Hybridization as practice: clinical engagement with performance metrics and accounting technologies in the English NHS

Abstract

Purpose: This study aims to investigate the hybridization practices which medical managers engage with to promote accounting and performance measurement in the hybrid setting of healthcare. In doing so, the authors explore how medical managers enact and become practitioners of hybridity.

Design/methodology/approach: The authors adopt a practice lens to conceptualize hybridization as an emergent, situated practice and capture the micro-activities that medical managers engage with when they enact hybridity. The authors conducted semi-structured interviews with medical managers, business managers and coding professionals and collected documents at an English NHS hospital over the course of five years.

Findings: The findings accentuate two emergent practices through which medical managers instil hybridity to individuals who are hesitant or resistant to hybridization. Medical managers engage in *equivocalizing* and *destigmatizing* practices to broaden the understandings, further diversify or reconcile the teleologies of clinicians in non-managerial roles. In doing so, they signal the merits of accounting in improving care outcomes and remove the stigma associated to clinical engagement with costs.

Originality/value: The study contributes to hybridization and practice theory literature via capturing how hybridity is enacted in practice in a healthcare setting. As medical managers engage with and promote accounting information and performance measurement technologies in their practice environment, they transcend professional boundaries and hybridize the professional spaces that surround them.

Keywords: hybridization, practice, accounting technologies, performance, NHS, medical managers, clinical engagement

Paper type: Research paper

1. Introduction

Hybridity resides in organizational forms, structures, roles and processes that encapsulate a complex entanglement of heterogeneous values, divergent and potentially conflicting goals and logics (Conrath-Hargreaves & Wüstermann, 2019; Johanson & Vakkuri, 2017; Pache & Santos, 2013; Skelcher & Smith, 2015). This conceptualization of hybridity accentuates two broad areas where extant studies have dwelled on: first, on the characteristics which constitute an entity or practice as hybrid (e.g. Battilana & Lee, 2014) and second, on the implications of said hybrid state on inter-organizational relationships, accountabilities and processes (e.g. Broadbent & Guthrie, 2008). Contrary to the plethora of such studies on the traits and implications of hybridity (e.g. Grossi et al., 2019; Battilana & Lee, 2014), there is a surprising paucity of research on the *practice* of hybridization and the micro-activities of how hybridity is enacted within organizational contexts. In addition, studies have recently highlighted the lack of theorization in how individuals design, implement and engage with accounting technologies in hybrid organizations (Grossi et al., 2019; see also Berry et al., 2009; Dobija et al., 2019) and have further identified the distinct research gap on the nexus of performance measurement and hybridity (Grossi et al., 2017).

The concerns outlined above motivate our core research question: "*What are the hybridization practices which medical managers*[1] *engage with to promote accounting and performance measurement in the hybrid setting of healthcare*?". We explore our research question through an in-depth case study approach to investigate the multiple ways that medical managers engage with accounting technologies and performance measurement information at an English hospital. In specific, the study focuses on the hybrid role of Clinical Directors[2]: senior clinicians with managerial responsibilities who adopt a dual professional identity (Kurunmäki, 2004; Llewellyn, 2001), and seeks to understand how they enact hybridity via engaging with and promoting accounting tools and performance measurement in their practice to serve the diverse goals pertaining to their hybrid role.

In light of our aims, we conceptualize hybridity as the outcome of a hybridization practice. While the wider literature in management accounting has scrutinized the notion of hybridity focusing primarily on organisational forms or professional identities, the process of hybridization and thereby its situated practices have received less attention (Kastberg & Lagström, 2019; Wiesel & Modell, 2014; Kurunmäki & Miller, 2011; Miller et al., 2008). As such, we engage with the practice theory perspective (Schatzki, 2002; Reckwitz, 2002) to explore how medical managers enact and become practitioners of hybridity. A practice lens enables us to treat hybridization as a situated social practice where the *doing* of hybridity is framed by the abilities, activities and background knowledge of medical managers who, as practitioners of hybridity, both perform the doing of hybridity and carry its practices in their day-to-day actions (Reckwitz, 2002; Whittington, 2006; see also Hopwood, 1983). Arguably, it is practitioners of hybridity who enact and have profound impact, through their practices, on the design, performance measurement and evaluation of hybrid organizations (Grossi et al., 2017). This approach seeks to focus less on investigating the characteristics and implications of hybridity on organizational forms and

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[1] Medical managers are clinicians who undertook formal managerial responsibilities and also practice medicine in their day-to-day activities. Clinicians are health professionals who are directly involved in the provision of patient care, such as doctors, nurses and physiotherapists.

[2] We use the term 'medical managers' to refer to Clinical Directors for the purposes of this paper.

processes, but accentuate the micro-activities that medical managers engage in as they enact hybridity.

This study empirically explores a publicly-funded healthcare organization and explicitly interrogates the understandings and teleologies (see section 3.1) wherein hybridization occurs (Schatzki, 2002, 2005). We focus on medical managers: professionals with diverse and often divergent teleologies, such as aiming to increase quality of treatment or invest in new equipment while achieving savings. They are knowledge experts with a varying level of competence and understanding of accounting and business processes, due to their limited management training (O'Riordan & McDermott, 2012). Yet, medical managers often engage with accounting to serve their diverse purposes via contesting, circumventing or conforming to accounting functions (Begkos et al., 2019, 2020) and extract financial value that benefits their business unit (Llewellyn et al., 2020). In addition, medical managers interact with various professional spaces in dynamic and unclear relationships characterized by great indecision and equivocality (Denis et al., 2001; 2011). For example, medical managers need to collaborate and liaise with various healthcare and management professionals, such as non-managerial medical staff (other doctors and nurses), accountants and business managers, IT and coding specialists, in their day-to-day activities. As such, how medical managers' hybridization practices broaden the understandings, further diversify or reconcile the teleologies of professionals in non-hybrid roles, such as clinicians without managerial responsibilities, is important but underexplored.

Through our theoretical framing of hybridity and in-depth qualitative methods, the paper contributes to hybridization and practice theory literature in two significant ways. First, the paper responds to calls for research on how hybridity manifests in knowledge-intensive settings (Grossi et al., 2019) and extends our knowledge on accounting and processes of hybridization (e.g. Kastberg & Lagström, 2019). We develop a dynamic perspective of hybridization which captures and articulates the practices through which hybridity is enacted. Our abductive analysis highlights two emergent practices: equivocalizing and destigmatizing, through which medical managers, consistent with the emphasis of their hybrid role on medical and management purposes, signal the merits of accounting in improving patient and financial outcomes, as well as remove the stigma associated to clinical engagement with costs. Thus, we contribute a practice-theoretical view to hybridization literature via demonstrating how hybridity is enacted in practice through manifestations of understandings, teleologies and professional identities. Second, our identified practices contribute to a view of how medical managers engage with and promote accounting information and performance measurement technologies. Along these lines, the paper demonstrates that medical managers do not simply mediate between professions but hybridize the various professional spaces that surround them. This is vital, in turn, as the paper responds to a call for further interdisciplinary exploration of how clinicians transform to medical managers in hybrid settings (Grossi et al., 2019; see also Kitchener, 2000; Llewellyn, 2001; Begkos et al., 2019), thus extending previous studies that explore clinicians' understandings and overall engagement with accounting (e.g. Eldenburg et al., 2010; Pettersen & Solstad, 2014; Cork & Devine, 2015). Overall, our focus on the practices and micro-activities of medical managers adds insight to how practitioners of hybridity engage with and promote accounting and performance measurement information to serve the diverse goals of their hybrid identity.

The remainder of this paper is structured as follows: first, we explore the hybrid role of medical managers and review existing literature to investigate the extent to which clinicians and medical managers understand and engage with accounting technologies and performance information. The

following section outlines the performance challenges and the contemporary accounting technologies in the English National Health Service (NHS). Next, we adopt a practice perspective to outline our theoretical framing, position our emergent notions of equivocality and destigmatization and discuss our methodological approach and analysis. Then, we present our empirical findings and explore medical managers' hybridization practices. Finally, we draw on this analysis to develop novel insights into the way medical managers engage with and promote accounting and performance measurement, highlight our study's limitations and suggestions for future research.

2. Hybridity, medical managers and accounting: related literature and conceptual basis

To study how practitioners of hybridity engage with and promote accounting and performance measurement, it is imperative to explore accounting studies to investigate the extent to which clinicians and medical managers understand and use accounting information, their financial training and their role within healthcare organizations. As such, the following section explores clinicians' identity, knowledge, understanding and overall engagement with accounting and relevant performance measurement technologies.

2.1 Accounting and the hybrid role of medical managers

Hybridization research accentuates clinicians' strong professional identity. Earlier studies comment on clinicians' reluctance in engaging with management and control practices, in fear of the de-professionalization of the medical domain and having their clinical autonomy and values stigmatized by a managerialist culture (e.g. Bourn & Ezzamel, 1986; Jones & Dewing, 1997; Kitchener, 2000). In specific, studies have explored clinicians' perceived identity as distant from the accounting and management profession (Bartlett & Le Grand, 1993), their lack of conformance to accounting practices (e.g. Kitchener, 2000; Pollitt, 1993) and their lack of interest in financial training and accounting (e.g. Kurunmäki, 2004; Jones & Dewing, 1997; Preston et al., 1992; Gatrell & White, 1996). However, more recent studies highlight that clinicians have been hesitant but increasingly receptive to uses of accounting information in healthcare (Jacobs, 2005; Robbins & Lapsley, 2015). Within this context, Jacobs (2005) indicated that some clinicians acknowledge the merits of accounting and are willing to engage, while other clinicians consider clinical engagement with accounting and performance metrics as an ethical departure from their main identity. It is therefore not surprising that clinicians' indifference and general lack of engagement with accounting and management practices has tended to change in recent years, with clinicians showing an increasing willingness to engage (Robbins & Lapsley, 2015).

