Simon Moralee
Manchester Business School
simon.moralee@mbs.ac.uk
Sub-theme 18: Actors and Institutions: Alternative Currents

Relegitimizing the medical profession: the role of opinion leaders in maintaining institutions through engaging with change.

Purpose of the paper

This paper seeks to address how actors from an elite social position (known herein as 'opinion leaders') have engaged with change, which maintains the institution and relegitimizes its role. Situated in the case of the medical profession within the English National Health Service (NHS), this paper aims to explore and explain how individuals have taken the opportunity and advantage of a particular context, time and space in the NHS 'story', to practise, act and work to bring about change to medical education. Its key focus considers change affecting the medical profession and medical education, within the case study of the *Enhancing Engagement in Medical Leadership* (EEML) project (Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement, 2010). Medical education plays a key role in forming the medical profession and both can be conceived of as institutions, within a wider institutional field of the NHS. In linking to this sub theme it aims to offer some explanations as to why certain actors have the capacity and freedom to exercise agency within a particular institution or culture and explores the links between actors and institutional outcomes.

Context and background

There have been a number of changes and events in the NHS, and in the subset of medical education, which have created changes and shifts in the medical profession. Successive UK governments have long been faced with multiple challenges in providing health care to the population centred on an increasingly ageing population, technological advancement, public expectations and the impact these have on providing sustainable services within a cash-limited public sector operating budget. Of course, this is not unique to England. Many of these changes and resultant challenges can be characterized as part of the trend towards New Public Management within the public sector in the UK and notably within the NHS

(Kirkpatrick et al., 2005), starting with the publication of the so-called Griffiths Report or *NHS Management Inquiry* (Department of Health and Social Security, 1983). One of the ways in which government has, over a long period of time, sought to gain greater control over the money spent is through greater control over the clinicians, notably doctors, making the decisions to treat (or not). As Kirkpatrick et al. (2005) argue, medical knowledge improves all the time and so do treatments. Along with the "…increased organizational efficiency, effectiveness, and productivity defined and measured in technological terms" (Diefenbach, 2009: 894), which has created a secure market for drugs and machinery, standards of health are increasingly seen more as conventional and societal rather than absolute, so ever growing demand and capped supply, together have the potential to lead to tension and conflict.

Moreover, other factors have contributed to general conditions for change, out with the above rationale, notably a number of 'scandals' of care in recent NHS history. The Bristol Royal Infirmary Inquiry (Kennedy, 2001) took place in response to higher than expected death rates in paediatric cardiac surgery between 1984-1995, where poor leadership, staff shortages and a culture of secrecy were blamed. In Liverpool, organ retention without consent at Alder Hey Hospital led to a change in the way in which tissue samples and organs were handled in the 1990s (Royal Liverpool Children's Inquiry, 2001). The Shipman Inquiry (2005) was an independent private inquiry into the practices of Dr. Harold Shipman, a Greater Manchester GP, which took place after a criminal investigation into Dr. Shipman, who was found guilty of the deaths of at least 15 patients in his care, with the suspicion of hundreds more.

In addition, within medical education there has been the failure of the Medical Training Application Service (MTAS), which was an online application system, set up as part of *Modernising Medical Careers* (Department of Health, 2004), through which doctors in training were required to apply for posts. Candidates were asked questions which were then used to shortlist them for interviews, giving greater weighting to their short answers rather than prior experiences or qualifications. This led to criticism and lack of support from the medical profession, which ultimately led to its failure.

More widely the conditions for change generated by social movement and the general direction of various governments' policy, with the increased appeal of 'managerialism' or 'leaderism' (O'Reilly and Reed, 2010) have helped to establish an

alternative narrative (Ackroyd et al., 2007; Bolton et al., 2011) and usher in an emergent institutional logic, which is part of a broader trend of professionals within modern businesses and corporations (Muzio et al., 2013). Conflict between this emerging logic and the established, institutionalized logic of the medical profession (of 'doctor knows best' and its regard as the highest of health professions) and its relationship with the public and the state has created pressure for change (Thornton, 2002). Such changes have impacted on the role of medical professionals and the arrival of the EEML project may only serve to further shape the relationship between government and the medical profession, impacting on their professional autonomy, self-regulation, authority, theoretical knowledge and distinctive occupational culture (Davies & Harrison, 2003; Freidson, 1984; Macdonald, 1995; Russell et al., 2010; Storey & Holti, 2009).

Whilst this case study might not be considered a purely medical 'professionalization project' for jurisdictional maintenance (Abbott, 1988; Kitchener and Mertz, 2012), a number of key occupational actors have used such changes and events – alongside their unique social positions – to bring about a project that in many senses aimed to change, renew or even relegitimize, the medical profession.

Theoretical background

This paper draws upon theoretical and conceptual positions located broadly within the field of neo-institutional theory, in particular the emerging field of institutional work (Lawrence and Suddaby, 2006). With that, its focus is more towards agency than structure, whilst accepting their inherent duality (Giddens, 1984). Within a broader context of professionalization and change, it draws also on concepts within practice theory (Feldman and Pentland, 2003; Feldman and Orlikowski, 2011) and sensemaking (Weick, 1988, 1993, 1995), whilst findings offer a contribution to concepts of symbolic capital (Bourdieu and Wacquant, 1992) and social position, building on the work of Battilana (2011) and notably Lockett et al. (2014). The relationship between these different theoretical concepts is depicted in figure 1.

Institutional work is described as the "...purposive action of individuals and organizations aimed at creating, maintaining and disrupting institutions" (Lawrence and Suddaby, 2006: 215). It is a relevant theoretical construct because it enables the

study of agency (the actions of individuals) within a professional field (medical education). It can be applied at the multi-organizational level, where organizations are embedded in society and supported by other institutional structures, allowing for analysis that transcends any particular organisation or institution.

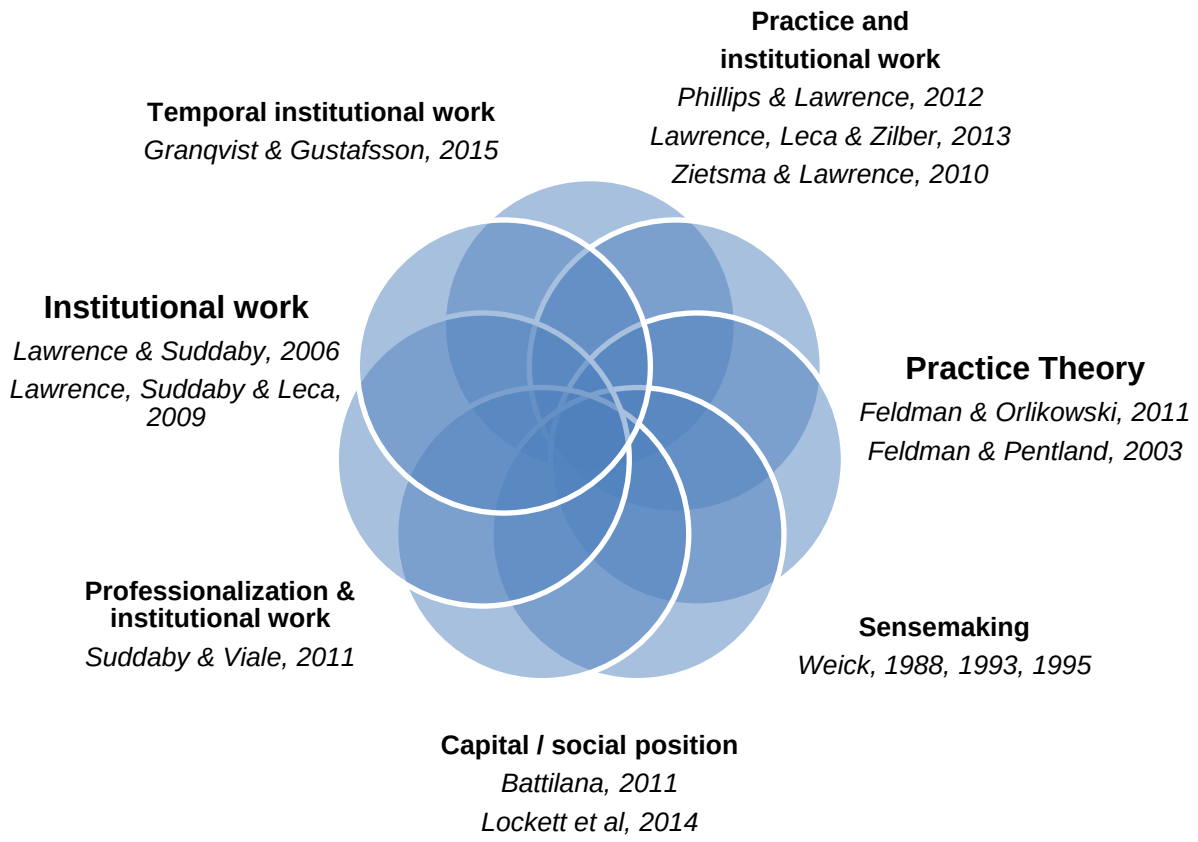


Figure 1. Theoretical Map

In trying to understand these practical actions and how they impact on institutions, institutional work chooses to look at "...the nearly invisible, often mundane, day-to-day adjustments, adaptations and compromises of actors attempting to maintain institutional arrangements" (Lawrence et al., 2009: 1). The emphasis here lies in understanding "...the ways in which disparate sets of actors, each with their own vision, can become co-ordinated in a common project" (Lawrence and Suddaby, 2006: 249) such as the EEML. Using institutional work as a key theoretical framework allows the exploration of how a number of opinion leaders, in their practices and actions, engaged with and responded to changes and events in the institutional field of medical profession and medical education, and have used those changes and events to effect change within medical education.

