dirty leadership work.

10.1.2. Nurses: Administrators with leadership competence

While dominant discursive conceptions of professional practice dissociate the medical profession from leadership as a concept by equating leadership practice with medical knowledge and responsibility, the nursing profession is instead recognized for its association with leadership competence. However, dominant conceptions of medical superiority – reinforced through mundane interaction – construct (intentionally or unintentionally) leadership competence as overvalued in a
healthcare context. The dynamics of negotiation thus reinforce hierarchical understandings of professional practice, where a nurse – despite their leadership competence – does not become acknowledged as a legitimate leader because of limited medical knowledge. These assumptions particularly shine through in a narrative about the appointment of an acting department director at one of the hospital’s clinics. During an interview, the female department director (physician) explained how the position had historically been assigned to a section manager (physician). However, since a care manager (nurse) was introduced at the clinic, the department director thought that it made sense to let this care manager step in as her temporary substitute. As care managers are not allowed to claim responsibility for medical management, however, this task was assigned to a senior consultant. Still, the department director described how her decision evoked the following reaction among her physician colleagues (clinicians):

**Clinicians:** Why should she become acting department director?  
**Department director:** Because you don’t want to take over the administrative tasks like…  
**Clinicians:** But she can’t be responsible for medical management!  
**Department director:** No, I have assigned that to you […] so what’s the problem?  
**Clinicians:** Well, it’s good for us to practice.  
**Department director:** But if you are going to practice, you need to take over the administrative tasks.  
**Clinicians:** Well, what’s that then?  
**Department director:** […] You take over wards for instance…  
**Clinicians:** What? We don’t want that!  
**Department director:** [And] you authorize all invoices…  
**Clinicians:** No, we don’t want that.

The department director further explained how a similar situation had been observed at another clinic within the hospital, but also how her physician colleagues ‘came to their senses’ when she advised them to apply for the contentious position:

‘I was actually proud that [the physicians] didn’t react last year because at another clinic all hell had broken loose and I thought that it was so silly of the doctors to react. [So, I told them that] if you want to become department director, you should just apply for the position, it’s yours! And this made them calm down because they didn’t want to be as silly as the other clinic. […] We had to hold a whole meeting about this though, it was actually quite laughable,
The obvious resistance to losing control over administrative management positions – although not showing any initial interest for these – clearly demonstrates how a hierarchical social order informs leadership discourse. Even if nurses with their recognized (administrative) leadership competencies have all the possibilities to perform excellently in the role as department director, dominant notions of professional practice make it impossible to think that a (sub)profession less associated with medical knowledge should claim formal influence over the medical profession, although influence in this administrative form seems neither qualifying, nor highly valued (even the department director refers to administrative tasks as ‘boring work’). These insights link back to Mintzberg’s (1980) description of how established professions have historically maintained collective control of the administrative apparatus of the organization. In an era when nurses formally have taken over leadership positions (e.g. in the form of care manager), the ‘silly’ reactions outlined above could be interpreted as an expression of how physicians seek to maintain control over administrative decisions that affect them. It should also be acknowledged how the female department director holds a different opinion than her male colleagues. While this might imply that she has embraced the role of ‘paper pusher’ in her professional identity, it also suggests that values and assumptions are gendered on an individual level. This might in turn have implications for how individuals within different sub(professions) are allowed to claim place within the interprofessional room, as will be further elaborated on in Chapter 11.

10.2. Relating images to organizational goals
As explained by Lindgren and Packendorff (2011), images of organizational roles are related to expectations on how organizations should work in order to reach their goals. The constructed image of physicians as natural leaders allows the medical profession to claim responsibility for organizational development. Where a discursive antagonism has opened up for conflicting interpretations of legitimate professional practice, organizational actors associated with medical knowledge and medical responsibility thus control the direction within healthcare operations. Initiatives stemming from foreign knowledge bases (e.g. Lean production, caring, etc.) can be embraced if they are acknowledged as adding value to medical operations. If not, they are (‘humorously’) disarmed through collective processes.
Having noted how (sub)professions drawing on a subject position as (fully) included often experience influence in the immediate situation – where they are able to take part in medical decisions – their role in the strategic development of healthcare typically remains more limited. This resonates well with the socialized role expectation that ‘doctors evaluate and determine the extent to which they will accept the input into patient care delivered by those with different professional backgrounds’ (Nugus et al., 2010).

The identified dynamics of negotiation suggest, in line with Crevani et al. (2010) and Lindgren and Packendorff (2011), that relational leadership is anything but a harmonious process where organizational actors jointly define notions of organizational practice. Acknowledging how the emerging flows of influence allow some actors to benefit from more influential roles than others, the findings further support Endres’s and Weibler’s (2016) argument that leadership processes do not necessarily construct distributed forms of leadership. The present work has seen how a limited set of organizational actors is assigned the interpretative prerogative in organizational development. In an era of interprofession-based organizing – where formal influence is distributed between different organizational functions – the findings thus suggest that professional practice is decoupled from ideological understandings of democratic work arrangements where different professions are expected to collectively find direction in the provision of professional services.