A well-established body of literature has also commented upon clinicians' knowledge, understanding and access to accounting information and relevant performance measurement technologies. Earlier studies argue that clinicians demonstrate little to no understanding of accounting information (e.g. Jones & Dewing, 1997; Preston et al., 1992). However, more recent studies highlight clinicians' competences and skills, suggesting that they progressively display an increased understanding, access and general engagement with accounting information (e.g. Jacobs et al., 2004; Eldenburg et al., 2010; Robbins & Lapsley, 2015) as accounting plays a valuable part in reducing ambiguity in managing clinical directorates (Ellwood, 2008; Lapsley & Schofield, 2009; Pettersen & Solstad, 2014; Begkos et al., 2019). For example, the implementation of casemix accounting in New Zealand public hospitals established

a better understanding of cost information and changes in clinical practices (Lowe, 2000) yet also facilitated uncertainty and equivocality amongst managers and clinicians (Lowe & Doolin, 1999). Jacobs et al. (2004) suggest that only clinicians at senior levels have access to performance information regarding cost and activity, even though there is interest from more junior clinicians; and Scarparo (2006) suggests that medical managers embrace the value of understanding and using accounting information but the integration of clinical and accounting information is nevertheless strongly criticized. Furthermore, Eldenburg et al. (2010) argue that clinical engagement with the development and implementation of costing systems significantly affects clinicians' resource allocation practices, since clinicians reduce resource utilization for inpatients, they increase procedures on outpatients and focus the consumption of resources on patients that are more severely ill.

Considering that the hybridization of clinicians involves diversifying their knowledge basis to reduce ambiguity of costs, scholars have paid attention on clinicians' lack of financial and management training (e.g. Ferlie et al., 1996; Llewellyn, 2001; Jacobs, 2005; Kirkpatrick et al., 2007; O'Riordan & McDermott, 2012; Bethune et al., 2013). Instead of formal financial training options, Jacobs (2005) argues that clinicians improve their financial literacy mostly via learning-by-doing; by collaborating with senior clinicians and managers while only a few medical managers have the option to attend in-house financial seminars and workshops, but lack the incentive to do so since business managers support them. Similarly, recent survey findings indicate that 95% of medical managers in the English NHS reported that they primarily learned how to use accounting information via learning-by-doing, 60% via collaborating with business managers and only 28% through in-house financial training courses and workshops (Begkos, 2016). In addition, it is still evident that the integration of management studies in medical training exists only in limited UK medical schools and only few clinicians engage in MBA or PhD studies of their own volition (Cork & Devine, 2015). Studies also suggest that, although clinicians have displayed resistance in fully embracing accounting in the past (Kurunmäki, 2004), they have also displayed eagerness to learn about accounting and management practices (Jacobs, 2005) but they lack the time to engage in training and management activities (O'Riordan & McDermott, 2012).

Despite the plethora of studies that investigate clinicians' understandings and professional identity in relation to accounting, research on how clinicians engage with different accounting practices is still relatively scarce. Some scholars have attempted to address this issue by discussing that medical managers mostly use financial statements, activity plans and budgets for future projections on activity, and to a lesser extent, they use long-term plans, cost and capacity level analyses (Pettersen & Solstad, 2014). Others have conveyed that hospitals that implement patient-level costing share patient costs with senior managers and clinicians to a great extent (Llewellyn et al., 2016) and inform clinicians of their costs (Chambers et al., 2014; Ellwood et al., 2015).

An important addition to these views is extant research on the mediating role of medical managers between clinicians and senior management, and the benefits of clinicians' engagement with management and accounting practices (e.g. Dorgan et al., 2010; Jacobs, 2005; Kirkpatrick et al., 2012; Nyland & Pettersen, 2004). Studies indicate that the participation of medical managers in hospital boards is positively related with good financial performance ratings (Veronesi et al., 2014) and that the establishment of clinical directorates in secondary care[3] aimed in engaging clinicians with the

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[3] Secondary care broadly describes hospital care and may be planned (elective) or emergency.

management of their services (Kirkpatrick et al., 2012), in order to "*transform doctors into managers by giving them freedom to govern their directorates as more or less semiautonomous and self-managed entities*" (Nyland & Pettersen, 2004, p. 87). Furthermore, Nyland and Pettersen (2004) have reported that medical managers engage in conversations with both clinical colleagues and senior management and customize their vocabulary, filter information and adapt their identity, depending on their audience. Kurunmäki (1999, 2004) raised similar points, arguing that clinicians' knowledge and understanding of accounting enables the reconciliation of competing clinical and managerial logics in a time of healthcare reforms. However, what tends to be overlooked is a holistic perspective regarding the actual practices of clinicians that contribute to hybridization.

With these views as a backdrop, the next section presents the increasing emphasis on conjugating clinical engagement with accounting technologies and performance measurement information in the English NHS.

2.2 Performance challenges and contemporary accounting technologies in the English NHS

Performance information and accounting technologies in the UK have been a part of NHS financial management since the 1970s. Early financial management practices included specialty costing and cost-benchmarking at an aggregate level (Magee & Osmolski, 1980; Perrin, 1978; Bourn & Ezzamel, 1986). Clinicians were neither engaged nor pleased by such practices, as they held significant control over resources, favoured their own directorates and endeavoured additional funding as a response to overspending (Llewellyn, 2001; Brunsson, 2000). In the early 1990s, the creation of clinical directorates intended to engage clinicians with management and accounting practices. The hybrid role of Clinical Directors emerged, through which clinicians obtained the power to manage their specialties as semi-independent and self-directed units and started participating in resource allocation decisions within their responsibility centre (Ezzamel & Willmott, 1993; Llewellyn, 2001; Begkos et al., 2019). Similar medical manager positions gradually emerged in primary[4] (Sheaff, 2009) and secondary care (Llewellyn, 2001), increasing the impact of managerial power over medical practice. Overall, this new hybrid role exerted control on the performance management of clinicians and increased their accountability for resource consumption, thus changing professional relationships and identities (Eve & Hodgkin, 1997; Broadbent et al., 1997).

Over the last decade, radical government reforms cut down on government spending and introduced a plethora of efficiency savings measures to close a funding gap of £30bn by 2021 (NHS England, 2013). In light of these pressures to improve provider performance, the NHS has been placing an increasing emphasis on accounting technologies and clinical engagement with management practices and performance metrics. Clinical engagement is essential to put resources to best use and achieve cost improvement targets, since clinical decision-making accounts for most of hospital expenditure (Jones & Dewing, 1997; Hillman, 1986). In response, the English NHS has implemented a large array of accounting technologies and management tools in recent years. For example, Patient-level Costing and Information Systems (PLICS) is a costing tool that traces all the resources consumed by an individual patient from the moment of admission until the point of discharge, thus allowing clinicians and managers to identify cost variations between patients (Ellwood et al., 2015; Llewellyn et al., 2016).

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[4] Primary care is the first point of contact for people in need of health advice or treatment. It is provided by professionals such as General Practitioners (i.e. local doctors), pharmacists and dentists and is available in every local area. A referral from a primary care practitioner is usually needed to access planned, secondary care.

Patient-level costing facilitates a bottom-up costing approach and have the ability to enable better informed decisions regarding the cost and quality of care, improve transparency, promote service integration and increase clinicians' involvement in financial management and commitment to organizational cost-efficiency (Chapman & Kern, 2010). Such accounting systems are expected to facilitate the refined calculation of future reimbursement tariff prices to NHS care providers under the English tariff-based Payment by Results[5] funding system (NHS improvement, 2018).

Another well-established tool is Service Line Reporting (SLR) – a performance measurement system that identifies the total costs of activities for individual service lines (e.g. ophthalmology). SLR represents a more top-down reporting tool that calculates direct costs for service lines to which overheads have already been assigned (Chapman & Kern, 2010). SLR can identify total costs of activities though averaging processes, which constitutes SLR valuable to professionals who are primarily interested in the aggregate numbers attached to service lines and activities, such as medical managers, the finance team or external regulators (Fitzsimmons, 2011). Other existing accounting tools include bubble charts, planning tools such as budgeting and variance analysis, and business cases for capital investment decisions (Llewellyn et al., 2020; Begkos et al., 2020).

Considering the concerns outlined above, we draw upon the practice perspective to explore the hybridization practices through which medical managers promote accounting and performance information. Within this context, the following section describes our theoretical framing upon which we root our analysis.

3. Theoretical framework

3.1 A practice perspective on hybridization

This study engages with a practice-theoretical approach to investigate how medical managers enact hybridity. The theoretical foundations of the practice perspective are generally embedded in social theory (e.g. Bourdieu, 1977, 1990; Giddens, 1979), are particularly influenced by social theory's recent practice turn and focus on individuals' actual activities (Schatzki et al., 2001; Reckwitz, 2002; Feldman & Orlikowski, 2011). The practice perspective has experienced significant growth over the last two decades and is evident in fields such as accounting (e.g. Ahrens & Chapman, 2007; Jørgensen & Messner, 2010; Bui et al., 2019; Begkos & Antonopoulou, 2020), strategy (e.g. Jarzabkowski et al., 2007; Vaara & Whittington, 2012), marketing (Korkman et al., 2010; Araujo et al., 2008), and innovation and technology research (Barrett et al., 2012; Orlikowski, 2002). In general, the practice turn investigates "*the coordinated activities of individuals and groups in doing their 'real work'*" (Cook & Brown, 1999, p. 386-387) and places the spotlight on their behaviour and activities within their highly specific organizational context, instead of directly focusing on the organization itself and on abstract notions such as hybridity, accounting or strategy (e.g. Chua, 2007; Whittington, 2003).