As Barley and Tolbert (1997) suggest, where an institution is at risk of change over a period of time, where flows of actions can be charted over that period and where scripts can be identified and then examined for evidence of change, then an institution can be studied and any results linked to other sources of change within that institution. Incorporating an institutional work approach allows for a focus on the agency perspective related to this process of change within such institutions. For example, as the project that was conceived was purposive, intended, and effortful, it is a clear example of institutional work (Lawrence et al., 2009). Therefore, in the given context, how organizations and actors interact, what levels of agency they display and the role of 'institutions' in governing and guiding behaviour are central to understanding how change is enacted within this project.

The institutional field in this case also incorporates national health policy. Whilst this was not an imposed policy change, the general conditions for change do raise questions about why the project (as an instance of change) was instigated and how the change was implemented and practised, opening up avenues for exploring the dynamics and tensions inherent in change processes. Two recent studies (Suddaby and Viale, 2011; Granqvist and Gustafsson, 2015) help to elaborate on such matters.

Suddaby and Viale (2011: 423) investigated the reciprocal dynamics between processes of institutionalization, incorporating institutional work, and processes of professionalization, "…explicat[ing] the professional project as an endogenous mechanism of institutional change." What is particularly relevant from their research with regard to this paper is the focus on both institutional work and professional agency. As it explains, they observe:

> "…four essential dynamics through which professionals reconfigure institutions and organizational fields. First, professionals use their expertise and legitimacy to challenge the incumbent order and to define a new, open and uncontested space. Second, professionals use their inherent social capital and skill to populate the field with new actors and new identities. Third, professionals introduce nascent new rules and standards that recreate the boundaries of the field. Fourth, professionals manage the use and reproduction of social capital within a field thereby conferring a new status hierarchy or social order within the field" (Suddaby and Viale, 2011: 423)

Suddaby and Viale (2011: 429, 433) argue that "…professionals initiate institutional change as an inherent component of redefining their own professional projects" and

thus "…hold considerable power to effect change not only because of their expert knowledge, but also because of their sensitivity to, and skill in manipulating, the social order within a field." Such enactment of endogenous change, rather than just responding to any external 'shock', is crucial in understanding how the project in this case study may have been initiated in response to general conditions of change and how actors seized upon a window of opportunity to bring it about.

Another such study into the dynamics of institutional work comes from Granqvist & Gustafsson (2015) with the identification of *temporal* institutional work. Departing from Emirbayer and Mische's (1998: 962) view that agency is a "…temporally embedded process of social engagement", their development of this concept demonstrates how actors engage in action despite the accepted pressures of time inherent within institutional processes to "…construct, navigate and capitalize on timing norms in their attempts to change institutions" (Granqvist and Gustafsson, 2015: 38). By doing so, they undertake three distinct processes: firstly, constructing urgency, whereby actors express "…perceptions that change was necessary" (p.17); secondly, entraining, where activities were aligned with external timing norms and finally through enacting momentum, which describes how processes are "…in motion towards future outcomes" (p.18).

To help further understand the dynamics and tensions within this case, the related theoretical concepts of practice theory and sensemaking can help us to understand how individuals make sense individually and collectively to navigate their way through this institutional and policy field.

Incorporating a practice theory perspective allows for an understanding of how institutions, which are acclaimed for their stability and enduring nature, can be subject to change, yet remain institutions within a social world. In a typical organization theory diagram Feldman and Orlikowski (2011) depict practice as the 'arrows', which permits an understanding of how actions produce outcomes. The use of practice theory allows for focus, not only on the entity that results from actions and practices and ultimately the change they create, but also on understanding the dynamic and relations between practices that constituted the entity. Chia (2003) explains how people and their actions, within the context of their 'in-work' and 'out-of-work' experiences, form institutionalized codes of behaviour, rules, procedures – and

practices – that give them an organizational world that appears external, objective and seemingly stable. Focussing on what interactions may have occurred between different agents (individual actors, organizations and institutions), may include consideration of the resistance of individuals towards the context (organization, institution etc.), without falling into a trap of reifying either the individual or institution. Practice theory therefore allows a focus on the practices themselves and the dynamics between practices, agents and the routines and processes they negotiate and (re)produce. The subsequent findings and insight resulting from its application can therefore help to understand how agency is shaped by but also produces, reinforces and changes structure (Feldman and Orlikowski, 2011). What is less understood is how this reality gets constructed and from what it is constructed in the first place.

Where institutional work and practice theory can be drawn together is in the recognition of "…the role of actors in socially constructing elements of work and organizations that were previously seen as either 'natural' or beyond the control of individual actors" (Phillips and Lawrence, 2012: 224). As Lawrence et al. (2013: 1024) reflect on Phillips and Lawrence (2012), what connects these kinds of work is that actors are engaged in purposeful effort, one of the key tenets of institutional work. This highlights institutional actors as reflexive, goal-oriented and capable, focusing on their actions as the centre of institutional dynamics and striving to capture structure, agency and their interrelations (Lawrence, et al., 2013: 1024; Battilana et al., 2009).

Moreover, Zietsma & Lawrence (2010: 190) discuss explicitly the links between institutional work and practice, referring to "…institutional work aimed at creating, maintaining or disrupting practices as 'practice work,'" expanding our understanding of the interplay between institutional and practice work, the latter of which is defined as "recognized forms of activity" (Barnes, 2001: 19). Smets and Jarzabkowski (2013: 1279, 1280) take this beyond purposive institutional work to further "…current understanding of agency, intentionality and effort in institutional work by demonstrating how different dimensions of agency interact dynamically in the institutional work of reconstructing institutional complexity," thus situating "…institutional work in the practical work through which individuals encounter

contradictory institutional practices, negotiate adaptations that facilitate task accomplishment, and reconstruct their underlying institutional logics."

Therefore, in concert with institutional work, practice theory can offer an innovative and critical perspective on the role of institutions and agency within them, given that institutions not only shape individuals' practices but individuals' practices constitute and reproduce institutions (Battilana and D'Aunno, 2009).

How might such practice be informed? A further theoretical construct could be considered to be relevant here and therefore within the framing of this case. In bringing about change, the stakeholders engaged with the project would also need to make sense of their aims, their practices, their relationships, their emerging outcomes and so on. In conceptualising how individuals make sense of change, Balogun and Johnson (2005: 2) recount how "…recipient interpretations of change plans, and how these interpretations are mediated by their existing context of action, ways of thinking, and interactions with others, are likely to be key." Whilst no single definition exists, Brown et al (2015: 266) explain that there is "…an emergent consensus that sensemaking refers generally to those processes by which people seek plausibly to understand ambiguous, equivocal or confusing issues or events." The concept of sensemaking within organization studies is associated primarily with Weick (1988, 1993, 1995) and is relevant in this type of research because it can offer insight and explanation as to how individuals choose to practice, interact, behave, make decisions and form ideas and actions. Weick established seven sensemaking properties (Weick, 1995) that comprise the concepts of identity, retrospection, enactment, socialization, as well as detailing how sensemaking is ongoing, that individuals 'extract cues' from the context and how plausibility is favoured over accuracy in accounts of events and contexts.