10.3. Negotiating leadership beyond the healthcare setting
Having discussed leadership processes within a healthcare context, it should further be theorized on how the identified dynamics of negotiation are expected to inform power mechanisms within other fields of interprofession-based organizing. As already concluded, medicine has for many decades been referred to as the prototypical profession (Freidson, 2001), and is still closer to the ideal type of profession than any other occupation (Gadolin, 2017). While the healthcare organization is indeed unique in its composition of internal professional networks (Ackroyd et al., 2007), it has further been noted how many other professional environments are currently seeing the same shift towards distributed forms of formal leadership in the form of joined-up services, multi-disciplinary and multi-agency teams, multi-professional and multi-agency partnerships, inter-professional collaboration, multi-professional practices, integrated services, etc. (Noordegraaf, 2011). As the phenomenon of interprofession-based organizing has found recognition
throughout society, similar trends of restructuring have thus been noted in different fields of professional services. In the most typical case, the previously unquestioned autonomy of an established profession (e.g. medicine or law) has recently been challenged by new discourses on professional practice, where structural reconfigurations now offer upcoming professions (e.g. nursing or business advisory) to formally occupy more influential positions in interprofessional work arrangements.

Noting how collective processes of interrelating enable physicians to draw on a subject position as superior – and accordingly engage in social practices that informally reinforce the medical profession’s control over healthcare operations – it seems legitimate to assume that institutionalized professions in our society still today control the interpretative prerogative in organizational development. These insights resonate well with notions of medical dominance (Reeves et al., 2009; Nugus et al., 2010; Liff & Wikström, 2015), but also with how Muzio and Ackroyd (2005) have contended that the legal profession succeeds in preserving a hierarchy dominated by professionals. If discursive conceptions allow upcoming professions to be associated with power bases connected to the esoteric knowledge bases of the more established professions, there is reason to assume that the upcoming professions might be able to exert influence in the immediate situation, but still – through mundane interaction – continue to reproduce an established social order. These dynamics draw attention to the hierarchical flows of influence emerging in leadership processes (cf. Lindgren & Packendorff, 2011).

Within organizational arrangements building on corporate notions of professionalism or KIF practices, the dynamics of leadership processes could, however, be expected to take other forms. It has been noted how occupational fields such as consultancy, project management, information technology, advertising, supply chain management and human resource management are associated with knowledge bases that become more difficult to systematize to a high level of abstraction, and how these entrepreneurial professions therefore rely on market mechanisms in stimulating a demand for new specialties (Muzio et al., 2011). Accordingly, socioculturally informed conceptions of organizational practice should make it harder for these professional communities to draw on power bases connected to esoteric knowledge bases. Rather, power bases connected to formal leadership roles could be expected to ascribe appointed managers/leaders a more
generous space of action within these arrangements of interprofession-based organizing. Still, it is important to stress how corporate professions as well as KIF practices are currently experiencing increased professional recognition, suggesting that the dynamics between different power orders are changing in these organizational contexts. As knowledge bases become more esoteric, not only educational level, but also power bases that can indirectly be connected to this knowledge (seniority, gender, responsibilities, etc.) might thus be constructed as more influential.

The dynamics through which social practices inform the social order are also expected to differ between different forms of interprofession-based work arrangements. It has been noted how a plethora of external factors today advocate more distributed forms of leadership, and how institutionalized professions consequently find it difficult to openly draw on knowledge credentials in the continuous negotiation for influence. Referring to how Johansson and Woodilla (2005) have described humor as a strategic tool for power elites wanting to preserve current values and distance themselves from new organizational or social movements, it has accordingly been suggested that established professions engage in a more tacit form of negotiation, where practices of humor are employed as a defense mechanism. Corporate and knowledge-intensive notions of professionalism, on the contrary, appear to experience increased possibilities to draw on educational credentials in the continuous negotiation for influence. This development speaks against the need for defense mechanisms, in turn suggesting that humor practices become less articulated. However, strategic endeavors masked as humor could still prevail in these organizational contexts. As corporate professionalism climbs the social ladder, the reasoning above suggests that other occupations (e.g. formal managers) might engage in humor practices to defend organizational influence. Within information technology, these undertakings might for example manifest themselves as sarcastic remarks where the professional practitioners are portrayed as geeky and asocial. In line with how some subdisciplines of nursing have been described as devaluing their own knowledge base in claiming loyalty to the more influential medical profession, strategic humor practices might become loyalty tests where less influential practitioners indirectly reinforce an established social order by conforming to ‘appropriate’ ways of behaving and thinking. Regardless of context, it is thus important to highlight the performativity of leadership processes, where
different power orders continuously interplay in a tacit, indirect negotiation for influence.

Stressing how professional responses to external pressures (re)construct notions of interprofession-based organizing, the continuous negotiation for influence further draws attention to Noordegraaf’s (2011) notions of organized professionalism. In an era where professional and organizational domains should be understood as being interconnected, the dynamics of leadership processes emphasize how professionalism in no way stands in contrast to organizing, but is rather (re)organized through mundane instances of interrelating. Shedding light on how conceptions of management, organizing and professionalism are – in an interconnected way – (re)constructed through recurrent patterns of (non)interaction, the identified finer-grained mechanisms thus add a relational, processual dimension to the emerging field of organized professionalism.