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[5] Payment by Results uses national average treatments costs to calculate reimbursement tariffs, which are then linked with Healthcare Resource Groups (HRGs). Similar to Diagnosis related Group (DRG) classification systems that are commonly used in other countries (cf. Chapman et al., 2014), HRGs are groupings of services that are considered comparable in relation to their clinical complexity and resource intensity under the NHS context.

Practices have been defined by practice theorists in various ways, such as "*organized human activities*" (Schatzki, 2005, p. 471), "*routinized types of behaviour"* (Reckwitz, 2002, p. 249) and "*background coping skills"* (Chia, 2004, p.32). According to Schatzki's descriptions, organizations are constituted by interconnected practices that are mediated by material arrangements (Schatzki, 2006). He defines material arrangements as '*set-ups'* (Schatzki, 2005, p. 472) or '*assemblages'* (Schatzki, 2006, p. 1864) of material objects such as human beings and other organisms, artefacts and things. For example, a hospital consists of clinical practices such as treating patients and prescribing drugs, or accounting and management practices such as preparing budgets and evaluating performance. Such practices are enacted in interconnected material assemblages such as wards, laboratories, theatres and offices, by professionals who use medical equipment, computers and various communication and reporting tools. Reckwitz (2002) also highlights the relationship between practices and material orders, describing practices as constituted by interrelated "*forms of bodily activities, forms of mental activities, 'things' and their use, a background knowledge in the form of understanding, know-how, states of emotion and motivational knowledge*" (Reckwitz, 2002, p. 249). Furthermore, practices are framed by the abilities and knowledge that practitioners employ in their day-to-day existence, thus highlighting how practices are a constituting factor of acting (Chia, 2004; see also Jarzabkowski & Spee, 2009). Overall, the various practice framings focus primarily on *doing*, allowing researchers to identify people's patterns of *doing* in a field of study.

This practice lens enables us to conceptualize hybridization as an emergent, socially situated practice. Through the practice perspective, we envisage hybridity as the output of a hybridization practice. In other words, hybridity is something that organizations or individuals have, whereas hybridization is something that individuals do in their everyday activities. This subtle ontological shift enables us to focus our attention on the notion of '*practices of hybridization*' - the *doing* of hybridity - thus placing human agency to the forefront of our analysis and concentrating on the micro-activities and material arrangements that medical managers engage with when they enact hybridity.

The investigation of the practice of hybridization mandates a closer examination of elements of hybridity and how the micro-activities of its practitioners affect them. Practice studies have employed a plethora of terms and phrases to theorize the "*micro"* level emphasis of the practice approach, such as "*praxis"* (e.g. Reckwitz, 2002; Whittington, 2006), "*micro-activities*" (e.g. Johnson et al., 2003; Hendry & Seidl, 2003), "*micro-practices"* (e.g. Rouleau, 2005) and "*micro-processes"* (e.g. Chia & MacKay, 2007). Such a vocabulary aims to highlight the often ignored minutiae of practices "*just as using a microscope helps understanding of the whole through its tiny parts*" (Rouleau, 2005, p.1419), by providing an "*empirically based micro-view on what people actually do*" (Ahrens & Chapman, 2007, p.186) and linking how micro-activities are embedded in broader, macro-institutional contexts (Vaara & Whittington, 2012). In this paper, we adopt the term "*micro-activities"* to describe medical managers' situated bundles of bodily doings and sayings and the material artefacts that they use (Schatzki, 2002) as they enact hybridity.

In our empirical healthcare setting, we engage with Schatzki (2002, 2005) and accounting studies which employ a practice-theoretical approach (e.g. Ahrens & Chapman, 2007; Nama & Lowe, 2014) to contextualize medical managers' hybridization practices with respect to their understanding of accounting and diverse goals. According to Schatzki (2002), practices are partially constituted by individuals' practical understandings, general understandings and teleologies. Practical understandings describe individuals' *"...knowing how to X, knowing how to identify X-ings, and*

8

knowing how to prompt as well respond to X-ings" (Schatzki, 2002, p.77), such as medical managers' accounting knowledge and ability to perform accounting activities in the case under analysis. General understandings describe broader, sense-making knowledge such as a general awareness of strategy (Ahrens & Chapman, 2007), an open judgement of risk (Bui et al., 2019) or the aesthetic evaluation of performance (Begkos & Antonopoulou, 2020) and may help individuals navigate through ambiguity and a lack of calculability (Jørgensen & Messner, 2010). Teleologies describe '*a range of normativized and hierarchically ordered ends, projects, and tasks'* (Schatzki, 2002, p. 80). In plain terms, teleologies outline the goals or purpose of an array of activity, such as the pursuit of profit and self-esteem (Schatzki, 2002), servicing clients (Nama & Lowe, 2014), achieving strategic milestones (Jørgensen & Messner, 2010) and improving one's reputation (Begkos & Antonopoulou, 2020). In a hospital setting, professionals may pursue diverse and often divergent teleologies which may result to tensions that transmute and never remain stable (Jarzabkowski & Fenton, 2006; Denis et al., 2011). For example, medical managers' pursuit of improving cost efficiencies and quality of care in a specialty may not equate to value for the hospital or the local health economy and lead to contestations of the accuracy and use of accounting (Llewellyn et al., 2020; Begkos et al., 2020). In contrast, clinicians in non-managerial positions may be hesitant to pursue cost savings targets in fear of diluting quality of care and stigmatizing their professional identity. In addition, recent practice-based studies suggest that accounting does not only serve a managerial agenda but often acts as an obligatory passage point that medical managers need to tread through to achieve their diverse intentions (Begkos et al., 2019, 2020).

3.2 Equivocalizing and destigmatizing practices

A practice view of hybridity enables the investigation of the practices which medical managers, as practitioners of hybridity, engage with. Inspired by our practice lens and through our abductive analysis (see section 4.2), our findings demonstrate two emergent practices, which we coin *destigmatizing* and *equivocalizing*, through which medical managers employ accounting to leverage their hybrid identity, broaden the understandings, further diversify or reconcile the teleologies of clinicians in non-managerial roles. In what follows, we explore individuals' understandings and teleologies in related literature to explain our conceptualization of the two practices.

First, we term *equivocalizing* as the enactment of hybridity aiming to broaden meanings, teleologies and understandings relating to clinical and financial interventions. The notion of equivocality commonly refers to the existing multiple, unclear, ambiguous and often conflicting understandings of organizational issues, goals or knowledge (e.g. Daft & Lengel, 1986; Daft & Weick, 1984), a phenomenon which instigates individuals to "*agree, share, disagree and contest understandings*", thus shaping their own individual identity (Brown et al., 2008, p.1039). Schatzki (2002) suggests that there is equivocality in people's understandings and studies that adopt a practice-theory lens often explore how individuals' understandings, teleologies and identities shape amidst ambiguity. For example, Jørgensen and Messner (2010) investigate new product development practices and accentuate the role of accounting in reducing uncertainty and reconciling goals. In a healthcare setting, studies further demonstrate that accounting may mediate conflict and facilitate a shared understanding between clinicians and senior management, even when the goals of profitability and maintaining the quality of treatments seem incongruent (Begkos et al., 2019, 2020).

Such insights are useful in the study of how medical managers' hybrid identity manifests in practice, since "*identity-bestowing understandings of action inhabit and thrive within the manifolds of doings*

9

and sayings in which the identities involved take hold" (Schatzki, 1996, p.93). In our study, we theorize that medical managers embrace ambiguity as they are not able to provide unequivocal interpretations of the diverse purposes and multiple understandings of their hybrid identity. Thus, we adopt the literal etymological interpretation of the term to describe the emergent practice of medical managers placing '*equal voice'* to both clinical and managerial understandings and teleologies that characterize their hybrid role.

Second, we conceptualize *destigmatizing* as the enactment of hybridity aiming to overturn clinical disengagement pertaining to understandings and teleologies that are linked with a resolute clinical identity. The notion of destigmatization broadly refers to practices that aim to reduce the perceived stigma of social identities that leads to discrimination, labelling and stereotypes (cf. Goffman, 1963). According to Schatzki (2002), a practice lens is useful to analyse social phenomena such as discrimination and social structure as it provides insight on how identities, teleologies and understandings are formed in practice. An example of such focus is the study by Janssens and Steyaert (2019, p.532) who engage with practice theory to explain diversity-related phenomena, such as inequality in career mentoring, as "*the result of meaning-making, identity-forming, and order-producing practices*". According to such views, social order is bound by interrelated identities and meanings (Schatzki et al., 2001) and warrant the investigation of 'individuals-in-interaction' to avoid reductionist approaches of how such identities are formed (Jarzabkowski et al., 2013). At a practice level, a person's self-understanding of their identity may contradict the identity that is attributed onto them by others and is tied to where they fit into social arrangements (Schatzki, 2002). In our hybrid setting of healthcare, a medical manager and a clinician without managerial responsibilities may both identify as medical professionals, yet they may ascribe different meaning, even stigma, to clinical engagement with accounting. Such insight is relevant to our study since the practice of accounting is often linked with negative stereotypes (Miley & Read, 2012, 2018) and clinicians often remain distant from management and accounting practices to shield their professional identity from a managerialist culture (e.g. Bourn & Ezzamel, 1986; Llewellyn, 2001; Kitchener, 2000).

In light of the above, we argue that medical managers leverage their hybrid identity and engage in such an emergent practice to reduce the stigma that often permeates clinical engagement with accounting and management practices, such as clinicians' fear of the de-professionalization of their clinical identity and abatement of their clinical autonomy (e.g. Jones & Dewing, 1997; Kitchener, 2000). In doing so, medical managers, through their parallel practice of medicine and management, highlight the value of engagement with accounting technologies and performance metrics in clinical decision-making and attempt to reconcile understandings with regard to differing motivations, goals and priorities.