For example, in the case of understanding how decisions are made, March (1989: 14) argues that "…decision making is a highly contextual, sacred activity, surrounded by myth and ritual, and as much concerned with the interpretive order as with the specifics of particular choices." A sensemaking perspective offers an opportunity to examine the interpretive order of actions, practices and decisions that individuals embark upon to give order and meaning to their lives (Currie and Brown, 2003), because it allows multiple voices and actively authored narratives to be heard and

interpretive discourses to be explored (Buchanan and Dawson, 2007; Brown et al., 2015). Zilber (2007: 1049) argues further that the processes of social construction and sensemaking are useful for understanding "…the micro processes that underlie macro processes" within institutions. This helps to draw sensemaking and the field of institutional work together.

In trying to further understanding of the interpretive order of sensemaking, Lockett et al (2014: 1122) examined the influence of actors' unique context, as characterized by their social position, on their sensemaking about organizational change and concluded that "…actors within a professional group may sensemake in different ways which are shaped by their individual endowments of cultural capital." From the starting point of the influence of context on sensemaking, Lockett et al (2014) frame context as the raw materials for actors' "disciplined imagination" (Weick, 1995: 18) to help explain why their "…sensemaking may differ when confronted with a common phenomenon and how the social processes of sensemaking will be influenced accordingly" (Lockett et al., 2014: 1103).

Relatedly, Battilana (2011) examined the relationship between social position and organizational change in diverging from the institutional status quo and found two types of change that diverged from the institutionalized template of role division: firstly, among organizations and professional groups and secondly, how actors with different social position profiles were likely to undertake the different types. Actors may be at the centre of one field but at the periphery of another and high-status individuals may be the ones to initiate organizational change. In understanding this puzzle of "…how central players become motivated to effect changes in practice" (Zietsma and Lawrence, 2010: 190), the interdependence of practice, context and social position (Suddaby and Viale, 2011) becomes more important. Each actor's context and endowments of cultural, social and economic capital can act as a force that impinges "from the inside" (Martin, 2003: 1), which may help us to understand how endogenous change occurs even from those in positions of strong structural legitimacy (Lockett et al., 2012; Suddaby and Viale, 2011).

Influenced by their social position, which helps actors to utilise their cultural capital, both the Battilana (2011) and Lockett et al (2014) papers further help to frame the exploration of the role of opinion leaders within a change initiative, by highlighting the

role, position and capital endowments they have that inform their sensemaking – and how they make decisions regarding practice – in the organizational change process (see figure 1a).

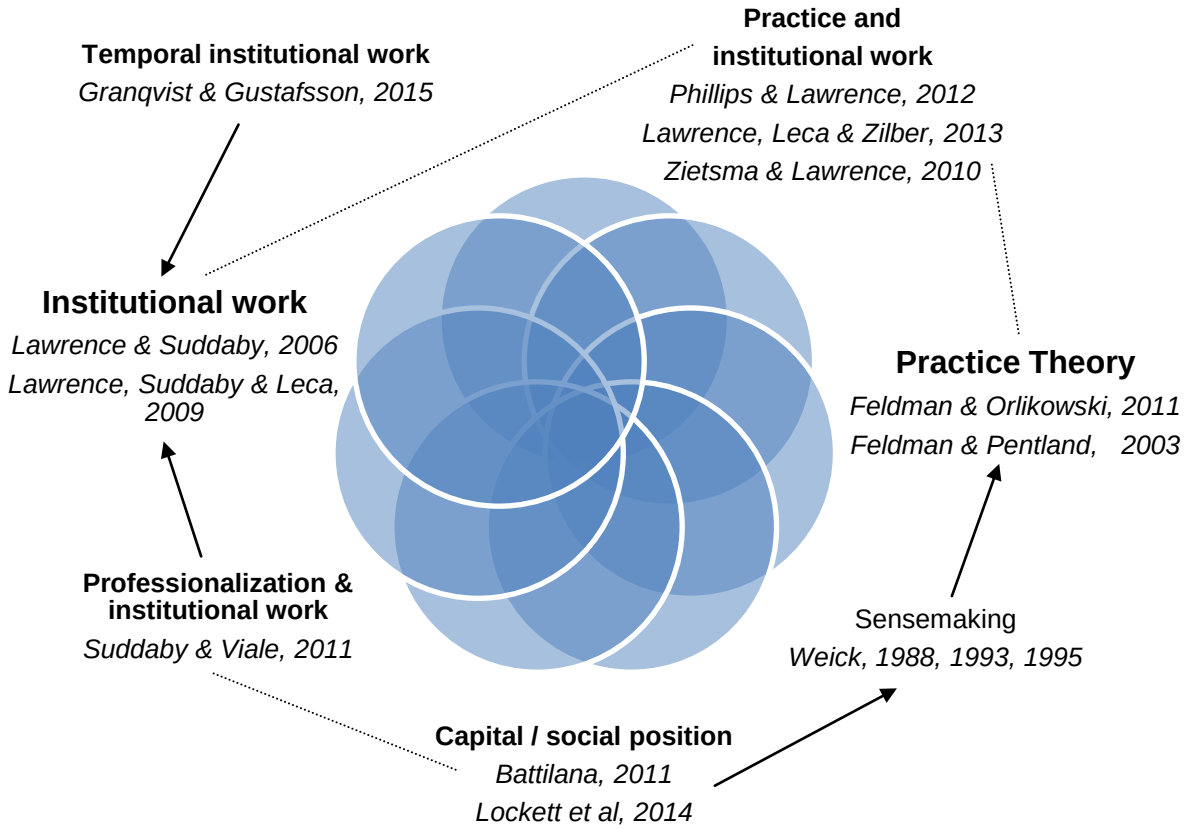


Figure 1a. Theoretical Map revisited

<u>The research gap that is addressed</u>

The case under consideration focuses on a group of opinion leaders and their work within a medical education change initiative. The opinion leaders were members of a project team and steering group of a change initiative called *Enhancing Engagement in Medical Leadership*.

In 2005, government and the medical establishment, seeking to introduce new training and development in leadership and management for trainee and established doctors, began a project entitled *Enhancing Engagement in Medical Leadership* (EEML) (Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement, 2010), which, amongst other things, resulted in the creation of the *Medical Leadership Competency Framework* (MLCF) and *Medical Leadership*

Curriculum (MLC) (Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement, 2009a, 2009b). This framework (figure 2, below) describes the leadership competences doctors need to become more actively involved in, when it comes to the planning, delivery and transformation of health services (Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement, 2009a).

Figure 2. Medical Leadership Competency Framework (Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement, 2009a)

It forms part of a wider approach to leadership within the NHS, centred on a model of shared or distributed leadership, which is deemed appropriate where tasks are complex and highly interdependent (National Leadership Council, 2011). The rationale for its implementation comes from the premise that leadership is a key part of a doctors' professional work regardless of speciality and setting. It is already a requirement of all doctors as laid out in *Good Medical Practice* (General Medical Council (GMC), 2009) and *Management for Doctors* (GMC, 2006). The framework focuses on four key competence areas: knowledge, skills, attitudes and behaviours, which doctors will work towards achieving as they progress through their training. Whilst it may be too early to fully evaluate its impact, its implementation may have significant implications in effecting change within the medical profession and medical education and these changes may be experienced differently across specialty training programmes and across different grades of doctors in terms of how the role, perception and identity of doctors is affected.

The MLCF/MLC outcomes could be cast as mediating objects (Macpherson et al., 2006) in changes to medical education as well as the final entities of the EEML

project, within an institutionalized and relatively stable world of the medical profession. As practices occur, individuals take action, processes change and routines are established and then subsequently reproduced. The resulting outcomes can be understood not so much as to why they happened, but in the way in which and how they occurred, and how individuals made sense of what occurred. The research, upon which this paper is based, aims to examine what individuals did and how and when they carried out their actions in relation to others, as well as the introduction of the MLCF/MLC, to bring about a better understanding of micro-level processes of change within the medical profession and medical education. By doing so, it aims to inform how successful change can be enacted within wider professional groups through the elite social position of embedded institutional actors that expands on and challenges the dominant institutional logic, building on the theoretical concepts outlined above, including the work of Battilana (2011) and specifically Lockett et al. (2014) on social position and organizational and institutional change.

The approach taken

The EEML project could be considered a single case study, within a complex institutional setting, much like the *Europeana* initiative (Kallinikos et al., 2013). The rationale for choosing the EEML project as an object of empirical inquiry was threefold. Firstly, it had national-level sponsorship and status, making it an intriguing case for examination. Secondly, this project directly involved a multitude of senior NHS bodies, representatives and individuals, all drawn together under one project banner. Thirdly, as outlined above, whilst engagement involving the medical profession in policy change had been attempted before, there had been limited attempts to do so conspicuously through the curriculum, the primary means by which doctors' competence are assessed and the philosophical aims of educating doctors are achieved. Moreover, there was also very little in the existing literature that had explored how doctors could be developed in leadership and management skills and knowledge through the curriculum and by way of competency framework.