10.4. Summarizing the dynamics of negotiation in a dominant leadership culture

Conforming to institutionalized ways of socializing, people learn how to behave and how to think. Mundane instances of interrelating reinforce cultural constructions of how interprofessional work should be organized, establishing a social order while producing flows of influence. Acknowledging how cultural constructions thus inform the organizational direction that unfolds, it seems productive to introduce leadership cultures as a means of summarizing how dominant notions of professional practice are (re)produced in leadership processes. Crevani et al. (2015) have touched upon leadership cultures in their study of organizational reforms within higher education, stressing how the construct informs organizational direction through mundane instances of interrelating:

‘Our way of relating to each other becomes a central aspect of leadership cultures, defining the possibility and premises for people to join the doing of leadership, which in turn means that the ways in which leadership is produced in an organisation are crucial for what kind of actions that are seen as possible/impossible and desired/unwanted. Leadership cultures thus enable and sustain the space of action for people in the organisation, and hence the organisational direction that unfolds.’

– Crevani et al., 2015, p. 152
Organizational culture, in a broader sense, has for many decades constituted a recognized framework for exploring how deeply rooted assumptions enable or constrain organizational values, and – in turn – inform behavior. Schein (1984) portrays organizational culture as ‘the pattern of basic assumptions that a given group has invented, discovered, or developed in learning to cope with its problems of external adaptation and internal integration, and that have worked well enough to be considered valid, and, therefore, to be taught to new members as the correct way to perceive, think and feel in relation to those problems’ (p. 3). Problematizing this definition, Hatch (1993) stresses the dynamism of culture and suggests a processual understanding of the construct. From what has been concluded in the present work, flows of influence emerge within a continuous negotiation for influence. Adapting Schein’s (1984) definition of organizational culture to a social constructionist ontology – where culture is acknowledged as a process (Hatch, 1993) – a leadership culture within profession-based forms of organizing could thus be understood as the pattern of basic assumptions that a given group – the organizational arrangement of professional workers – (re)constructs in negotiation to cope with conflicting understandings of influence. These patterns stand in close proximity to a social order, informed by values in a larger sociocultural context. It becomes important to stress, therefore, how leadership cultures in no way should be understood as unitary, but rather as informed by different landscapes and timescapes. Still, constructed dominant assumptions are repeatedly – through formal and informal practices (i.e. humor, stories, rituals, etc.) – taught to new members as the correct way to perceive, think and feel. These mechanisms link back to Lindgren’s and Packendorff’s (2011) description of how the constant search for organizational order and clarity fosters endeavors to process issues, resolve ambiguities concerning responsibility, and develop understandings of identity bases within the organization. The patterns of basic assumptions that on the basis of prevailing social norms are allowed to establish themselves as obvious produce dominant notions of professional practice by constructing images of different organizational roles and relating these to expectations on how strategic goals should be achieved. By reproducing values and assumptions, dominant notions of professional practice are further reinforced in the dynamics of leadership culture.

In the healthcare case, it has been noted how deeply rooted assumptions of medical superiority construct a hierarchical relation between organizational actors. These
assumptions are – predominantly through ‘humorous’ practices – taught to new members as the correct way to perceive, think and feel. For interprofession-based organizing on a more general level, it has been acknowledged how contextual variations in values and assumptions might construct different power bases as more or less influential in negotiation. While different landscapes and timescapes could thus present diverging associations between (sub)professional belonging and esoteric knowledge bases, similar (‘humorous’) social practices are expected to teach organizational actors how to perceive, think and feel.

10.5. Professional pride and prejudice

Noting how traditional, hierarchical notions of influence informally seem to endure in the era of interprofession-based organizing (cf. Mintzberg, 1980; Mintzberg, 1983), it should be acknowledged how a general phenomenon of professional pride and prejudice permeates the dominant leadership culture described above. Within the healthcare context, it has already been stressed how established notions of medical superiority are reinforced through medical training. Elaborating on this phenomenon, Orchard et al. (2017) have explained how uniprofessional education fosters a similar pride within the nursing profession:

‘[When] nurses only study with their own nursing group they develop strong cohesion to that group. Nurses then see themselves as having unique skills that other health professionals do not have. When nurses then work with other health professionals, they consider these others as out-group members whose capabilities are not as wholesome as their own. Nurses then “judge” the others as out-group members who are less trusted. This phenomenon occurs across all members of a team with each believing their knowledge, skills and expertise is somewhat better than others.’

– Orchard et al., 2017, pp. 20-21

These insights suggest that contemporary arrangements of interprofession-based organizing are characterized by institutionalized notions of professional pride, but also by professional prejudice where organizational actors judge and mistrust each other. In the continuous negotiation for influence, this general phenomenon of pride and prejudice draws attention to status differences between knowledge bases. Rather than opening up for interprofessional collaboration in leadership work, mundane instances of interrelating reinforce the conception that organizational actors connected to the most esoterically constructed knowledge base should claim
responsibility for professional practice. These mechanisms sustain the hierarchical dimension of leadership culture.