With this theoretical backdrop in mind, we next present our methodological approach.

4. Methodology

4.1 Research design and data collection

We investigate the intricacies of how hybridity is enacted via an in-depth single case study approach (Eisenhardt, 1989; Yin, 2013). We empirically explore an English NHS hospital[6]. The site was deliberately selected as a representative or typical case (Yin, 2013) to exemplify a broad range of case organizations (Bryman, 2012). We identified potential case study sites that are described by some degree of clinical engagement via reviewing the Department of Health's annual reference costs survey results which classify the relationship between clinical teams and finance professionals in four distinct levels of engagement; from purely board level (level 1) to full engagement at different levels and across all clinical specialties (level 4). Therefore, we initially identified organizations that described their clinical engagement as a level 4: '*Joined-up collaborative working between clinical and finance teams is the norm across all clinical specialties/departments*', or a level 3: '*Joined-up collaborative working between clinical and finance teams is the norm in at least one clinical specialty/directorate*' (Department of Health, 2013, p. 29). One level 4 organization, Delta (pseudonym)*,* was selected as the study's main case study site due to the organization's availability and implementation of innovative patient-level costing systems.

Delta is a large integrated care provider that offers acute and community care services to approximately 240,000 people across the greater geographical region. It has one of the highest patient and staff satisfaction rates across all NHS hospitals and has received awards for outstanding performance from the Care Quality Commission, the independent regulator of health and social care services in England. Its structure consists of four broad directorates, namely the directorate of Delta Health Care (providing local services), the directorate of Surgery, the directorate of Clinical Support Services and Tertiary Medicine, and the directorate of Neurosciences and Renal, which are managed by a total of 19 Clinical Directors, each responsible for a corresponding specialty[7]. In addition to reporting a high level of engagement across finance and clinical teams, the hospital also implements an array of accounting technologies and digital tools. For example, Delta was one of the first NHS hospitals to utilize patient-level costing systems, implements service line reporting, digitises patient care pathways and electronic patient records.

A total of 18 semi-structured interviews were conducted with medical managers and senior clinicians, business managers and coding specialists in charge of recording clinical information for reimbursement and healthcare planning purposes. Under the NHS context, the term '*medical manager*' encapsulates both Clinical Directors and Medical Directors: clinicians with varying degrees of financial training and business knowledge (cf. Cork & Devine, 2015) who have formal managerial responsibilities and also practice medicine in their day-to-day activities. Clinical Directors are located at the middle of the medical hierarchy, are responsible for a distinct clinical directorate or medical specialty and report to the Medical Director who is part of a hospital's senior management team (West et al., 1999). As of 2015, a total of 1,536 Clinical Directors and 322 Medical Directors were employed in the English NHS (Begkos, 2016). At Delta, a total of 19 Clinical Directors and 1 Medical Director formed the organization's clinical leadership team. Overall, we conducted a total of 13 interviews with Clinical Directors and three of our interviews were conducted on a group basis with Clinical Directors and their corresponding business managers to accurately capture the clinical and financial insight of

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[6] Our empirical evidence was gathered as part of two larger, successive research projects which investigated clinical engagement at four NHS hospitals. This study draws on qualitative data from one of these case studies.
[7] Specialties are divisions of clinical work, such as dermatology and oncology. Directorates are groups of specialties that are responsible for the provision of care, such as the directorate of Surgery, which may include specialties like neurosurgery and orthopaedics.

11

the study's participants simultaneously. Due to the timespan of our study, we were able to interview either the same professionals or the successive leads of the same departments over the course of five years. In specific, nine interviews took place from January 2014 until May 2015, and an additional nine follow-up interviews were conducted from November 2018 to January 2019. This timeframe reflects the boundary conditions (Shepherd & Suddaby, 2017) in our study of clinical engagement with accounting since NHS reforms in 2013 drastically cut back on healthcare funding and emphasized productivity gains to close a funding gap of £30bn (NHS England, 2013), while a funding increase materialized in 2018 when the British Government committed to additional spending (Department of Health, 2018). The average duration of each interview was approximately one hour and all interviews were recorded and transcribed verbatim. In Appendix A, we outline information with regard to our research participants.

Documents and other secondary data were also collected from our case organization, such as annual strategy and financial reports, newsletters, business cases, presentation slides, board meeting minutes, patient-level costing analyses, print screens of accounting dashboards and performance matrices.

4.2 Data analysis

The analysis of the empirical material centered on an iterative, abductive approach. Abduction is the theoretical explanation of emerging empirical observations and involves the continuous assessment of the explanatory powers of different theories as empirical data is collected and analysed, in an iterative fashion, to better explain the explored phenomenon and develop thick descriptions (Modell, 2009; Lukka & Modell, 2010). First, we drew on our theoretical framing and interrogated our data in search of practice elements which condition hybridization practices, such as medical managers' understandings of accounting and teleologies which condition their clinical directorates' performance and operational activities. This step enabled us to provide the context for medical managers' hybridization practices, in relation to their accounting knowledge, diverse teleologies and overarching professional identity (see section 5.1).

Second, we proceeded to investigate medical managers' hybridization practices. We explored their enactment of hybridity via *"zooming in"* (Nicolini, 2009, 2012) on their situated micro-activities and investigating what they do and say, what tools, artefacts and mediating instruments they use as they promote accounting and performance information, and "*zooming out*" to capture the emergent and meaningful patterns of such activities. Our research approach in capturing such micro-activities is situational (Nicolini & Monteiro, 2017), as we concentrate on occasions such as meeting rooms and hospital wards where organized activities manifest. In doing so, we investigated how medical managers engage clinicians without managerial responsibilities with performance measurement and accounting technologies. At this stage, we employed data triangulation to identify convergence or divergence of findings and enhance the trustworthiness of our study (Denzin, 1970; Lincoln & Guba, 1986). We compared and contrasted different data sources between them and across time, a process that was facilitated by interviewing the same participants or organizational roles multiple times across our five-year investigation. This method was also useful for accurately portraying the multivocality of micro-activities and perceptions which permeated our identified hybridization practices. Thus, we created a number of vignettes which focused on describing medical managers' key micro-activities in enacting hybridity.

12

Then, we sought to identify how medical managers' hybridization efforts attempted to impact clinicians' level of engagement and overall receptivity to accounting and performance measurement tools. This step highlighted the recurrence of local practices, yet we acknowledge the inherent relativism of claims regarding clinicians' receptivity and engagement, in light of our efforts in making sense of situated meanings through the "*inescapable role of judgement*" (Lukka & Modell, 2010, p.463). Finally, we examined the relationship between our identified practices and investigated whether they are conceptually and empirically distinctive. Thereby, in response to our research question, we were able to identify two emergent hybridization practices, namely *destigmatizing and equivocalizing,* which we then anchored in extant hybridization theory. This iterative, abductive process throughout the duration of the study aimed in achieving a refined explanation of medical managers' hybridization practices and thus strengthen the link between our empirical observations and practice framing.

The presentation of our findings is structured around our theoretical framework. The first empirical section investigates medical managers' teleologies and understandings, elements which are constitutive of practices (Schatzki, 2002). Then, the second empirical section explores medical managers' equivocalizing and destigmatizing practices. In doing so, we present our findings in a holistic rather than a chronological manner since our study does not aim to capture change between our two data collection periods. Yet, we often highlight the chronological dimension of our observations to better capture the richness of our 5-year investigation.

5. Findings

This section explores how medical managers enact hybridity at Delta, our hospital setting. First, it outlines medical managers' understandings and diverse teleologies, and comments on the professional culture that permeates their identity. In doing so, we explain via evidence the varying levels of clinicians' knowledge of accounting and explore their motivation, or lack thereof, for engaging with accounting and performance measurement information. We then proceed to capture how medical managers mediate between their clinical colleagues and senior management to resolve different and often conflicting goals, and explore the various *destigmatizing* and *equivocalizing* mechanisms which medical managers employ to engage reluctant or opposing clinicians in non-managerial positions with accounting information and performance measurement tools.

5.1 Diverse teleologies, understandings and professional identities

Delta is a very controlled and organized environment. A total of 19 medical managers supervise more than 730 medical staff, 850 beds and 19 theatres spread across four broad directorates. Delta consistently reported the highest level of engagement (level 4) between the hospital's clinical and finance teams, as reported by the Department of Health's annual reference costs survey results (e.g. Department of Health, 2013). Overall, our empirical evidence suggests that medical managers across all directorates shared diverse teleologies which focused on quality of care, operational and financial performance. Such performance targets were driven by the clinical and financial needs of their directorates and were framed by the performance oversight framework of the organization.

In their everyday practices, medical managers strived to improve quality and health outcomes such as optimizing patient pathways, controlling patient flow, theatre and bed utilization and reducing patients' length-of-stay. Across our investigation, the organizational impetus accentuated continuous improvement on quality of care, services and costs and Delta provided both medical managers and clinicians in non-managerial positions with opportunities and support to share and realize their improvement ideas. In 2018, a business manager succinctly described this organizational emphasis on quality improvement over the last few years.

"…[O]ne of [Delta]'s principles is around continuous improvement, and there's a big quality improvement focus, and there's always been a lot of resource in […] service improvement and quality improvement; and that's always been a big thing here. And I think consultants[8] and everybody's been given the opportunity to come forward and give their ideas around what can be done, and been supported to make it happen". [BM-7b]

In relation to financial performance, medical managers attempted to achieve cost improvement targets via controlling expenditure, increasing activity and setting savings and income targets. Financial performance targets were significantly influenced by the organization's cost improvement programme which usually dictated recurrent savings of 2%-5% on an annual basis for most directorates. Throughout our 5-year empirical observation, medical managers' emphasis on financial performance was noticeable, yet we do not argue that this was to the detriment of medical managers' focus on quality and health outcomes. In 2018, the following medical manager acknowledges this emphasis and places the cause on the financial hurdles that the NHS has been experiencing for the past decade, in light of funding shortages and substantial net deficits of recent years (National Audit Office, 2019).

