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The doctor's dilemma: clinical performativity and medical director identity

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Medical directors, senior doctors at board level, identify as doctors and rely on clinical credibility for their authority. However, there are tensions in combining clinical practice with senior management responsibilities. Interviews with 20 medical directors, explored their hybrid role and produced accounts of the dilemmas of combining senior management and medical practice. Performative discourses emphasised the importance of recognition and revealed both the power and insecurity of doctor identity. Medical directors must be doctors. Doctors are recognised through practice. However, medical and management practice compete for time priority. Bending citations of practice could ease this dichotomy between management and medicine.

Introduction

Medical management has proved frustrating for policy makers and stimulating to research (Cascon-Pereira & Hallier, 2012; Ainsworth, Grant & Iedema, 2009; Iedema et al 2003). While the problems are global perhaps nowhere is this split more obvious than in the National Health Service where successive governments have sought both to curb spending and to maintain the principal of free healthcare by introducing greater management control. Professional resistance to threats to autonomy has been addressed by recruiting doctors and nurses into senior management roles.

Doctor identity is high status, morally, socially and often economically. The role of Physician or medical doctor is rated at the top in occupational status rankings and the most highly trusted (Mackinnon & Langford 1994). There is an argument that doctors are no longer regarded as god like and put on pedestals as they once were (Lupton, 1997). However, doctors in her study reported that in spite of changes attributed to education, media coverage and greater emphasis on consumer power "few had noticed that their own patients were displaying less respect or even reverence towards them" (Lupton, 1997 p.483). Doctors voice nostalgia for the old role of doctors (professional identification) (McDonald et al 2006). The role of doctor is a familiar one, reinforced through play and representation in the media.

The elite position of doctors is reinforced through competitive selection and lengthy socialization. The training is long, arduous and structured (Pratt, Rockman & Kaufmann, 2008). Hospital practice marks clear hierarchies and in-groups and out groups through uniforms, use of titles and the possession and practice of unique and highly prized skills and knowledge.

Medical directors are doctors at board level. Research on the difficulties for doctors in management has focussed on the failure of doctors to fully identify with organization and management. The underlying issue is of continuing professional identification. Their identity has been studied as hybrid, conflicted and multiple (Cascon-Pereira et al, 2012;Joffe & Davey, 2012; Iedema et al 2003). Witman et al, (2010) described the role of clinical directors as "janus-faced", a doctor facing one way and a manager facing the other. The power of the medical is such that authority for clinical directors is from their recognition as "wise men" rather than any position power. This implies that giving up clinical practice might cost the credibility by which they influenced their peers as well as their own work satisfaction.

Giving an account

The focus on clinical practice by medical directors provides a basis for a performative examination of doctor identity to explore both the routines that maintain doctor identity and the pressures that undermine them.

Butler theory of performative identity argues that the way we behave links us to shared categories or discourses, such as doctor, which will be recognised by those with whom we interact. Their responses will reinforce our own positioning. These scripts are powerful, however, they cannot fully determine what we do. Even direct mimicry will not be identical. The clarity and prestige of doctor identity and the recognised performances associated with this suggest that it is an effective performative (Butler, 1997). It gives an identity which is easily recognised and likely to influential. Clinical practice is a core routine that reinforces the performative nature of doctor identity. However, for medical directors, this practice is threatened by the demands of management. This research focuses on the role of clinical practice in the performative identity of medical directors. In doing so it raises wider questions about the nature of doctor identity, the possibilities for change and the future management of health services.

The research drew first on document analysis and observation to clarify organizational role of medical director. Interviews lasting 60-90 minutes were carried out with 20 medical directors to explore their experiences of the role. This paper draws on micro analysis of discourses of clinical practice by medical directors to explore the performative nature of doctor identity and inform our understanding of the future role for medical directors. First we look at the common elements across interviews to identify shared discourses. Secondly, we examine the ways that individuals draw on these materials to explore the ways they are used and the inconsistencies, anxieties and contradictions that emerge.

First, we argue, "clinical credibility" is used as a discursive resource to maintain doctor norms around practice. That is a medical director is recognised through clinical practice. There are practices that are allowed or suspect for doctors and that failing to conform to these practices threatens the claims to doctor identity. Secondly, we examine the ways that this claim is challenged or troubled in relation to ongoing practice. This raises questions about 1) the amount of clinical practice necessary for credible performance 2) the competence of this performance if carried out with credible managerial performance, 3) the relevance of clinical performance for Medical Directors 4) the motives for ongoing performance. Finally we examine the implications of this for change in the bending of citations of what it means to be a doctor.