However, as contemporary forms of profession-based organizing have formally abandoned meritocratic structures for influence and decision-making, professions find it difficult to explicitly rely on educational credentials in leadership processes. Engaging in more tacit forms of negotiation, humor is a productive means of claiming organizational influence by devaluing other knowledge bases. Still, educational credentials – as well as other power bases that can directly or indirectly be connected to esoteric knowledge bases – become critical for how different professions are enabled to engage in ‘humorous’ social practices. Acknowledging how the interplay between dominant discursive conceptions and power bases typically restricts the nursing profession to subject positions as submissive and included, leadership processes within the healthcare context enable physicians to set the agenda for social interrelating. As nurses drawing on a subject position as included seek immediate influence through informal loyalty tests, medical superiority is sustained without explicitly referring to superior and inferior knowledge bases. In reproducing a hierarchical leadership culture, professional pride and prejudice not only constructs different possibilities of informing the unfolding organizational direction, but also presents challenges for professional practice. These implications will be discussed in the following.
11. Discussion

The leadership dynamics outlined in Chapters 8–9 have shed light on how power mechanisms enable and constrain certain directions in leadership processes within contemporary arrangements of interprofession-based organizing (RQ1). Within the curious case of healthcare – where the prototypical profession currently negotiates for influence through mundane instances of interrelating with upcoming professions – dominant conceptions within an elitist and a pragmatic discourse articulate notions of medicine as the most esoteric knowledge base. These notions further interfere with power bases in the process of subject positioning. (Sub)professions that can directly be connected to medical knowledge (e.g. through medical education and/or medical responsibilities) are allowed to draw on a subject position as superior, while (sub)professions that can indirectly be connected to medical knowledge (e.g. through non-medical specialist education and/or seniority) are invited to the subject position as included. Professional groups that find it difficult to draw on power bases to claim medical knowledge become constrained to a subject position as submissive. The subject position as superior comes with a generous space of action, inferring opportunities to draw conclusions about professional competence, make sarcastic remarks, engage in jokes, voice opinions, express emotions, and demean initiatives not stemming from one’s own profession. The subject position as included similarly enables (sub)professions to take part in jokes and sarcastic conversations, but also to make suggestions and take part in emotional reactions. As these interaction possibilities, nevertheless, become more restricted within the latter subject position, its associated space of action unfolds as superficially generous. The subject position as submissive is finally associated with a plethora of constraints, inferring a limited space of action. The substantially diverging opportunities to engage in social practices within the interprofessional room establish recurrent patterns of interrelating, where the many faces of humor become particularly prominent in tacitly reinforcing dominant discursive conceptions through (mainly) conformity-constructing mechanisms. The social practices thus further stabilize a hierarchical social order, where (sub)professions associated with power bases connected to the superior knowledge base of medicine are enabled to draw on the most influential subject positions, and accordingly to reinforce medical dominance through collective processes of (non)interaction. Acknowledging how internal stratification has retained
a professional hierarchy also within the legal profession – and how similar power bases have indeed been seen to prevail across contextual boundaries – it seems reasonable to assume that the same kind of indirect negotiation for influence occurs also in other arrangements of interprofession-based organizing, although different power bases and humor practices might be more or less articulated in the dynamics of reinforcing superiority.

What dominant notions of interprofession-based organizing are (re)constructed when these power mechanisms play out in practice (RQ2) have further been described. Where a discursive antagonism today presents conflicting interpretations of legitimate structures for authority and decision-making, hierarchical flows of influence assign organizational actors connected to the most esoterically constructed knowledge bases roles where they are allowed to set the agenda for organizational development. Within healthcare, physicians are constructed as natural leaders dissociated from leadership, while nurses are portrayed as administrators with leadership competence. The continuously reconstructed hierarchy between medicine and leadership accordingly enables physicians to enjoy an interpretative prerogative in organizational development – in which the superiority of their own knowledge base is also further reinforced through the dynamics described above. Rather than opening up for interprofessional collaboration in leadership work, less established knowledge bases are thus rebuffed through mundane instances of interrelating. This further implies that organizational direction is more about informally reinforcing an organizational hierarchy than about pursuing change and moving beyond professional boundaries in decision-making structures – that is, contrary to how contemporary organizational arrangements presume dispersed forms of leadership. The dynamics and organizational consequences of leadership processes are productively summarized in a hierarchical leadership culture, where a general phenomenon of professional pride and prejudice sets the tone for recurrent patterns of interrelating.

While the present work in no way seeks to take a stand on the issue of whether a hierarchical leadership culture should be considered productive or problematic for operations within interprofession-based forms of organizing, it is important to highlight how unclarities and inefficiencies nevertheless arise when formal expectations of decision processes today prove inconsistent with collectively produced flows of organizational influence. It should further be stressed how the
hierarchical leadership culture presents challenges for organizational development, and how local variations in ways of reinforcing superiority seem to produce unequal possibilities for men and women within institutionalized professions. These phenomena will be elaborated on throughout the remainder of the chapter.