"I think if we'd been in our [medical manager] roles ten years ago, when money was not so much of an object, I think it would be very different. I think this is very much a fact of our times in the NHS. I think our [medical manager] roles are particularly difficult at the moment because it is all based on, you know, the bottom line is the money. I think in the past, you could much more argue well this is good for patient care and you'd get something through and I think that [it] is much harder now because the focus is a lot on the money." [MM–9]

An acceptance of financial performance targets was also evident with clinicians in non-managerial roles and other specialties. In 2019, the following business manager claims that this manifested in recent years due to clinicians' general understanding that clinical and financial outcomes are often mutually constitutive.

"I think years ago people would come out with comments that we don't need to look at finance; we're here for the clinical outcomes, that's all, and, blah. But actually without financing it, you won't have the clinical outcomes (laughs) they do go hand in hand. And I think that's become more accepted over time." [BM-6]

Medical managers at Delta also demonstrated a good level of practical and general understandings of accounting. Despite the fact that the organization offered in-house training options on management, leadership, finance and clinical coding, medical managers indicated that their general financial and

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[8] Consultants are senior hospital doctors of a specific medical field who have completed their specialist training.

14

management knowledge was primarily acquired through learning-by-doing processes and facilitated by the support of their directorates' business manager and lead nurse. The following medical manager explains that, although few clinicians sign up for management and leadership training in his directorate as of 2018, medical managers usually assume such roles on a voluntary basis and learn how to direct their department via engaging with management in practice. In the following quote, he further highlights the need for medical managers to engage with management training but also expresses his cynicism towards leadership training.

> *"…[D]octors can and one or two do in our [directorate] – doctors can go down a management path and go on courses and leadership development and all that, but I think the majority of Clinical Directors become so because somebody has got to do it and they volunteer. I did it… So, in order to do that, one has to engage with management, work with management and under my directorship, the department grew, it became more efficient… There's management training and leadership training. Leadership training, I am fantastically cynical about. I just think it's absolute bollocks and costs a fortune."* [MM-7]

Although medical managers' understandings were broadly shaped in their day-to-day practice, evidence suggests that Delta offered various mandatory or well-attended training options to clinicians and other professionals throughout our investigation. For example, interviewees highlighted the compulsory nature of coding training and that the clinical coding department had a regular representation on the foundation programme of newly appointed clinicians, offered regular coding awareness sessions and hosted seminar days which were attended by up to eight junior doctors in a day. In the following quote, a medical manager suggests that optional management and leadership training was often over-subscribed in 2018.

> *"…[T]here's a new consultant programme […], and there's also sort of a leadership development that the hospital runs, I think it's twice a year… It's always over-subscribed, but that's not just for doctors, that's for anybody who wants to do it, all they have to have is the support from line manager that, actually, we think it's a good thing."* [MM-5]

In addition, medical managers perceived accounting tools such as profitability and activity reports, SLR and PLICS systems as powerful tools in primarily consolidating financial performance targets. Medical managers demonstrated a very strong interest in accounting and performance information, an interest that was reinforced by investment opportunities in their specialty upon satisfactory financial performance. This is evidenced in 2018 by a business manager who comments on the extent of medical managers' overall engagement and links it with financial incentives at a service level.

> *"…[A]s an organisation [we are] fairly good at engaging [medical managers] and making them aware of the financial situation and […] how their service is doing, both in terms of costs, but income as well… [M]ost people seem to be quite engaged and interested in how their service is doing and whether they're spending too much, or not bringing in enough income; and actually, ultimately we've tried to design the system across the hospital in such a way that if your service is doing well financially, if you can make a surplus, some of that money can come back to be reinvested within your service, so that's like, maybe an incentive."* [BM-7b]

Although medical managers' level of engagement was informed by their hybrid organizational role, some perceived that their clinical subordinates who did not share managerial responsibilities were

often reserved in engaging with accounting information and performance measurement tools. Such hesitancy was often due to an emphasis on quality and health outcomes, a lack of accounting knowledge and an overall strong sense of commitment to their medical identity. For example, a medical manager consistently highlighted in interviews that clinicians' reserved engagement is linked with their main focus on patient care and limited trustworthiness of accounting figures.

> *"I think there will always be a majority of consultants who aren't interested in the business... They come to work, see the patients. "I'm a neurosurgeon, the money is not my problem"... [they] are either not interested in the money, or don't believe the figures." [MM-7]*

Our evidence suggests that medical managers perceived that clinicians did not share their levels of knowledge and understanding of accounting information, as organizational access to accounting technologies such as patient-level costing systems and service line reports was primarily granted to medical managers, while clinicians in non-managerial roles had to request access rights. Medical managers also claimed that a lack of such knowledge is usually less evident in junior clinicians, due to recent changes in college curriculums which now incorporate management training courses. For example, a medical manager suggests that younger clinicians demonstrate a better understanding of accounting due to the reformed specialty curriculum which recently integrated management training.

> *"…[N]ow when you come through speciality training, [management training]'s a whole bit of the speciality training that they're now exposed to that I don't think I ever was. The Royal College has changed the curriculum to include things like that… They're now tested on it. It forms part of their training."* [MM-4b]

Although our analysis focuses on the practice level, our empirical evidence allude to Delta being characterized by a high degree of connectivity between the clinical and corporate functions of the organization and retaining a fair balance between being clinically-led and "*managed*", between cost and care management, throughout our empirical observation.

5.2 Hybridization practices and engagement with accounting

Here, we concentrate our attention on our medical managers' practices and micro-activities through which hybridity was enacted. In our analysis, we proceed to pinpoint medical managers' day-to-day operational activities which facilitated clinicians' engagement with accounting. Via conceptualizing hybridization as a situated practice and our abductive analysis, we identify two broad, emergent hybridizing practices, namely *equivocalizing* and *destigmatizing*, through which medical managers enacted hybridity and promoted accounting information and performance measurement tools.

5.2.1 Medical managers' equivocalizing practices

First, we explore how medical managers interact through everyday activities with clinicians who are hesitant but willing to engage with accounting and management practices. We collectively refer to such consistent micro-activities as an *equivocalizing* practice.

Our evidence suggests that the most prominent methods of diversifying hesitant clinicians' understandings and teleologies were explaining the financial implications of their activities. Delta strived to involve clinicians in management, enhance their understanding of management practices and raise attention about the financial implications of clinical decision-making. Medical managers

frequently held discussions with hesitant clinicians where they highlighted both the positive and negative financial implications of their actions. For example, in the early stages of our study, a medical manager outlined how he employed patient-level costing information to inform clinicians of favourable reimbursement tariffs, encouraging them not to cancel surgeries and motivating them towards increasing their directorate's income.

> *"We've had some cases last week of [a] major surgery where there's a tariff of around £30,000 on it. And one of the managers was saying today, "How do we get this across to people that they can't cancel that case?" Well, you have to explain the financial implication to the business and that well, our unit's £1.4 million […] behind plan rather than overspent… [S]o so let's try and not cancel that one and work towards doing what we can. And I think people are engaged if you give them the information... But patient level costing helps you justify your argument."* [MM-1]

In the above example, the medical manager employed patient-level costing information in discussions with clinicians at the operational level, allowing him to better communicate the financial goals of his directorate and improve clinicians' practical understandings of accounting. The medical manager further claimed that clinicians may often display both a high level of engagement and a limited understanding of how to address financial problems at the operational level, a discrepancy that is mitigated through discussing the directorate's financial problems.

> *"There's a bit of this myth that surgeons aren't engaged and clinicians aren't engaged. I think clinicians really are engaged; they just don't understand. And once you stop and explain the [financial] problem, they do understand."* [MM-1]

In addition, medical managers often informed clinicians of the adverse financial consequences of their actions, in an attempt to reduce clinical variation and highlight patient outcomes. For example, a medical manager engaged with lean methodology techniques and deliberately encouraged the increase of the number of ordered investigations in his department, in an effort to optimize staffing costs and maximize patient flow. In 2014, the medical manager explained that he was involved in mapping exercises that visualized patient journeys, which facilitated the investigation of various points of downtime and instigated the increase of ordered investigations. In the following quote, the medical manager explains his rationale and the imposed investigation threshold in his department.

> *"… [I]n the early parts of your career, your investigations are quite high. You then tend to drop down as you gain confidence and become perhaps over confident. Then your levels of investigation start to rise again and then they sort of oscillate and […] reach an equilibrium point… So what we've done is set the bar probably above the level of investigations a senior doctor would do because […] time has become more important to us than perhaps over-investigating people… So paying for more tests, that actually allow us to move those patients through more efficiently and saves us on workforce."* [MM–4]

Contrary to this, his successor recently attempted to raise cost awareness, reduce variation and highlight patient outcomes via radically reducing the number of ordered investigations in her department, a strategy that is opposite to the one initiated by her predecessor, thus reflecting the equivocality that permeates clinical practices. The new medical manager explains how she developed a matrix (figure 1) to control for the amount of tests performed at patients who enter her department,

motivated by her heterogeneous knowledge that a moderate amount of tests are performed without any discernible patient benefits and as a cost to the hospital.