The research followed this case at the completion of the project in 2010 due to circumstance and serendipity as that is when the research study began and I was made aware of this recently completed project by an external academic advisor. The first stage involved the collection of background and contextual information from

known sources as well as the reading of relevant literatures on previous attempts at medical engagement. A second phase was undertaken in 2012, interviewing a number of key personnel from the project's main team and an associated project steering group. A third stage, the analysis of a collection of published and unpublished documents from the project has been recently embarked upon. This paper will concentrate on data emanating from the interviews' phase.

Methods of analysis

Drawing on concepts mainly within institutional work and practice theory and using an abductive style (Cunliffe, 2011), an open coding approach was initially adopted to ascertain key themes and significant events (Barbour, 2007). Each interview was analyzed and codes assigned, within NVivo 10 software (QSR International Pty Ltd, 2012), which related to relevant themes from either the main doctoral research question, relevant literatures or which were identified *in vivo*.

A sample of the coding frame (figure 3) is below:

Level 1 Node	**Level 2 Node**	**Level 3 Node**	**Definition**	**Linked to... (code / concept)**	**Source of Code**	**Created**
Actions						22.7.13
	Behaviours (Behaving)		Mindset, mental approach, personalities, attributes , OR actions/practices	Legitimacy	Lofland et al (2006); Taylor & Gibbs, 2010)	4.6.13
		Credibility	Any mention of the word OR similar	Legitimacy		4.6.13
		Culture	Working culture "getting on with others" (#16)	Teams Organization	Org/Inst. Theory literatures	5.6.13
		Enthusiasm	passionate, keen etc. LINKED TO motivation of individuals		*In vivo*	22.7.13

Figure 3. Coding frame or 'template'

Creswell (2008) describes how case study analysis should be both descriptive and thematic. The process should take the researcher from many pages of text, iteratively to tens of codes and ultimately to between five and seven themes.

In seeking out codes, a number of variables or elements could be considered, such as a participant's role in the project; their position or job; membership of a particular group or professional body; job and work experience; experience and involvement in change projects. In coding the data and drawing on constructs from the research design and literature review, codes were grouped together to become themes, some of which you would expect to see in research into a change initiative and others that were less expected.

As the analysis of all the interviews followed the same pattern as detailed in figure 3, the end result was the creation of a thematic map (see figure 4) which identified major elements of the case.

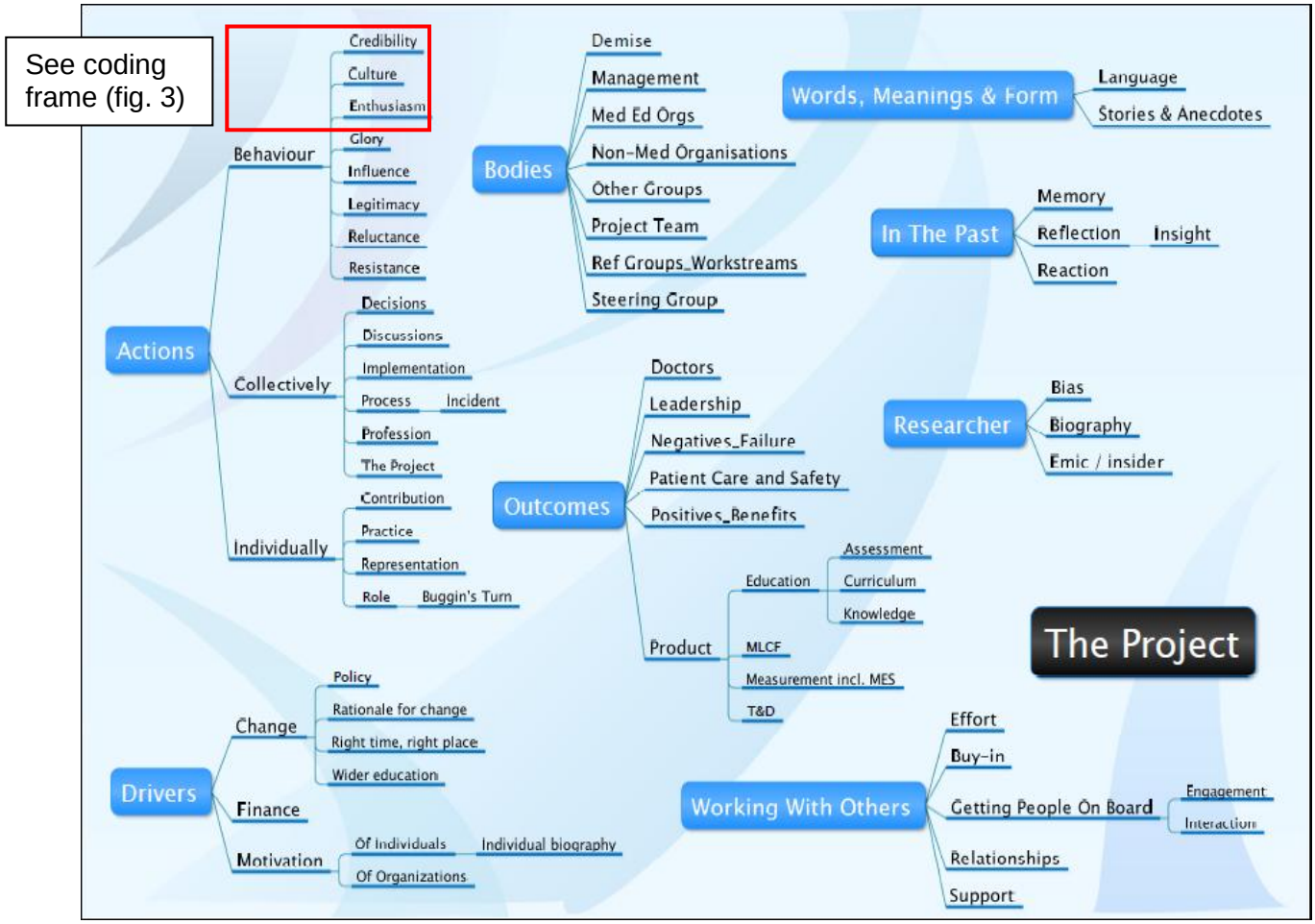


Figure 4. Thematic Map of "The Project"

Four key stories became prominent:

1. **“if we don’t do it to ourselves, somebody else will do it to us”** *(links to figure 4: action – behaviour – enthusiasm; drivers – motivation – of individuals/individual biography)*

This quote from interviewee #2 captured the idea that how the medical profession were trained, organized and managed with the NHS system was at a point of particular scrutiny and therefore subject to general conditions for change. This quote revealed that the medical profession had a choice: be part of influencing and leading that change if it decided to or choose to allow the change to happen to it.

2. **A sense of mission and purpose that the project was for the good of the profession** *(links to figure 4: drivers – change – rationale for change; outcomes – positives/benefits)*

All of the interview participants spoke of a need for the project, not as a defence mechanism to change as might be inferred by the above, but as a way of ensuring the profession was in the best possible state to carry out its role as care givers and system leaders within the NHS.

3. **A sense of belonging to a great team** *(links to figure 4: working with others – relationships)*

A number of participants discussed how working together, with people whom many knew from before, as well as others who shared the same desire for the project as a change initiative to succeed, was both motivating in bringing about change and crucial to ways and approaches of working.

4. **This was a particular time and space that allowed the project to happen** *(links to figure 4: drivers – change – right time, right place)*

Although a few participants did identify a key event in the NHS ‘story’ as a driver for the change initiative, there was little consensus around one event; rather, a number of events as well as general conditions for change were seen as creating an enabling environment for this change.

In considering the first story, the majority of the interviewees mentioned the need to do this project and the values that underpinned that [second story]. By considering drivers for change [the fourth story], it could also be seen that, alongside the new relationships created from working on the project, prior relationships [third story] that existed between the interviewees allowed a number of the key stages of the project to unfold and occur.

As a consequence of the number of participants mentioning their prior relationships to other participants, I began to explore which participants were connected to each other to see if there was anything significant in these relationships. Subsequently, a 'relationship map' was drawn (see figure 5) to indicate the key links that existed prior to the project and this highlighted those that were particularly between opinion leaders and others within the project team and steering group and the particularly important roles played by these few high-status individuals. I then explored all coding under 'relationships' to consider how their existing relationships influenced the process and practice of the project.