Clinical practice and clinical credibility: a position from which to speak

The discourse around clinical credibility for medical directors was universally acknowledged. The focus of discussion that emerged was on the ongoing importance of clinical practice. The congealed discourse was that a medical director must be a doctor and a doctor is recognised by the practice of medicine. While, to some extent this was caught up in maintaining the advantages (especially security) in the consultant contract, these accounts reveal deeper concerns about identity. The primary argument for continuing clinical practice was in order to maintain credibility with medical peers. This was itself interrogated to reveal a number of underlying tensions about maintaining doctor identity.

> I'm still too much of a clinician to give it up, and that's why I do too much clinical work. In some ways I think that makes me a more effective medical director in some of the things I do, because the consultants in the trust know that I'm still very much engaged in the front line. It makes it, on the other hand, however, this thing that I feel that, most of the time, juggling lots and lots of balls, and I don't always keep them in the air. (18 pt)

The argument here concerns both peer recognition and the shared experience of the core business of the hospital. While the speaker claims to do "too much clinical work", he also acknowledges the claims on his time.

A further challenge was the amount of clinical practice that was necessary to maintain competence and the quality necessary for credibility. At the extreme was an argument that Medical Directors had to be better clinicians than their peers to maintain credibility. However, the most fundamental challenge was to question whether or not continuing practice did influence peer credibility. Many medical directors who claimed maintaining credibility as a motive also mused that while they felt it was important they didn't know, some suggested that credibility based on past practice could be maintained, at least for a while. A further concern was about credibility to the wider public. One Medical Director argued that at public meetings people were not as rude to him as a jobbing doctor. Another described his father asking him how he could give up practice that was core of his medical training.

The most challenging comment from a full time Medical Director argued that it was not possible to maintain both, that they were contradictory and that Medical Directors could only play at clinical work.

> they're kidding themselves, because what you'll hear their colleagues say, as well, is they think they're still doing the work, but they never turn up at the right time. So if you hear colleagues talk about

> people who are medical directors, [...] it's that they think they're just playing at being a consultant. [...]. (Full time MD 13)

Related to this was the argument that clinical practice still allowed the Medical Director to be "one of the boys". They could be a Medical Director in the office but a doctor on the ward/in theatre. This enforced a clear division between the two roles with lines of authority differing between management and clinical structures. While many of these discourses stress the dichotomous relation between management and medicine, a shifting discourse explored the similarities between management and medical practice. The core argument was that all doctors manage, but not all managers are doctors.

Discussion

The concern about clinical practice is at the core of insecurity about credibility as a doctor on the board. The question they interrogated was whether or not they could still speak from the position of doctor if they were no longer practicing clinical medicine. This shows two aspects of performativity. First, is the power of the doctor role as an effective performative. It is a clearly established, well recognised position from which to speak. While it may be under threat it still allows a position from which to speak and be acknowledged. Secondly, however, and especially interesting in considering change and identity, is the insecurity of this position. To be able to speak as a doctor it is important to maintain practice. Being a doctor involves identity work through repeated performances of doctoring. This sense of repetition, recognition and identity work was especially vivid in accounts of their feelings of clinical work.

The transition from professional to manager has been especially critical in medicine where the high professional and social status of doctors has been contrasted to the uncertain status of managers. Doctors have a clearly recognised position from which to speak, that of knowledge, experience and practice in the skills of medicine. Medical management in comparison is newer, less easily represented and its practice is not so easily identified. The role of the Medical Director was formed to ally clinical and managerial interests.

While the explicit arguments concern peer recognition, knowledge of current practice, the underlying concerns are with identity and identification. MDs have limited time and there are questions of how much time they allocate to each role. There are also concerns about the conflict in underlying values between the professional prioritisation of the patient and the organizational focus on resource efficiency. Thus apparently practical concerns about time allocation are grounded in fundamental and emotional concerns around identity. This presents doctors with a dilemma in identification where their clinical practice provides reassurance that they can maintain their doctor identity. This research supports Witman et al (2010) argument that the medical hierarchy should be respected and brought into the organizational structure without challenging medical director practice.

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