11.1. A clash between formalities and realities

Interprofessional management teams have strategically been assembled with the aim of making decision processes more rational and efficient (Noordegraaf, 2011). In an era where multifaceted social problems and overlapping knowledge bases render professional boundaries more complex than ever, it seems uncontroversial to argue that shared responsibilities should present favorable preconditions for increased quality and efficiency in professional services. However, it is also widely acknowledged how culture eats strategy for breakfast. The present study has elucidated how status differences between occupational groups are reproduced within a continuous negotiation for influence, and – further – how the unfolding organizational direction typically diverges from formal establishments of influence and authority. Through professional pride and prejudice, possibilities to inform the organizational direction become restricted to a professional elite, thereby impeding opportunities for interprofessional collaboration in leadership practice. Consequently, the dominant leadership culture cultivates irritation and unclarities, which in turn creates inefficiency in the services offered to a client or a patient. These insights resonate well with how Edmondson (2015) has noted that status differences in the complex healthcare context render decision processes unproductive within some of the most critical care flows:

‘Busy emergency departments depend on fast-paced communication among a constantly shifting mix of physicians, nurses, and other caregivers. Communication is essential for triaging, treating, and discharging patients who arrive in an unpredictable stream and with diverse needs. Status differences, such as those that exist between physicians and nurses and between attending physicians and residents, contribute to misunderstanding, hesitation to speak up, errors, and long throughput times for patients.’

– Edmondson, 2015, online

From a perspective where multiprofessional teams are expected to benefit from interprofessional collaboration in leadership practice, it could thus be argued that the hierarchical leadership culture impedes efficient operations within profession-based
forms of organizing (cf. Easen et al., 2000; Hall, 2005; Irajpour and Alavi, 2015). In strategic endeavors to reduce the status differences between occupational groups, it is important to critically reflect upon how different competences are valued within the organizational context. As leadership processes establish dominant notions of professional practice by constructing images of different organizational roles and relating these to expectations on how strategic goals should be achieved, the leadership culture reproduces norms and assumptions that consolidate a hierarchical relation between organizational actors. When seeking to interfere with this mechanism, consideration has to be taken of the social order that might undermine the existence of status differences. Only when dominant discursive conceptions are acknowledged and collectively reacted upon can they be challenged.

As the preceding discussion departs from the view that complex decision processes benefit from interprofessional collaboration in leadership work, it is important to stress how the dissonance between formal structures and leadership culture prevails also in other, competing understandings of professional practice. Within healthcare, critical voices have argued that deficient medical competence among nurses and junior doctors – combined with limited supervision and a heavy administrative workload for physicians – constitutes the major threat to quality and efficiency in interprofessional operations. Contending that the medical profession should enjoy more influence over processes by which organizational direction is established, this perspective thus maintains that interprofessional operations experience disadvantages by abandoning the meritocratic and bureaucratic structures for authority and decision-making. If medical superiority is considered an opportunity in today’s complex healthcare landscape, a hierarchical leadership culture should not be understood as being problematic. However, it should be acknowledged how formal structures that presuppose more equal flows of influence come to challenge interprofessional operations by creating instances of frustration and unclarity in decision processes. Regardless of what conception of professional practice is advocated, it thus follows that formal structures for decision-making and informal flows of influence are at odds with each other in contemporary arrangements of interprofession-based organizing. These insights provide a richer understanding of why production processes often prove inefficient and why many multi-professional teams find it hard to excel.
11.2. Like herding cats: Pursuing non-medical change initiatives in a healthcare context

As already stated, the present work will not take a stand on the issue of how leadership work should be arranged in contemporary forms of interprofession-based organizing. Still, it is important to discuss how the identified, dominant leadership culture informs preconditions for pursuing change initiatives (regardless of whether these initiatives should be considered desirable or not). In a healthcare context, reinforced conceptions of medical superiority present challenges for organizational ideas stemming from non-medical knowledge bases (e.g. caring, operations management). By drawing attention to the informal power play in mundane instances of interrelating, a relational perspective on leadership has advanced the understanding of how these challenges are nurtured in a continuous negotiation for influence. The identified dynamics of leadership processes explain why managerial agendas typically are downplayed by influential formal leaders, but also why included professions become important gatekeepers in change processes.

11.2.1. Catch 22 in organizational development

While different healthcare arenas present contextual variations in their leadership cultures, they all seem to unite in a distrust of formal management functions. It has been described how an ‘us vs. them-mentality’ often creates an unspoken legitimacy to ignore directives from top management, and how organizational change initiatives that lack support from the operative core accordingly prove ineffectual in a healthcare context (SOU 2016:2). Having acknowledged how professional pride and prejudice permeates leadership processes in healthcare, it should be stressed how the distrust of managerial logics is continuously reinforced in mundane instances of interrelating. An important aspect of the phenomenon is also that many hospital directors and business developers who formally pursue change initiatives claim loyalty to the medical profession. Andersson (2015) has described how physicians in management positions struggle to find a balance between medical and managerial reasoning. As hybrid physician-managers predominantly become acknowledged as clinicians, the managerial agenda typically steps back in favor of a superior medical focus. In a similar vein, Cregård and Eriksson (2015) have contended that physicians who embark on a managerial career reduce their credibility as professionals rather than increase the standing for management within the medical profession. This dominant approach to hybrid manager/physician-roles is maintained through the
continuous negotiation for influence, where medical superiority is reinforced while leadership is constructed as an overvalued concept. Acknowledging how dominant conceptions of professional practice equate leadership with medical knowledge and medical responsibility, it is unsurprising to note how challenges arise when physicians in top management functions are expected to engage in non-medical aspects of organizational development.