Figure 1. Example of patient care and cost reconciliation

Presenting Complaint	CANNULA	PBC	U&E	CPR	Group & Save	Trop I	LFT's	Amylase	Clotting	INR	D-Dimer	Blood Glucose	Paracetamol Salicylate >4 hours	TFT's	Bone profile	Urine Dipstick	ECG	PEER	Venous Blood Gas Lactate	BM point of care	Urine	Pregnancy test Child bearing Age
Abdominal Pain - female	•	•	•	•	Rapid		•	•								•			Rapid			•
Abdominal Pain - Male	•	•	•	•	Rapid		•	•											Rapid			
Abscess local infection/cellulitis	•	•	•	•																•		
Allergic Reaction	•	•	•																			
Cardiac Chest Pain	•	•	•			•			•			•					•			•		
Collapse Cause	•	•	•	•																•		•
Diabetic Crisis (DKA)	•	•	•	•								•				•			•	•		
? DVT	•	•	•						•		•									•		
Elderly "Unwell"	•	•	•	•			•		•										•	•		
GI Bleed	•	•	•		•		•		•										•			
Head injury on warfarin	•	•	•						•													
? Malaria	•	•	•	•			•															
Major Trauma	•	•	•		•		•	•	•										•	•		
? NOF	•	•	•	•																•		
Overdose (just paracetamol) (Only do 4hrs after ingestion)	•	•	•				•			•			•						•			
Overdose Mixed	•	•	•				•			•		•							•			
Palpitations	•	•	•												•		•			•		
Pleuritic Chest Pain	•	•	•	•					•								•			•		
Pregnancy AbdoPain/PVB>6/40	•	•	•	•					•							•				•		•
PV Bleed	•	•	•		•				•													•
Seizures	•	•	•	•																•		
Sepsis/qSOFA	•	•	•	•			•									•			•			
Shortness of Breath {walk in}	•	•	•	•														•		•		
Shortness of Breath {Rapid}	•	•	•	•													•	•	•	•		
Stroke / Tia	•	•	•						•			•					•			•		
"Unwell" (inc. severe headache)	•	•	•	•			•		•						•				•	•		

? Malaria	•	•	•	•				•	Malaria Screen
Needle stick Injury	2 Brown tubes on virology form Send up with patient

Source: Delta - specialty 4

Such an intervention is clearly driven by the medical manager's hybrid identity and diversified teleologies pertaining to cost improvement and patient care. As evidenced in figure 1, the medical manager, in collaboration with her business manager, developed a matrix which tabulates patient complaints with investigations that should, or should not, be performed[9]. In the following quote, the medical manager describes the creation and functionality of this matrix.

> "We looked at all of the blood tests that we're doing in the department and developed a matrix for the triage presentations. So, if someone comes to the front door of the department and they book in and they have chest pain, then they will get this test, that test and this test and there will be no deviation from that, unless the medical team then decide that they need something else." [MM–4b]

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[9] Investigations that should be performed are indicated by a dot where the complaint row meets the investigations column.

The matrix was posted on walls at her department. During the process of creating this matrix, the medical manager sought and gained agreement across all clinicians in her department. Upon disseminating her motivation behind producing this matrix, she explained that the matrix was revised twice based on clinical evidence and constructive argumentations from her clinical colleagues. She explained that its purpose lies not in prohibiting the provision of specific tests, but in raising awareness, reducing overtreatment and seeking justification for unwarranted but performed investigations. Following the implementation of this engagement initiative and alerted by the hospital's high turnover rates, the medical manager frequently analyses patient-level data to identify when the numbers of certain tests increase, upon which she engages in further actions.

> *"So, we look at individual patient detail and go back to who is taking that test. We go back to ask [clinicians] to justify it, they can't justify it, so therefore, sorry but this is the matrix and that is how it's got to be. It's there for a reason."* [MM–4b]

In addition, medical managers were proactive in identifying clinicians who are prone in engaging with management and encouraged such participation, a tactic that was evidenced by the following business manager in 2018.

> *"…[W]e can see through daily practices who is a clinical member of staff and has no intention of going into that sort of role, and who's got that sort of – like I say, the right attributes, and those are the people that we focus on and there's a clinical leadership programme that the hospital offers, where we would push them in that direction. We've got one of our consultants who's doing that currently."* [BM–9]

Although most medical managers at Delta attempted to improve clinicians' financial literacy via learning-by-doing processes and informal interactions at the practice level, our analysis indicated few instances where medical managers were also involved in the delivery of formal financial and leadership training. For example, the following medical manager had extensive experience in bidding for capital investments and was involved in the formal business case training of newly appointed clinicians who start their specialist training at Delta. Throughout our investigation, the medical manager employed real and hypothetical scenarios of how clinicians could address operational problems through business cases within his classes. Further to such formal training, he would also peer-review clinicians' business cases before they were submitted for approval.

> *"No-one ever told me how to write a business case, whereas now we do teach the trainees at least what a business case is… I teach the FY1s [Consultants on Foundation Year 1] every year, how to write a business case in a context of how I've written business cases to develop a service to get it to work, and as a part of that, I make them think about something that isn't right in a hospital, and what would they like to do about it."* [MM-5]

Finally, although most medical managers at Delta exhibited a high degree of financial literacy and competence which they leveraged in discussions with clinicians, few medical managers demonstrated restrained engagement with accounting. For example, the following medical manager was consistently critical of other medical managers who displayed high levels of engagement, suggesting in both interviews that the primacy of his role lies in signalling to business managers what the clinical need is, thus making sure that the '*bigger picture*' is not lost.

19

"*There are other clinical directors that love looking at the numbers. To me, I think it's almost a bad thing. That's an extreme statement, but I think that my job is to take into context the financial considerations needed to provide a good service. I think my job is to take to the [business] managers and the accountants and so on, the need for the good service and then be challenged very robustly as to how we can deliver that based on my full support of the need to provide a service that is financially sound. I think that if you have doctors looking into too much detail of the finances, they are in danger of losing the big picture of what the clinical need is. It needs to be a two-way conversation…*" [MM-7]

The above empirical examples demonstrate that medical managers engaged clinicians with multiple interpretations and understandings of how to achieve diverse teleologies pertaining to improving clinical outcomes and financial performance.

5.2.2 Medical managers' destigmatizing practices

This section explores medical managers' hybridization practices which aim in *destigmatizing* the accounting function in the eyes of clinicians who are strongly resistant or oppose engagement. Such activities are different from equivocalizing practices where clinicians were hesitant but receptive to engagement and broadening their financial and management knowledge.

Clinicians were often adamant in abstaining from engaging with accounting and management practices. Our empirical evidence suggests that a certain degree of stigma permeated accounting and performance information in the eyes of clinicians who exhibited a resolute professional identity. For example, clinicians often questioned the accuracy of information and the overall legitimacy of utilizing accounting information in clinical decision making. They often proclaimed that they are not interested in engaging with management and accounting practices since such actions deviate from their core professional identity. Clinicians were reluctant to embrace the concept of providing a profitable service in a non-profit setting and intentionally abstained from profitability discussions. They often contested management practices through a sense of entitlement that derived from their strong professional identity and culture. In an example from the early stages of our empirical observation, a medical manager suggested that few of his colleagues have an instinctive aversion towards information in profitability reports due to their inability to embrace the concept of providing a profitable service in a non-profit setting.

"…*[W]e now look at profitability analyses as opposed to budget setting. And I think that's been difficult for clinical colleagues because the argument is, but we're not meant to be profitable. We're not making a profit, so therefore the financial data was immediately pushed away [because of] the slightly distasteful view that we shouldn't be talking about this.*" [MM–8]

Likewise, another medical manager suggested in the early stages of our study that a few surgeons in his directorate were disconnected from the public nature of their employment within the hospital and displayed arrogant behaviour.

"…*[T]he issues in [specialty 1] was the dysfunctional surgeons... Late and thought they were special. They were all making money operating. Comments like, "Well, you should fete us." That was a great comment... You should fete me for being here. I know I'm not here all the*

time, but you should pay me more in the time I'm actually here, just for having me here." [MM–1]

In response to such behaviours, the medical manager often verbally demonstrated through everyday interactions how clinical decisions affect patient pathways in terms of both costs and patient outcomes. In the example below, the medical manager explained how he persuaded a surgeon that was consistently running late to change his practice, by informing him that his absence increases waiting times and costs £12 per minute.

"[I]t was pointing out to them that, "Okay; you're late a minute or twenty minutes, but actually eight people have been waiting for you and the infrastructure has been £12 a minute while you've been late if you're taking your kids to school. So what can we do to solve it?" And he changed his practice..." [MM–1]

The cultural divide between clinicians and managers was evident during the early stages of our investigation, as indicated in the following quote by a medical manager who highlights how surgeons at times showed contempt for people and practices that deal with managing money.

"You go to meetings and you hear — Friends of mine, people I like very much, very good neurosurgeons - "All managers are bastards"… It's pathetic… They think that somehow, because the state pays their salaries, that it's rather below them to talk about money." [MM-7]

In our empirical analysis, we identified efforts to bridge this cultural divide. In 2015, Delta launched the "*Better Health at Lower Cost*" initiative[10], which constituted a re-branding of its long-standing cost improvement programme that determined annual cost savings targets for each responsibility centre. The motivation behind this reinvention lied on removing the stigma associated with cost improvement plans, in intensifying cost improvement efforts and improving clinical engagement via highlighting the link between cost efficiencies and better health outcomes. Such motivation is evidenced by the following medical manager.

"… [W]e've changed name from cost improvement to Better Health at Lower Cost, just to subtly change the message, this isn't about cost improvements or saving money […] but it's about saying, can we do better health at a lower cost?" [MM–5]

In addition, the following business manager suggests that the reinvention of the cost improvement programme aspires, not only to raise awareness about quality issues, but also to instigate action in actively pursuing ways to link costs with quality outcomes.