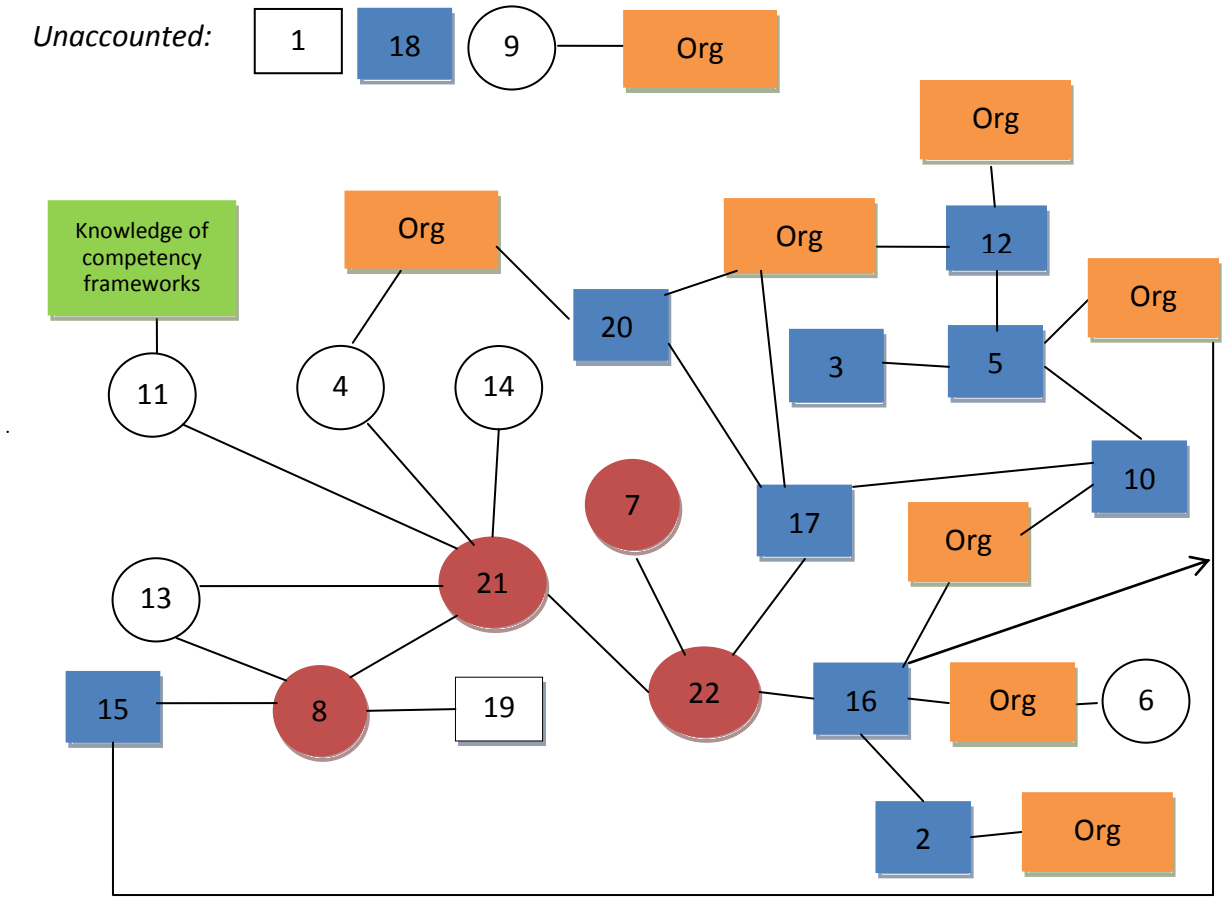
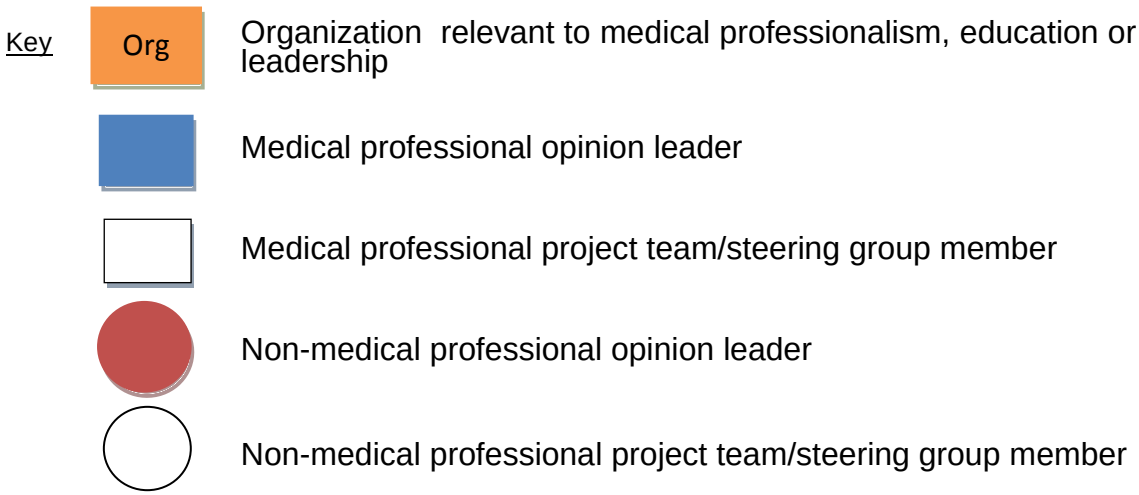


Figure 5. Relationship / Network Map



What was evident from this map was the nature of the relationships between certain stakeholders that had been developed over a number of years, largely because of their shared interests in medical leadership and management. They were all in senior positions within the NHS and had been involved in previous change initiatives within the medical profession, medical education and in relation to organizational development, leadership, management and service improvements.

This discovery helped to elucidate Battilana's (2011) work, which examined the relationship between social position and organizational change in diverging from the institutional status quo. In the two types of change that diverged from the institutionalized template of role division both among organizations and professional groups, her study found that actors with different social position profiles were likely to undertake the different types. Significantly, actors at the centre of one field (medical education) were at the periphery of another (leadership and management development and change) and my findings confirmed that high-status individuals – opinion leaders – were the ones to initiate organizational change. Moreover, Lockett et al. (2014) examined the influence of actors' unique context, as characterized by their social position, on their sensemaking about organizational change. They concluded that "…actors within a professional group may sensemake in different ways which are shaped by their individual endowments of cultural capital" (Lockett et al., 2014: 1122). An initial interpretation of findings, which is presented in the next section, builds on Lockett et al.'s (2014) work, adding further constructs to their model of sensemaking about organizational change.

Main findings and contributions

There are two key and emerging themes from the initial interpretation of data findings.

Firstly, the findings argue that individuals' unique contexts and positions contributed towards their own sensemaking, even when confronted with a common phenomenon. This builds on the work of Battilana (2011) and Lockett et al. (2014) and extends the latter's model of the influence of social position on sensemaking about organizational change (see figure 6) by adding two emerging concepts, *system capital* and *system centrism*, to the debate about sensemaking.

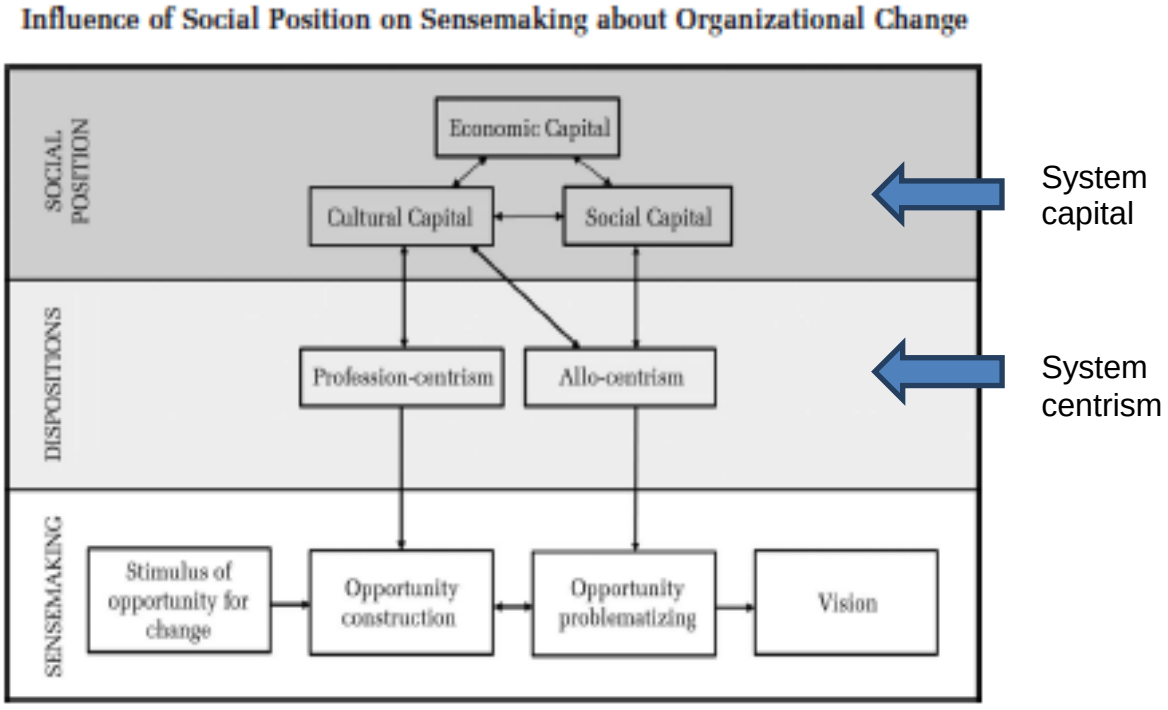


Figure 6. Lockett et al (2014: 1119)