A recent example of how non-medical initiatives have encountered obstacles in the healthcare context is the mistrust of Lean healthcare that has permeated debates in the past decade. One major explanation for the controversies around this concept is how physicians in top management positions, in their (superficial) endeavors to pursue change, rather seem to reproduce medical superiority. In a previous study at the university hospital in Stockholm (Lokatt & Sack, 2013), it was noted how the social practice of exempting exceptions offered the medical profession special privileges in the implementation of Lean-inspired work procedures. First and foremost, physicians were allowed to disregard the concept of Lean as long as they engaged in continuous improvement work. Accordingly, it became difficult to see how Lean differed from previous managerial initiatives on performance improvement, and the foreign concept was humorously rebuffed as ‘The Emperor’s New Clothes’. Referring to the same social practice, it was further observed how the training in Lean healthcare often became adapted to the physicians’ own requests. If learning modules were met with skepticism, they were readily removed from the agenda and the physicians were dismissed to engage in mundane medical work. By emphasizing the need to treat the medical profession as an exception and the need for a manager to be pragmatic, these dynamics of interrelating thus reinforced the power imbalance between medicine and management.

As medical superiority is continuously reinforced through leadership processes, legitimacy in managerial positions seems to presuppose a medical background. Still, influential formal leaders tend to fall back on a physician identity, and the Lean healthcare case clearly demonstrates how challenges arise when managers claim loyalty to the medical profession. This could be understood as the Catch 22 in organizational development. While legitimacy in managerial positions calls for a medical background, this background reinforces medical superiority. The phenomenon links back to traditional notions of the professional bureaucracy (Mintzberg, 1980), where the operative core maintains control over administrative
decisions by governing managerial positions. Although contemporary notions of profession-based organizing have formally abandoned the meritocratic structures for decision-making, it appears that similar hierarchical flows of influence are still reproduced in mundane instances of interrelating. Drawing on these insights, it is insufficient to conclude that the operative core simply ignores organizational change initiatives stemming from top management functions. It is equally important to acknowledge how the initiatives are often pursued in noncredible ways, impeding their legitimacy. These mechanisms provide a richer understanding of why change initiatives stemming from non-medical knowledge bases typically encounter obstacles in a healthcare context.

11.2.2. The included gatekeepers – guardians of the status quo
Recognizing physicians as informal leaders, it is often being stressed how change initiatives within healthcare operations must be anchored within the medical profession. While insights from the present study indeed confirm how leadership processes reinforce the organizational influence of the medical profession, it is also important to acknowledge how ‘included professions’ play a critical role in change processes.

It has been concluded how professions drawing on the subject position as included are often subjected to informal loyalty tests. Seeking to enjoy influence in the immediate situation, these professions typically adjust to ‘appropriate’ ways of behaving and thinking, reproducing a hierarchical leadership culture. As long as these patterns are repeated, the dominant leadership culture will be reproduced and the Catch 22 in business development will be nurtured. However, the present study has also been able to identify how (fully) included professions sometimes engage in social practices that could potentially be interpreted as an attempt to challenge the social order. If change is advocated, commitment from these included professions (predominantly some subdisciplines of nursing) might thus unfold as equally important as the medical profession’s support.

11.3. The including and excluding dimensions of leadership culture
As the present work in many regards has treated physicians as a homogeneous entity, it is important to finally address the individual level – and specifically explore how institutionalized ways of interrelating come to construct diverging
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preconditions for men and women within the medical profession. These mechanisms draw attention to the including and excluding dimensions of culture, as highlighted by Rutherford (2001):

‘Most of the managerial literature on culture refers to its inclusive properties. It refers to the intangible part of an organization, which gives it its cohesiveness. Cultures embody systems of meaning and signification. They may act a defense against the unknown and a means of providing stability […] But cultures exclude as well as include.’

– Rutherford, 2001, p. 372

It has already been outlined how leadership cultures enable and constrain connections between power bases and dominant understandings of legitimate knowledge, thus excluding certain professions from influential subject positions. On an individual level, it has also been noted how a gendered power order seems to allow female nurses to experience a more generous space of action in cooperation with male surgeons than in cooperation with female gynecologists. Elaborating on how a similar gendered power order constructs diverging preconditions for men and women within the medical profession, previous research has concluded that female physicians are often excluded from the most influential subdisciplines of medicine. Diderichsen (2017) describes how female students during clinical rotations find it difficult to embrace the jargon within surgical disciplines, and accordingly fall back on other specialties in their professional careers. She further stresses how the fact that women more often than men discard certain specialties due to the local culture indicates unequal preconditions for career choices. These insights not only link back to how individuals position themselves in relation to normalized values (Leonard, 2003), but also support Lindgren’s (1992) description of gender as a central power base in the social ordering of healthcare. As professions have traditionally been male-dominated communities, it has been argued that ‘unpredictable’ female physicians constitute a ‘threat’ to sustained medical honor (Lindgren, 1992). It has further been noted how a majority typically reacts to a minority in a token position by reinforcing their dominant culture (Kanter, 1977), and how homosocial practices are often employed to defend an institutionalized social order when threats appear (Lindgren, 1992; Holgersson, 2013). Acknowledging how a general phenomenon of professional pride and prejudice sets the tone for contemporary leadership processes in healthcare, it is thus unsurprising to note how the most prestigious medical disciplines seek to protect their status by reinforcing a masculine jargon when female
physicians (potential threats) appear during clinical rotations. In line with how Kanter (1977) has described that the token minority’s loyalty towards the majority is tested, the female physicians experience loyalty tests similar to those that have been described for shop floor workers (Collinson, 1988), but also for medical apprentices (Tariq et al., 2016; Wear et al., 2006) and included professions in the present study. The willingness to give and take a joke, to laugh at oneself and expect others to respond likewise to cutting remarks is tested. Female physicians who do not embrace this jargon typically orientate themselves towards other specialties. Female physicians who instead adapt to the ‘appropriate’ ways of thinking and behaving are disciplined to the established masculine routines and become gatekeepers within the most prestigious medical disciplines. The latter mechanism resonates well with how Kanter (1977) has described that a token minority seeks social invisibility by adapting to the majority’s culture.