"They re-badged it a few years ago to move away from the cost improvement because that suggests that we're not bothered about quality. The rebranding of it […] is trying to change the emphasis so that there'll be more idea generation." [BM–9]

Overall, medical managers were all aware of the programme's rebranding. They still had to achieve cost objectives that were similar to the ones prior to the programme's reinvention and complained that they lacked incentives or rewards when engaging in this initiative. Furthermore, they felt that the

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[10] The name of the initiative has been altered to preserve anonymity of the case organization.

21

rebranded initiative simply regurgitated the same cost improvement narratives as before, serving a rhetoric that is devoid of any practical ideas on how to combine improved cost savings and better care outcomes. The following medical manager reinforces the notion that Delta has moulded the Better Health at Lower Cost programme into a facade of integrated care that simply accentuates cost pressures without emphasizing on better health outcomes.

> *"... [Senior Management] are just looking at lower cost (laughs) so when they say, "What's your better health, lower cost plan?" - they don't want to know about the better health, they just want the lower cost. So BHLC, nobody sees it as better health.... So I think people stop using the term BHLC now. They call it cost improvement plan, CIP."* [MM-6b]

Through our analysis, we reaffirm the medical manager's claims via further reviewing hospital documents. Quarterly staff newsletters which are published and distributed to hospital members described the Better Health at Lower Cost initiative as a programme which aims to retain a balance between improving productivity, efficiency and standards of care. On the contrary, upon reviewing Delta's annual operational plans – documents which are not intended for mass media consumption – we identified that the Better Health at Lower Cost programme is coupled with an overwhelming plethora of explicit financial performance targets but scant targets relating to health outcomes. Although this observation reflects Delta's emphasis on financial targets for this specific programme, we do not claim that this is representative of the organization's focus.

In response to a lack of existing organizational practices that highlight the relationship between costs and healthcare outcomes, medical managers assumed responsibility in associating the patient experience with the financial implications of clinical action and emphasizing such links to clinicians. For example, medical managers often engaged in discussions with clinical colleagues around redesigning patient pathways. The fundamental principle behind pathway redesign is that a reduction in patients' length-of-stay improves the patient experience and reduces costs. In our empirical observation, medical managers shared few examples of how they involve clinicians in such endeavours. For example, a medical manager was successful in reducing waiting times for patients with swollen legs via obtaining approval for a business case that sought the outsourcing of scanning appointments. In collaboration with clinical and business colleagues in her department, they drafted a business case which highlighted the prolonged waiting times' financial cost and various implications to patient outcomes. In a similar pathway redesign case, another specialty wanted to reduce the length-of-stay of patients with minor spinal procedures (discectomies). In the following quote, a business manager explains how clinicians were recently involved in this pathway redesign initiative.

> *"... [A] couple of surgeons reviewed the data nationally, and internationally, around whether other places were doing [...] discectomy as a day case. They reviewed data around complications, so if somebody has a post-operative complication, how soon after surgery is it likely to happen, and that indicated that the vast majority of complications will happen within six hours of finishing the operation. So we therefore discussed as a group, if we could keep people in for six hours, in the day case unit, observed, then actually the chance of them having a problem after that, is very, very low."* [BM–7b]

Overall, our analysis suggests that it was medical managers' destigmatizing practices rather than Delta's rebranded cost improvement narrative that informed clinicians' understandings of how to deliver better health at lower costs. Although clinicians at Delta were sceptical of the rebranded

organizational rhetoric, our case evidence indicates that medical managers, through discussions and everyday interactions, highlighted links between costs and patient care in practice. We argue that such interactions facilitate in reluctant clinicians eventually becoming more susceptible to changes which integrate improvements in both patient outcomes and costs. In a recent interview, a business manager attested such increasing engagement with the accounting function.

> *"I think years ago people would come out with the comments that we don't need to look at finance; we're here for the clinical outcomes, that's all, and, blah. But actually without financing it, you won't have the clinical outcomes (laughs) they do go hand in hand. And I think that's become more accepted over time."* [BM–6]

5.2.3 Summary of medical managers' hybridizing practices

In summary, our findings accentuate the two distinct practices through which medical managers instil hybridity to clinicians who are hesitant or resistant to hybridization.

First, medical managers engage in equivocalizing practices through which they aim to broaden hesitant clinicians' knowledge, understandings and interpretations of clinical and financial interventions. Through everyday operational activities, they engage clinicians via raising cost awareness, reducing clinical variation, encouraging discussion and reflection upon the implications of clinical decision-making. This reinforcing role was succinctly summarized since the early stages of our empirical observation by the following medical manager who suggests that clinicians simply lack an understanding of accounting and performance information, but are indeed engaged once information is explained.

> *"It's getting it to the [clinicians] that see themselves as surgeons and their job is to save lives and to operate and the money is somebody else's issue. And it's breaking that barrier. But I mean that's my job really, to make that apparent."* [MM–1]

Second, medical managers engage in destigmatizing practices through which they attempt to overturn clinical disengagement by signalling the merits of accounting on improving care outcomes. Our findings demonstrate the various situated micro-activities through which medical managers overturned an organizational initiative in removing the stigma associated with clinical engagement with costs. This destigmatizing role is accurately described in the following quote by a medical manager who was interviewed across both stages of our observation.

> *"I think that where hospitals fail is where money is a dirty word, where managers are a dirty word, where doctors have the arrogance to think that money and turnover and eighteen weeks, and all these targets are a bad thing… My job is to translate the hard core management stuff, including the finances, into an understandable and acceptable way to the clinicians and my job is to convert the clinical concerns into a financial and management sense that makes that coherent and to balance the two."* [MM–7]

Overall, medical managers acted as a conduit between senior management and the clinical body and facilitated the bilateral interpretation and pursuit of financial and clinical teleologies. Our identified hybridizing practices explicate how medical managers provide synergy between and across the finance teams and their clinical colleagues, reconcile diverse teleologies and broaden understandings via interpreting managerial jargon in forms that fit within clinical culture. The practices proposed above

23

have significant implications for the hybridization literature, in providing an in-depth account of how hybridity is enacted. In what follows, we explore in more detail the theoretical and practical implications of our findings.

6. Hybridization as practice and clinical engagement with accounting

This study adopts a practice lens and conceptualizes hybridization as an emergent, socially situated practice, which enables us to investigate the micro-activities that medical managers engage in when they enact and become practitioners of hybridity. The paper's contribution is twofold. First, we contribute to hybridization and practice theory literature via capturing and theorizing two hybridization practices, equivocalizing and destigmatizing, which broaden the understandings, further diversify or reconcile the teleologies of individuals who are hesitant or resistant to hybridization. Second, we contribute to the nexus of hybridization and healthcare literature via demonstrating how medical managers promote accounting and performance measurement technologies to instil hybridity to clinicians in non-managerial roles. In doing so, this paper moves away from static views of hybridity and captures hybridization in practice as it manifests through action.

6.1 Hybridization practices, understandings and teleologies

First, our paper contributes to hybridization and practice theory literature via conceptualizing hybridization as an emergent, dynamic and socially situated practice. Our findings capture assemblages of situated practices which aim in further diversifying and reconciling teleologies, broaden meanings, augment understandings and resolve conflict. Our emphasis on the *doing* of hybridity, human agency and the micro-activities they entail (Schatzki, 2002) add a novel, practice-theoretical view of how hybridity manifests in knowledge-intensive settings (Grossi et al., 2019) which are prone to diversifications of values, identities and motivations. Although accounting and public sector studies have dwelled on explorations of the attributes of hybridity and its ramifications on logics, identities, organizational forms and processes, we concur with prior studies which suggest that accounting research has not yet adequately investigated the process of hybridization and its situated practices (Kastberg & Lagström, 2019; Kurunmäki & Miller, 2011; Wiesel & Modell, 2014). As such, this paper distances itself from static views of hybridity, but instead contributes a dynamic perspective of how hybridity is enacted in practice through manifestations of understandings, teleologies and professional identities.

This study adds important insight on how hybrid identities are formed through a practice lens that allows for the investigation of 'individuals-in-interaction' (Jarzabkowski et al., 2013) and the ongoing asymmetries that characterize diverse, pluralistic organizations (Janssens & Steyaert, 2019; Denis et al., 2007). Our findings demonstrate an equivocalizing practice through which medical managers foreground the use of accounting in facilitating both financial and patient outcomes through everyday interactions with clinicians who are receptive to engagement with costs. Our theorization derives from the view that meanings, goals and understandings are equivocal (e.g. Weick, 1995; Schatzki, 2002). In doing so, medical managers '*constitute worlds*' (Schatzki, 1996, p.115) which reflect the duality of their medical and managerial responsibilities and aim to broaden the understandings and teleologies of clinicians in non-managerial positions. At a practice level, extant studies accentuate that accounting information may facilitate goal congruence and reduction of uncertainty, even though it may not be

24

able to unequivocally reflect such goals but instead instil a general awareness of them (Jørgensen & Messner, 2010; Ahrens & Chapman, 2007). We extend such studies by highlighting that accounting may facilitate the commensuration of individuals' diverse teleologies and embracing of uncertainty through providing voice to multiple understandings that, prior to the enactment of hybridity, may be seen as antithetical or ambiguous. We further highlight that, for hybridization to occur under such circumstances, receptivity to engagement with costs is a catalytic factor.

In addition, we identify instances where clinicians in non-managerial positions consider engagement as an ethical and cultural departure from their core professional identity (see also Jacobs, 2005). In our case, clinicians who displayed a resolute clinical identity were often disengaged and contested teleologies and understandings that were cost-related. Hybridization here occurred through medical managers emphasizing teleologies around patient outcomes to resolve conflict (see also, Begkos et al., 2019). In doing so, they cultivated clinicians' interest in accounting information and performance measurement technologies via broadening their understandings on how to provide better care at lower costs. Thus, medical managers pursued social order through interrelating identities and meanings (Schatzki et al., 2001) to actively destigmatize the function of accounting in the eyes of such disengaged clinicians. Janssens and Steyaert (2019, p.532) suggest that "*the particular social order of a diverse organization is constantly accomplished through the enactment of practices*". We contribute to this view by arguing that, through their destigmatizing practice, medical managers engage in manifolds of doings and sayings to enable individuals in non-hybrid roles to develop a better understanding of their hybrid identity (cf. Schatzki, 1996) and thus achieve order.