System capital is an extension of social capital (SoC), but which incorporates symbolic (SyC) and cultural capital (CC). It incorporates knowledge, skills, tastes and preferences (CC) as well as mutual relationships and acquaintances (SoC) and honour, prestige and recognition (SyC). Individuals with a social position that incorporated system capital were uniquely able to come together to bring about the EEML project, which was a nationally and professionally recognised, well-funded project that successfully introduced leadership and management knowledge, skills, attitudes and behaviour (KSAB) development into every medical curriculum; for the

first time, this ensured that every doctor in training and up to five years post training would develop KSAB regarding leadership and management within the context of the NHS.

Following Suddaby and Viale (2011: 434), this was a professional change project of largely endogenous origin enacted by a few opinion leaders, drawing on "their unique access to a wide range of different forms of capital within an organizational field as well as their facility in moving between different forms of capital." Firstly, the EEML's opinion leaders used their expertise and legitimacy to challenge the incumbent order – *the one in which they were the incumbents* – to define a new, open and uncontested space for medical professional identity. Secondly, they used a related form of their inherent social capital – which I have called *system capital* – and skill to populate the field with new ideas and entities. For example, by creating and then utilizing the artefact that is the Medical Leadership Competency Framework (MLCF) itself, they were able "…to facilitate the transition between past habits and the elaboration of new habits for the future" (Lawrence et al., 2013: 1028; Raviola and Norbäck, 2013; Callon, 2009) and bring about a new language of medical leadership. Thirdly, and again through the introduction of the MLCF, these opinion leaders introduced nascent new rules and standards that recreated the boundaries of the field, as MLCF competencies became newly embedded into curriculum standards. Finally, they used and reproduced their system capital to confer a new status hierarchy or social order within the field, which was the cultural acceptance of doctors as leaders within the health system.

Using their prominent and powerful position within this institutional field and drawing together their reserves of system capital, these opinion leaders collectively were able to exert profound social change towards and within the medical profession (DiMaggio and Powell, 1983; Dorado, 2013).

System centrism is a disposition – defined as habitualized know-how's and enduring ways of seeing (Bourdieu and Wacquant, 1992) – that extend beyond orientations towards one own's inter/intra professional groups (profession-centrism) or is contingent on thoughts and actions of others (allo-centrism). In line with Lockett et al (2014), system centrism is both profession-centrism and allo-centrism but crucially also extends to awareness and understanding of the interests and perspectives of

non-professional groups (such as taxpayers and service users) and captures a system-wide perspective that is yet to be accounted for. Responding to a series of events (see Table 1), these opinion leaders were able to translate them into motivation to effect changes in practice (Zietsma and Lawrence, 2010), demonstrating how a combination of exogenous and endogenous change, led to system wide change.

Factors ('drivers') bringing about the EEML project, both exogenous (events) and endogenous (professional project):
a. European Working Time Directive (1998, 2004) impact on training time
b. Agenda for Change (2004)
c. *Doctors in Society: Medical professionalism in a changing world* report (Royal College of Physicians, 2005)
d. Medical Training Application Service (2006/7)
e. *Modernising Medical Careers* inquiry (Tooke Report; MMC Inquiry 2008)
f. *High Quality Care for All* (Darzi Report; Secretary of State for Health, 2008)
g. GMC appraisal / revalidation / fitness to practice, e.g. Bristol, Alder Hey, Shipman
h. International comparators, e.g. Kaiser Permanente, Cleveland Clinic
i. Various articles in the British Medical Journal / Health Service Journal / King's Fund reports/articles
j. Enthusiasm of younger doctors

Table 1: A series of 'related' events

None of these alone was a significant 'shock' to the system to motivate any particular group of individuals to enact change to the role and training of doctors in management and leadership. However, collectively, they constituted general conditions for system change and may help to explain why the opinion leaders took advantage of this window of opportunity. As Zietsma and Lawrence (2010: 217) contest, "…(f)ields and firms that expose their practices to societal influences are likely to experience regular incremental change that maintains their legitimacy, rather than threatens it, and ensures that insiders' practices are in step with societal norms."

In summary, the key argument here is how opinion leaders used their prominent social positions, reserves of system capital and disposition towards system centrism to take advantage of a window of opportunity caused by a number of related events to bring about fundamental institutional change.

Secondly, building on Granqvist and Gustafsson's (2015) notion of temporal institutional work, the findings offer insight into how individuals practised change and offer an empirical contribution to working with professions to deliver successful institutional change (Zietsma and Lawrence, 2010).

This can be conceptualised as a *five-step "mirroring"* process:

1. Foresee prevailing conditions: doctors had a role and responsibility to be engaged and only someone or a group of opinion leaders from inside the system could see the opportunity and use it. This is supported by Granqvist and Gustafsson's (2015) notion of constructing urgency, whereby all research participants expressed the need for change, including those in prominent positions, as exemplified by these examples:

   > *"I think, in a broader sense, that compact between doctors and the public had started breaking down because of the number of incidents. And I guess that led to the Doctors in Society report by the Royal College of Physicians, it's like actually, we, as the medical profession, we're in danger here that if we don't do something about this, and actively demonstrate that we are making every effort to make sure we are professional, that we are safe clinically, that we're looking for good quality outcomes, that we can regulate ourselves, then the profession's going to be in a lot of strife. So I guess that set the scene.* [Interviewee #4]

   > *"So part of it, I think, was a recognition about, you know, the stereotypical golf and the black hole, you know, and going to the dark side and all of those things that people quote. So I think to begin with it was much more around a recognition, we can't have doctors outside the tent, we need doctors to be very much in the driving seat. And this was ahead of reform agenda, of course, but this was recognising that doctors had an absolute essential role to play, and a responsibility actually. So it was a both/and."* [Interviewee #13]

2. Link the opportunity to key policy thinking and the societal 'temperature' towards the role of the profession (doctors). This relates to both exogenous and endogenous factors identified in Table 1 above and supports the direction of travel that emerged as part of the *Health & Social Care Act* (2012) around medical leadership. Likewise, this is related to Granqvist and Gustafsson's (2015) notion of entraining, where key stages in the project were linked to events such as

the consultation on the GMC's (2009) *Tomorrow's Doctors*, as demonstrated by these examples:

> *"How do we get the undergraduate medical schools to take this seriously? Well we have to incorporate it in Tomorrow's Doctors. And if it's in Tomorrow's Doctors, they have no choice. So how do we get it into Tomorrow's Doctors? Well there's a Tomorrow's Doctors working group led by such and such. So we'd say, well could you perhaps arrange for us to be invited and maybe you could come with me to that meeting and so they'll be really clear that you support this and then I'll do the talking."* [Interviewee #21]

> "*There were always ebbs and flows. There were stages where for example we needed it to get into Tomorrow's Doctors, where we needed it to be embedded in the specialty curricula that each of the medical royal colleges produced. Those were a lot of waiting periods where in some ways there wasn't a lot we could do until we knew that it was going to be included in Tomorrow's Doctors. So Tomorrow's Doctors which is the guidance for undergraduate education, we lobbied for, we created guidance to make sure it was integrated into, or guidance to help medical schools integrate the competency framework into their curriculum and everything."* [Interviewee #4]

3. <u>Build the project infrastructure.</u> This also positions the project as legitimate in the eyes of the profession, through the creation of the project team and steering group, sourcing of funding and high-level sponsorship and support:

> *"The project, I think, gathered its momentum and I think because of its endorsement by quite a lot of high level organisations and individuals it gave people a sense of meaning, we are doing something quite useful here."* [Interviewee #8]