Interestingly, the insights further suggest that dominant leadership cultures present local variations in their ways of reinforcing superiority. While a general phenomenon of professional pride and prejudice sheds light on how power bases connected to medical knowledge are central in the (re)construction of hierarchical relations between professions, other power bases might thus prove more efficient in capturing inequalities on an individual level. The phenomenon of vertical gender segregation has also been observed within the legal profession, where women tend to practice in less prestigious subdisciplines of the law (see Kornhauser, 2004; Kay & Gorman, 2008). While contextual delimitations hinder the present study from concluding whether ‘humorous’ loyalty tests also here play a central role in establishing the social order, the unfolding organizational direction nevertheless witnesses to excluding mechanisms in the dominant leadership culture. This suggests that female practitioners still today are excluded from the most prestigious fields of the most prestigious professions, however in subtle ways showing resemblance with the tacit negotiation for organizational influence.

The including and excluding dimensions of culture have for many years played a critical part in sociological understandings of organizational processes. In the era of interprofession-based organizing, it is important to highlight how excluding mechanisms seem to become subtle and tacit, which challenges the quality of services offered to a client or a patient. While it is often assumed that interprofessional management teams meet multifaceted problems with a holistic approach – where
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Instant decisions as well as strategic developments are informed by multiple knowledge bases – important expertise is lost when proficient practitioners (groups or individuals) are excluded from subject positions that infer generous spaces of action, and – accordingly – possibilities to inform the organizational direction. Having acknowledged how dominant leadership cultures present local variations in their ways of reinforcing superiority, these contextual differences might prove important in strategic endeavors to challenge (gendered) notions of professional practice.
Conclusions and contributions

In an era of interprofession-based organizing – where traditional hierarchical dyadic relationships are replaced by more ambiguous and negotiated relationships amongst professional peers (Empson & Langley, 2015) – the present work has explored how dominant notions of professional practice are (re)produced in leadership processes. Acknowledging the performativity of leadership discourse (Crevani et al., 2007), a relational, processual perspective on leadership (Uhl-Bien, 2006; Drath et al., 2008; Crevani et al., 2010; Crevani, 2011) has been enriched with a negotiated order-perspective on interprofessional interaction (Svensson, 1996; Allen, 1997; Reeves et al., 2009; Nugus et al., 2010). Leadership processes have accordingly been conceptualized as a continuous negotiation for influence, where a relational understanding of power (Willmott, 2013) has shed light on how flows of influence emerge in mundane instances of interrelating. This theoretical approach heeds Endres’s and Weibler’s (2016) call for a stronger emphasis on communication, interactions and practice in leadership research, but primarily acknowledges the potential of new perspectives on leadership in profession-based forms of organizing. Where an established status hierarchy between professions is currently being downplayed through a discursive antagonism, the present study has contributed a perspective that allows for an understanding of how organizational direction is established among the many competing conceptions of professional practice. Elucidating the pattern of basic assumptions that organizational arrangements of professional workers (re)construct in negotiation to cope with conflicting understandings of influence, the findings stress how a general phenomenon of professional pride and prejudice stabilizes a hierarchical leadership culture where superior notions of esoteric knowledge bases still (informally) control the unfolding organizational direction. Drawing attention to these non-democratic flows of influence, the study has not only highlighted the critical aspect that is often found to be lacking in common understandings of relational leadership (Lindgren & Packendorff, 2011), but has also supported Endres’s and Weibler’s (2016) claim that relational leadership processes do not necessarily construct distributed forms of leadership.