Finally, our findings extend recent practice-based accounting studies that highlight the mutually constitutive nature between individuals' teleologies and understandings (e.g. Nama & Lowe, 2014; Bui et al., 2019; Begkos & Antonopoulou, 2020). In the case of disengaged clinicians, their limited understandings of accounting reinforced their interest in patient outcomes. Conversely, their predisposition in improving patient outcomes conditioned their understandings of what is deemed useful in achieving such goals. Yet, practice theory studies have not yet explored how such practice elements may shift or reconcile. We contribute to such debates by arguing that practitioners of hybridity facilitate the mutual constitution of individuals' teleologies and understandings through adapting their hybrid identity to bridge professional standards of conduct and raise awareness to differing understandings, goals and priorities.

6.2 Accounting and the proliferation of hybridity through practice

Second, our study contributes to hybridization and healthcare literature via responding to calls for research on how individuals implement and engage with accounting and performance measurement technologies in hybrid settings (Grossi et al., 2017, 2019; Berry et al., 2009; Dobija et al., 2019). Our findings add to existing studies which argue that accounting is increasingly perceived as an integral part of managing clinical practice (e.g. Pettersen & Solstad, 2014; Lapsley & Schofield, 2009; Ellwood, 2008) via demonstrating how medical managers instil such perceptions. Through their hybridization practices, medical managers promote engagement with accounting and performance measurement tools to bridge professional interests and promote synergy between healthcare and finance professionals. In doing so, they selectively emphasize the merits of accounting in improving patient and financial outcomes to clinicians in non-managerial roles. In addition, extant studies have focussed on the specific characteristics of the mediating role of medical managers, highlighting how their hybrid

identity reconciles competing clinical and managerial logics (e.g. Kurunmäki 1999, 2004) through, for example, customizing their vocabulary and adapting their professional identity (Nyland & Pettersen, 2004; Kurunmäki et al., 2003). We add to this stream of research by arguing that the implications of medical managers' engagement with accounting extend beyond their hybrid identity. As medical managers engage and promote engagement, they do not simply mediate between professions; they influence how different professions collaborate and perceive each other, thus inadvertently changing their identity and *hybridizing* them as well.

Our dynamic view of hybridization also responds to calls for further interdisciplinary explorations of how clinicians transform to medical managers in hybrid settings (Grossi et al., 2019; see also Kitchener, 2000; Llewellyn, 2001; Begkos et al., 2019). We demonstrate that medical managers, individuals located in the middle of the organizational hierarchy, shepherd their clinical colleagues through the extant hindrances of engaging with accounting, such as responding to financial pressures and improving their financial literacy through learning-by-doing interactions. At the same time, they educate them in financial jargon in an attempt to navigate them through their organizations' clinical and financial needs (see also Eldenburg et al., 2010; Cork & Devine, 2015). We contribute to prior research that underlines the need for healthcare organizations to cultivate the clinical interest in accounting and management practices (e.g. Kirkpatrick et al., 2012; Jacobs, 2005) via highlighting the constitutive role of medical managers in how hybridity is enacted, not in a vertical or imposed fashion, but also in an emergent way through the middle-out.

Our research also contributes to prior research that highlights that clinicians have traditionally been critical of the legitimacy of using accounting information in healthcare delivery (e.g. Jacobs, 2005; Kurunmäki et al., 2003). We add to such studies via accentuating the motivations behind clinicians' engagement with accounting; they engage, sometimes unwillingly, due to succumbing to cost pressures which derive mostly from centralized cost improvement initiatives. Hybridization, however, was more evident when the use of performance measurement technologies and accounting information was linked with clinical outcomes and potential improvements of their clinical practice. Such findings extend hybridization studies which suggest that clinicians have increasingly become more willing to engage with accounting and performance measurement practices (e.g. Robbins & Lapsley, 2015; Eldenburg et al., 2010; Jacobs et al., 2004) via delineating the practices through which medical managers spark clinicians' interest in improving patient outcomes through engagement with performance and accounting technologies.

6.3 Practical implications, limitations and suggestions for future research

Our study has significant practical implications. Our findings on medical managers' hybridization practices contribute to our understanding of how professionals such as medical managers engage with and promote accounting and performance measurement in their practice. Such findings are valuable to hospital managers and policymakers who are called to ignite the interest of disengaged clinical staff in managing increasing demand for services with constrained financial resources. Our findings extend earlier studies and provide contemporary evidence on clinicians' formal and informal means of financial training (e.g. Cork & Devine, 2015), their financial literacy (e.g. Jacobs, 2005), access and use (e.g. Pettersen & Solstad, 2014) and overall engagement with accounting (e.g. Eldenburg et al., 2010). Practitioners may leverage such evidence through adjusting their clinical engagement strategies at the organizational and national level.

The study is also subject to limitations. First, a limitation relates to the volume of conducted interviews and the two-year gap between our data-collection periods. Our case organization has 19 clinical departments, each led by a medical manager. Across our two data-collection periods, we examined 9 departments via conducting 13 interviews with medical managers. To alleviate such issues, we conducted further interviews with coding specialists who operate across departments, interviewed successive leads of the same departments, encouraged participants to reflect on past years and collected secondary data pertaining to all departments across time. Second, we examine our theoretical constructs to explore the enactment of hybridity through collectively drawing from our two data-collection periods, yet our study does not engage in a comparative analysis of our constructs between the two periods. Future research can engage in longitudinal analyses of how the enactment of hybridity changes over time. In addition, the theoretical framing of this study is limited on medical managers and highlights two recurrent hybridization practices. However, we do not claim that our identified practices are exhaustive but may be pertinent to our specific case organization and research participants. Future research can investigate further hybridization practices of multiple practitioners occupying diverse organizational roles, since findings of this study indicated that both accounting and clinical information are often accessible and used by a multiplicity of individuals.

Finally, our study adopts a practice lens to deliberately move away from a static view of hybridity and instead explore how hybridity is enacted via everyday action at a hybrid organizational milieu. Although our investigation of hybridization as a practice encapsulates many instances of the simultaneous co-existence of phenomena such as accountingization and medicalisation, for example, through medical managers' interpreting of clinical and financial jargon to their clinical and finance colleagues, this could be explored further. We encourage future researchers to further engage with the practice perspective to disentangle and explore the *doing* of accountingization, legitimation, professionalization and medicalisation (e.g. Kurunmäki et al., 2003; Arnaboldi & Lapsley, 2004; Pettersen & Solstad, 2014; Robbins & Lapsley, 2015; Ballard & Elston, 2005) in hybrid settings.

7. Concluding comments

Our study examines the *practice* of hybridization and the various intricacies of how hybridity is enacted in engaging clinicians in non-hybrid roles with the accounting function. We argue that, as medical managers engage with performance and accounting technologies at their practice environment, they enact hybridity and are able to transcend cultural and professional boundaries. As such, this paper responds to calls for further interdisciplinary research of how clinicians transform to agents of hybridity (e.g. Grossi et al., 2019, Llewellyn, 2001) and extends our knowledge around processes of hybridization (e.g. Kurunmäki & Miller, 2006, 2011; Wiesel & Modell, 2014; Kastberg & Lagström, 2019). Although hybridization is intrinsically linked with the notion of clinical engagement, this paper does not claim that clinical engagement with accounting is panacea for competent clinical decision-making. For example, a potential lack of financial training options and access to inaccurate performance information are not simply significant factors that may hamper clinical engagement at healthcare organizations; engaging under such circumstances may lead to unintended, misinformed adverse consequences.

27

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Appendix A

List of interviews

#	Organizational Role	Abbreviation	Date
1	Medical Manager of Specialty 1	MM-1	28/01/2014
2	Medical Manager of Specialty 2	MM-2	07/02/2014
3	Medical Manager of Specialty 3	MM-3	07/02/2014
4	Medical Manager of Specialty 4	MM-4	11/02/2014
5	Medical Manager of Specialty 5	MM-5	11/02/2014
6	Medical Manager of Specialty 6	MM-6	12/02/2014
7	Medical Manager of Specialty 7 and Business Manager of Specialty 8	MM-7 & BM-8	24/03/2014
8	Medical Manager of Specialty 8	MM-8	31/03/2014
9	Business Manager of Specialty 8	BM-8	30/04/2015
10	(former) Medical Manager of Specialty 7	MM-7	01/11/2018
11	Medical Manager of Specialty 9 and Business Manager of Specialty 9	MM-9 & BM-9	01/11/2018
12	(new) Medical Manager of Specialty 4	MM-4b	07/11/2018
13	(new) Business Manager for Specialty 7	BM-7b	09/11/2018
14	Medical Manager of Specialty 5	MM-5	09/11/2018
15	Clinical Coding Lead for Specialty 7	CCL-7	21/11/2018
16	(new) Medical Manager for Specialty 6	MM-6b	03/12/2018
17	Head of Clinical Coding and Clinical Coding Auditor	HCC & CCA	07/12/2018
18	Business Manager for Specialty 6	BM-6	23/01/2019

We interviewed professionals from the following specialties, presented in alphabetical order: Accidents & Emergencies, Critical Care, Dermatology, Emergency Medicine, Medical Neuroscience, Neurosurgery, Orthopaedics, Radiology and Renal Services. We refrain from categorizing interviewees to specific specialties to preserve anonymity.