> *"So at that meeting, [X] would kick it off by saying how important it is that young doctors of tomorrow, you know, have good management, leadership. It's critical isn't it and he'd see half the group nodding. And so from the start we put out that message that this is really important. And then it was me but it could be one of my other colleagues, you know, doing our little spiel around what we were doing. And then concluding that we'd like to come and meet each of you or your representative. With [X] then summing up at the end saying, this is so important you know and, if you like, this project needs to know what you're already doing in this area because that will inform, if you like, the finish*. [Interviewee #21]

> *"And if you look at the kind of trajectory of the project overall there is a period of about 18 months to two years at the front end of the project which was*

securing alignment and agreement about what it was we were trying to do here." [Interviewee #22]

4. Meet with and lobby key people and groups through the concept of "Mirroring." The style adopted here is a facilitative and consultative approach, through reference groups, deaneries, providing assistance for implementing the MLCF into specialty curricula as well as the employment of language that bought in the profession's ownership to the project and its aims. 'Mirroring' is used to demonstrate the project team's approach to 'reflect' where the profession was in terms of its thinking and not to be ahead of or behind that thinking:

   "What we started to do was spread the team out into these various sources of influence and power. So we'd go and meet with [organization], we would go and meet with some of the colleges and I would go to the medical schools. And we would sort of start to capture in weaving this group together over the year, that first year of you want this to happen don't you. And we didn't set it off going, we have to produce a competence frame, we almost delayed that question to, we need commitment that you do want to produce this, and do you have any thoughts about what it should look like. So the key for us was getting this sort of consultative agreement prior to producing the product so that it didn't sort of bounce on people's desk and they go 'what's this, I have never heard of this.' [Interviewee #8]

   "We need to go out and we need to find out what's currently happening. What is it that others would like to see happen and then for us to begin to sort of test out some of our thoughts and get reactions to. So I think right from the start, particularly as we were talking about medical engagement, I personally thought the answers are out there. So you know I would regularly say, what we've got to do is constantly pick up the nuggets because, if you like, part of our role is aggregating the nuggets. And so we've got to create the conversation that in the end gives us, 'wow, so you've got this module on service improvement that is now an option for some of your medical students, that's really interesting. I don't think anybody else has got that, can you tell us about it?' And, of course, then we'd be given the curriculum and so on. And all of a sudden, if you like, our thoughts around what we might be wanting to include on service improvement, got informed by the fact that somebody out there was doing something in that sort of, in that sort of domain. [Interviewee #21]

5. Launch an 'unsurprising' document/artefact/product (the MLCF) which is incorporated and embedded through curricula into medical training:

> *"So there is a danger you come and put something else in - oh no not another new thing. It was about trying to get a reassuring message out there and say look, this is stuff you are probably doing already. That was probably the single most common thing I used to say to people about the framework, actually relax; this is almost certainly stuff you guys are doing already. It's just about trying to move it from the implicit to the explicit a little bit more. And in doing that, to link up with other resources and maybe just spot the odd gap that you aren't doing and to think about ways that that can be filled in. So I think it's that really reassuring message.* [Interviewee #18]

This also relates to Granqvist and Gustafsson's (2015) third notion of temporal institutional work, namely enacting momentum, towards a 'future outcome', in this case, of the doctor-as-leader discourse:

> *"We started from a position where there was very little happening within medical training about talking about leadership, to one where it's still a buzz word on people's, everybody's mouths. It's still there and I think the leadership competency framework is largely accepted as being the one that all clinicians should work to. I think we got to the stage where we actually had a plan for embedding it in curricula and there was a commitment to implement it.* [Interviewee #10]

> *"I think doctors if they are going to be any good in the modern health care arena where things are done, it's not the whole, the old system of the doctor being the top of the pyramid and nothing else mattered. I believed you could deliver more efficient and high quality health care if you really did understand management, delivery, improvement technology. It was about how did you get doctors to really take some responsibility for and understand about management and communication skills."* [Interviewee #17]

The convergence of the first two steps provides what Granqvist and Gustafsson (2015) conceptualise as the *window of opportunity* for change, whilst the combination of the second and fifth steps demonstrate the *synchronicity* associated with project and wider change (putting those in the 'know' in charge through the establishment of CCGs following the *Health and Social Care Act* (Great Britain, 2012)) and the first and final steps establishing the *irreversibility* towards leadership as an embedded professional concept.

This finding considers the process by which individuals engaged in the project undertook their roles and helps us to understand how change was initially considered, pioneered and created. It has briefly established how a combination of

values-based intentions and a vision of the future of medical education were key to adopting an approach that mirrored the behaviours and thinking of the wider medical profession to enact a key moment of NHS organizational, institutional and system change.

Further investigation of the findings will be required to take these conclusions from an initial to a more sustained interpretation. Indeed, further analysis will need to be undertaken of key codes and themes, notably prior disposition towards change; expertise; prior involvement and experience in medical leadership development; and consideration of succession planning for medical leaders.

It has not been forgotten that this paper is entitled “Relegitimizing the medical profession” and yet there has been no explicit discussion of another potentially key area of literature within the institutional field, notably Suchmann’s (1995) work on legitimacy. However, much of the above discussion has focussed on the role of social position and the emerging concept of system capital, which is a reserve on which institutional actors (the ‘opinion leaders’) have drawn to maintain and revitalise the profession; indeed to ‘relegitimize’ it in the face of wider societal pressures and changes (table 1).

Indeed, the work of Feldman and Orlikowski (2011) in relation to practice also warrants further investigation in analyzing the five step mirroring process outlined above and more may be discovered through the investigation of the role of established networks and alliances tentatively outlined in the relationship/network map (figure 5).

Moreover, whilst EEML provided the context for the study, the findings reflect changes that confronted the medical profession that will allow some wider analytical generalization for other professional groups.

References

Abbott, A. (1988). *The System of the Professions*. London: University of Chicago Press.

Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement (2009a). *Medical Leadership Competency Framework*. 2nd edition, May: Coventry: NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges.

Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement (2009b). *Medical Leadership Curriculum*. Coventry: NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges.

Academy of Medical Royal Colleges and NHS Institute for Innovation and Improvement (2010). *Enhancing Engagement in Medical Leadership Project*. July: Coventry: NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges.

Ackroyd, S., Kirkpatrick, I., Walker, R.M. (2007). Public management reform in the UK and its consequences for professional organization: A comparative analysis, *Public Administration,* 85 (1): 9–26.

Balogun, J., Johnson, G. (2005) From Intended Strategies to Unintended Outcomes: The Impact of Change Recipient Sensemaking, *Organization Studies*, 26 (11): 1573-1601

Barbour, R. (2007). *Introducing Qualitative Research: A Student's Guide to the Craft of Doing Qualitative Research*. London: SAGE.

Barley, S.R., Tolbert, P.S. (1997). Institutionalization and structuration: Studying the links between action and institution, *Organization Studies*, 18 (1): 93-117.

Barnes, B. (2001). Practice as collective action*,* in Schatzki, T. R., Knorr-Cetina, K., Von Savigny, E. (Eds.). *The Practice Turn in Contemporary Theory*, pp.17-28. London: Routledge.

Battilana, J., D'Aunno, T. (2009). Institutional work and the paradox of embedded agency, in Lawrence, T. B., Suddaby, R., Leca, B. (Eds.). *Institutional Work: Actors and Agency in Institutional Studies of Organizations*, Cambridge: Cambridge University Press.

Battilana, J., Leca, B., Boxenbaum, E. (2009). How Actors Change Institutions: Towards a Theory of Institutional Entrepreneurship*, Academy of Management Annals,* 3 (1): 65-107

Battilana, J. (2011). The Enabling Role of Social Position in Diverging from the Institutional Status Quo: Evidence from the UK National Health Service, *Organization Science*, 22 (4): 817–834.

Bolton, S.C., Muzio, D., Boyd-Quinn, C. (2011). Making Sense of Modern Medical Careers: The Case of the UK's National Health Service, *Sociology*, 45 (4): 682-699.

Bourdieu, P., Wacquant, L.J.D. (1992). *An Invitation to Reflective Sociology*. Chicago: University of Chicago Press

Brown, A.D., Colville, I., Pye, A. (2015) Making Sense of Sensemaking in Organization Studies, *Organization Studies*, 36 (2): 265-277

Buchanan, D., Dawson, P. (2007). Discourse and Audience: Organizational Change as Multi-Story Process, *Journal of Management Studies*, 44 (5): 669-686

Callon, M. (2009). Civilizing markets: Carbon trading between in vitro and in vivo experiments, *Accounting, Organizations and Society*, 34: 535–548.