Where formal structures today suggest a more even organizational distribution of influence, the identified dynamics of leadership processes have further shed light on
how power mechanisms typically sustain an institutionalized hierarchical order through tacit, indirect forms of negotiation. When new discourses on professional practice prevent established professions from openly drawing on knowledge credentials in claiming authority and influence, established knowledge bases are rather defended through collective demeaning of foreign knowledge bases – ‘the upcoming threats’. Demeaning practices are – in turn – enabled and sustained by the negotiated organizational hierarchy, where interdependencies are organized in ways that promote values and interests of the social order. These insights advocate a more relational, processual understanding of how established professions often succeed in (superficially) protecting traditional conceptions of professional practice (cf. Muzio, 2005; Reeves et al., 2009; Nugus et al., 2010). Within the healthcare context, it has specifically been noted how medical superiority is reinforced through a set of ‘humorous’ social practices. Describing how these recurrent forms of mundane interrelating (including instances of interaction as well as noninteraction) enable physicians to reinforce their dominant role within the organization, the understanding has been advanced of ‘medical dominance’ as a phenomenon. A more dynamic explanation of protective routines has also been provided. While previous research has concluded how these mechanisms allow for different knowledge bases to coexist without conflict (Liff & Wikström, 2015), findings from the present study stress how the power dimension of negotiation reinforces standardized ways of working by reproducing a social order. While conflict might not be explicit in protective routines, established ways of interrelating nevertheless inform the prevailing social order, in turn reinforcing medical dominance. While it might provide conceptual clarity to distinguish between ‘physicians’ and ‘nurses’ on a general level, it should also be acknowledged how studies of organizational dynamics call for an increased problematization of sub-professional boundaries. These insights all add to the limited understanding of interprofessional relations between physicians and nurses on the interactional level (cf. Fitzgerald, 2016).

As the continuous negotiation for influence emerges in conflicting expectations of professional practice, leadership cultures could productively be understood as organized responses to external pressures. Having explored how dominant notions of professional practice are collectively established within these responses, the present work has added a relational, processual dimension to the emerging field of organized professionalism (Noordegraaf, 2011). It has been described how organizational direction is (re)produced in a continuous negotiation for influence
where professional roles are consolidated and related to expectations on how strategic goals should be achieved. While conventional research typically continues to make dichotomies between professionalism and organizing as well as between profession and management, the findings thus suggest that organizational tasks are not necessarily at odds with professional work. Rather, the identified dynamics of negotiation emphasize how professionalism is (re)organized through mundane instances of interrelating. These insights support Noordegraaf’s (2011) view that strict distinctions between management, profession and organization are problematic in ‘liquid times’ of organizing. Acknowledging how neither ‘a return to professionalism’, nor ‘a move beyond professionalism’ succeeds in capturing organizational dynamics, it should be stressed how dominant notions of management, organizing and professionalism continuously inform each other through collective processes of (non)interaction.

On a practical level, the study has been able to assess challenges in the face of inefficient teams and organizational resistance. While policy makers expect formal structures to set the boundaries for authorities and influence, and accordingly assume holistic, interprofessional perspectives in decision processes, it has been stressed how formal notions of dispersed leadership actually stand in contrast to informally negotiated hierarchies that are established when professional workers cope with conflicting understandings of influence. Regardless of what notions of interprofession-based organizing are advocated, this clash between formalities and realities has to be acknowledged in order to decide on the direction for future organizational development. As long as contradictory interpretations of leadership foster a negotiation for influence, mundane work relations will jeopardize the quality of service provision rather than embrace the potential of interdisciplinary collaboration in the light of more complex and multifaceted social problems. It should also be stressed how an established social order might undermine the existence of a hierarchical leadership culture, and – hence – hide contrarious expectations within the organizational setting. In order to critically evaluate dominant conceptions of professional practice, outside perspectives are therefore encouraged.

Having addressed some major limitations in the understanding of processes by which organizational direction is established, the present work also opens up for future contributions. While identified mechanisms of negotiation are expected to
present similar preconditions for leadership processes in different fields of interprofession-based organizing, the future calls for studies where contextual variations in negotiation dynamics are addressed more comprehensively. Having acknowledged how dominant leadership cultures seem to present local variations in their ways of reinforcing superiority, it should further be explored how these contextual differences do not only present possibilities and limitations in the continuous negotiation for influence, but also strategically could be approached in endeavors to change dominant (gendered) conceptions of professional practice.

In liquid times of organizing, it finally is important to stress how leadership processes could not, and should not, be studied without simultaneously paying attention to a professional and an organizational dimension. The present study has emphasized how conceptions of management, organizing and professionalism are (re)constructed in an interconnected way. In future endeavors to advance the understanding of leadership processes within different arrangements of interprofession-based organizing, these dynamics should thus be considered central to how power mechanisms are enabled to play out in mundane instances of interrelating. The relational, processual perspective becomes a prerequisite in the complex world of professional pride and prejudice, where knowledge is power and humor hides in every social corner.
Four doctors went duck hunting together. Together in the duck blind, they decided that instead of all shooting away at the same time, they would take turns as each duck came by. The first to have a shot would be the general practitioner, next would be the internist, then the surgeon, and finally the pathologist.

When the first bird flew over, the general practitioner lifted his shotgun, but never fired, saying, 'I’m not sure that was a duck'.

The second bird was the internist’s. He aimed and followed the bird in his sights, saying, ‘It looks like a duck, it flies like a duck, it sounds like a duck…’, but then the bird was out of range and the internist didn’t take a shot.

As soon as the third bird appeared, flying up out of the water only a few feet from the blind, the surgeon blasted away, emptying his pump gun and blowing the bird to smithereens. Turning to the pathologist, the surgeon said, ‘Go see whether that was a duck’.

– Butler et al., 2012, p. 266
References


References


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