Chia, R. (2003). Ontology: Organization as "World-making", in Westwood, R., Clegg, S. (Eds.) *Debating Organization: Point-counterpoint in Organization Studies*. Oxford: Blackwell, pp. 98-113

Creswell, J.W. (2008). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches*. 3rd edition, Thousand Oaks, CA.: Sage.

Cunliffe, A. L. (2011). Crafting Qualitative Research: Morgan and Smircich 30 Years On, *Organizational Research Methods,* 14 (4): 647-673

Currie, G., Brown, A.D. (2003). A narratological approach to understanding processes of organizing in a UK hospital, *Human Relations*, 56 (5): 563-586

Davies, H.T.O., Harrison, S. (2003). Trends in doctor-manager relationships, *British Medical Journal*, 326: 646-649

Department of Health (2004). *Modernising Medical Careers: The Next Steps*. London: Department of Health.

Department of Health and Social Security (1983) *Griffiths Report, NHS Management Inquiry Report*, London: HMSO.

Diefenbach, T. (2009). New Public Management in Public Sector Organizations: The Dark Sides of Managerialistic 'Enlightenment', *Public Administration*, 87 (4): 892-909.

DiMaggio, P.J., Powell, W.W. (1983). The iron cage revisited: Institutional isomorphism and collective rationality in organizational fields, *American Sociological Review*, 48 (2): 147–160.

Dorado, S. (2013). Small groups as context for institutional entrepreneurship: An exploration of the emergence of commercial microfinance in Bolivia, *Organization Studies*, 34 (4): 533–557.

Emirbayer, M., Mische, A. (1998). What is Agency? *American Journal of Sociology*, 103 (4): 962-1023

Feldman, M.S., Pentland, B.T. (2003). Re-theorizing organizational routines as a source of flexibility and change, *Administrative Science Quarterly*, 48: 94-118

Feldman, M.S., Orlikowski, W.J. (2011). Theorizing Practice and Practicing Theory, Available from: http://dspace.mit.edu/handle/1721.1/66516#files-area [Accessed 18.07.14]. Also available from: *Organization Science*, 22 (5): 1240-1253

Freidson, E. (1984). The Changing Nature of Professional Control, *Annual Review of Sociology,* 10: 1-20

General Medical Council (2006). *Management for Doctors***.** London: General Medical Council.

General Medical Council (2009). *Good Medical Practice: guidance for doctors*. March. London: General Medical Council. Available from: http://www.gmc-uk.org/Tomorrow_s_Doctors_0414.pdf_48905759.pdf [Accessed 10.02.15]

General Medical Council (2009). *Tomorrow's Doctors: Outcomes and standards for undergraduate medical education*. London: General Medical Council.

Giddens, A. (1984). *The Constitution of Society.* Cambridge, UK: Polity Press.

Granqvist, N., Gustafsson, R. (2015). Temporal Institutional Work*, Academy of Management Journal*, Published online before print April 30, 2015, doi: 10.5465/amj.2013.0416

Great Britain (2012). *Health and Social Care Act*. Available from: http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted [Accessed 15.08.14]

Kallinikos, J., Hasselbladh, H., Marton, A. (2013) Governing social practice: technology and institutional change, *Theory and Society*, 42 (3): 395–441.

Kennedy, I. (2001). *Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 -1995, CM 5207, Final Report: The Inquiry into the management of care of children receiving complex heart surgery at the Bristol Royal Infirmary*.

Kitchener, M., Mertz, E. (2012). Professional projects and institutional change in healthcare: The case of American dentistry, *Social Science and Medicine*, 74: 372-380.

Kirkpatrick, I., Ackroyd, S., Walker, R. (2005). *The New Managerialism and Public Service Professions.* Basingstoke: Palgrave Macmillan

Lawrence, T.B., Suddaby, R. (2006). Institutions and Institutional Work. In: S.R. Clegg, C. Hardy, T.B. Lawrence & W.R. Nord (Eds.). *The SAGE Handbook of Organization Studies*. London: SAGE Publications, pp. 215–254.

Lawrence, T.B., Suddaby, R., Leca, B. (eds.) (2009). *Institutional work: Actors and agency in institutional studies of organization*. Cambridge: Cambridge University Press, pp. 1–28.

Lawrence, T.B., Leca, B., Zilber, T.B. (2013). Institutional Work: Current Research, New Directions and Overlooked Issues*, Organization Studies*, 34 (8): 1023-1033

Lockett, A., Currie, G., Waring, J., Finn, R., Martin, G. (2012). The role of institutional entrepreneurs in reforming healthcare, *Social Science and Medicine*, 74: 356-363.

Lockett, A., Currie, G., Finn, R., Martin, J., Waring, J. (2014). The influence of social position on sensemaking about organizational change, *Academy of Management Journal*, 57 (4): 1102-1129.

Macdonald, K. (1995). *The sociology of the professions*. Thousand Oaks, CA: Sage.

Macpherson, A., Jones, O., Oakes, H. (2006). Mediating Artefacts, Boundary Objects and the Social Construction of Knowledge*, OKLC Conference*, University of Warwick, March 20-22.

March, J.G. (1989). *Decisions and Organizations*. Oxford: Blackwell

Martin, J.L. (2003). What is field theory? *American Journal of Sociology*, 109: 1-49.

MMC Inquiry. (2008). *Aspiring to Excellence: Final Report of the Independent Inquiry into Modernising Medical Careers.* (Tooke Report) London: Universities UK

Muzio, D., Brock, D.M., Suddaby, R. (2013). Professions and Institutional Change: Towards an Institutionalist Sociology of the Professions*, Journal of Management Studies*, 50 (5): 699-721

National Leadership Council (2011). *NHS Leadership Framework*. Coventry: NHS Institute for Innovation and Improvement.

O'Reilly, D., Reed, M. (2010). 'Leaderism': an evolution of managerialism in UK public sector reform*, Public Administration*, 88 (4): 960-978

Phillips, N., Lawrence, T.B. (2012). The turn to work in organization and management theory: Some implications for strategic organization, *Strategic Organization*, 10 (3): 223–230.

QSR International Pty Ltd. (2012) *NVivo qualitative data analysis software: Version 10*.

Raviola, E., Norbäck, M. (2013). Bringing technology and meaning into institutional work: Making news at an Italian business newspaper, *Organization Studies,* 34 (8): 1171–1194.

Royal Liverpool Children's Inquiry (2001). Summary and Recommendations, London: TSO, available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/250914/0012_i.pdf [Accessed 04.02.2015]

Royal College of Physicians (2005). *Doctors in society: Medical professionalism in a changing world*. Report of a Working Party, December. London: Royal College of Physicians.

Russell, V., Wyness, L.A., McAuliffe, E., Fellenz, M. (2010). The social identity of hospital consultants as managers, *Journal of Health Organization and Management*, 24 (3): 220-236

Secretary of State for Health (2008). *High Quality Care For All*: *NHS Next Stage Review Final Report* (Darzi Report). Norwich: The Stationery Office.

Shipman Inquiry (2005). Shipman: the final report The Stationery Office, January.

Smets, M., Jarzabkowski, P. (2013). Reconstructing institutional complexity in practice: A relational model of institutional work and complexity, *Human Relations*. doi:10.1177/0018726712471407

Storey, J., Holti, R. (2009). Sensemaking by clinical and non-clinical executive directors within new governance arrangements, *Journal of Health Organization and Management*, 23 (2): 149-169

Suchmann, M. (1995). Managing Legitimacy: Strategic and Institutional Approaches, *Academy of Management Review,* 20 (3): 571-610

Suddaby, R., Viale, T. (2011). Professionals and field-level change: Institutional work and the professional project, *Current Sociology*, 59 (4): 423–442.

Thornton, P.H. (2002). The rise of the corporation in a craft industry: conflict and conformity in institutional logics, *Academy of Management Journal*, 45 (1): 81–101.

Weick, K. (1988). Enacted sensemaking in crisis situations, *Journal of Management Studies*, 25, 305–317

Weick, K. (1993). The collapse of sensemaking in organizations: The Mann Gulch disaster, *Administrative Science Quarterly*, 3: 628–652

Weick, K. (1995). *Sensemaking in Organisations*. London: Sage.

Zietsma, C., Lawrence, T. B. (2010). Institutional Work in the Transformation of an Organizational Field: The Interplay of Boundary Work and Practice Work, *Administrative Science Quarterly*, 55: 189-221

Zilber, T.B. (2007). Stories and the discursive dynamics of institutional entrepreneurship: The case of Israeli high-tech after the bubble, *Organization Studies*, 28 (7): 1035–1054.