Developmental Paper BAM 2013 **June 2013**

Title

Individual engagement with change in medical education: an institutional work perspective.

Summary

This paper outlines some initial findings from a study into changes in medical education aimed at providing formal management and leadership training for doctors at all career stages. It sets out some of the evolution of medical education and training in the context of a publicly-funded health service. This is framed within the context of institutional work and how institutional actors engaged with and responded to a change that impacted on the medical profession. It draws on empirical data in the form of interviews with key individual actors engaged in the change. It offers insight into how actors both engage with and resist change at the same time, which could have potentially significant implications for medical training and working with the medical profession.

Track

Organisational Transformation, Change and Development

Word Count (excl. Tables / references)

2,164 plus summary / comments on paper development

Comments on how this paper will be developed prior to conference

This paper reports some initial findings from empirical data collection, which took place between October and December 2012 and it is based on the preliminary coding and analysis of that data. Between February 2013 and the BAM conference in September 2013, coding and analysis will continue to take place, allowing the paper to draw on further results in time for the conference.

Comments and feedback are invited on all aspects of the paper, from critiques of the literature and study design through to tentative findings and conclusions.

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Introduction

Aim and research question

The aim of this paper is to identify how institutional actors engage with and respond to institutional change in the context of medical education and the medical profession. It is based on a study of individuals from varying professional backgrounds and different organisations who were engaged with a project to embed leadership and management training into medical curricula.

Medical education practice and developments

The *Medical Act* of 1858 was the first legislation in the United Kingdom to restrict access into the medical profession and required practitioners to have a licence in order to safeguard genuine professionals and to protect patients. Training of doctors subsequently evolved from an individualised mentor-apprentice model into a standardised and evidence-based one (Anderson, 2011). Numerous short rotations through varied clinical specialties became the standard for modern medical schools and curriculum development so that trainees would be able to build up blocks of competency that could be achieved (Ringsted, 2011). Change continued with redesigned curricula at medical schools abroad and in the United Kingdom, offering their own particular perspectives on how medical education should be delivered in the latter half of the twentieth century, with approaches including problem-based learning (Weatherall, 2011). Kuper and D'Eon (2011: 37) reflect on how the modern medical curriculum exists as a "... mediated result of [...] social, political and economic forces" defining only what it is at the present time, rather than what it must be. Bordage and Harris (2011) describe how educational programmes are complex systems of inextricably linked components in which change is not restricted to one aspect, but impacts on other components and processes. They advocate stakeholder input, buy-in and, ultimately, support for any changes in curriculum design, requiring medical educators to develop leadership and management skills (Burch, 2011). Current developments in curriculum design owe much to such a "re-democratic" way of thinking regarding medical education (Anderson, 2011: 32).

Policy context

In the light of such practice, English health policy from recent as well as past decades can be seen to be influenced by greater patient and public involvement and patient choice (Department of Health, 2000, 2002, 2005, 2006). These factors are driven by the greater availability of information and the rise of the internet, as well as a desire from certain members of the profession to reach out to service users (Anderson, 2011). One approach to achieving this, in Canada, pursued a competency framework design, CanMEDS, identifying seven competencies required from doctors: medical expert (at the centre), along with communicator, collaborator, manager, health advocate, scholar, and professional (Frank, 2005). Such a 'blueprint' acts as a vision of what doctors, educators and the public expect doctors to be at the end of their training. This aims to encompass the requisite skills, knowledge and attributes to be excellent both technically and clinically; to work across organisational boundaries; to take into account individual preferences and diversity; and to reflect not only the demands of the profession, but those in their trust also. However, authors such as Dornan et al. (2011) offer a word of caution when questioning why doctors are expected to wear so many hats simultaneously right from the start of their careers.

The role of change

Change is not a modern phenomenon (Kotter, 1996) and within organizations can be seen simply as moving the organization from where it is currently to where it wants to be, in terms of any number of characteristics. In the context of care services, it is likely to encompass improvement of service

delivery or outcomes, which is underpinned by the training and development of staff. However, in a professional bureaucracy (Mintzberg, 1979) such as the NHS, the change can lead to resistance, characterised by the forces that lead employees to not accept it (Watson, 1982) or as reactive processes that oppose initiatives (Jermier et al., 1994). Staff can resist at different levels, be they emotional, intellectual or behavioural (Argyris and Schön, 1974; Coch and French, 1948; Lewin, 1952) and their resistance may be done with the best of intentions (Piderit, 2000); namely reluctance to embark on further organizational restructuring (Bent and Goldberg, 1999), ambivalence towards change (Piderit, 2000) or varying responses to diffusions of authoritative innovation (Rogers, 1962).

In the health service context, change involving doctors has often meant engaging them in leadership issues, such as resource management and service planning and delivery, with a long history dating back to the *Cogwheel Reports* of the 1960s (McClelland and Jones, 1997) and the *NHS Management Inquiry* of the 1980s (DHSS, 1983). Current policy rationale through the *Equity and excellence: Liberating the NHS* white paper (Department of Health, 2010) and recent *Health and Social Care Act 2012* have continued this trend.

Framing change within an institutional work perspective

The subsequent implications and effects of the above approach to medical education and engagement of doctors in change, alongside the current policy context, afford us an opportunity to explore change in the context of the medical profession. There are numerous ways in which this could be framed theoretically: through concepts in public policy studies, change management, professionalism and power, political science and institutionalism. All have their merits and offer different perspectives on change. Medical education and the profession can both be considered institutions in the way in which they are infused with certain values and how its curriculum is recognised as the way of educating the profession (Fineman et al, 2010). Moreover, the curriculum that sits at the centre of education is the "...product of common understandings and shared interpretations of acceptable norms of collective activity" (Suddaby et al., 2010: 1235).

Within organisational and institutional studies there has also been a recent focus on the ways in which individuals and organizations innovate, act strategically and contribute to institutional change, through concepts such as institutional work (Lawrence and Suddaby, 2006; Lawrence et al., 2009). Institutional work can be seen as the "...purposive action of individuals and organizations aimed at creating, maintaining and disrupting institutions" (Lawrence and Suddaby, 2006: 215), where it introduces a 'middle ground' of agency in which institutions are products of human action and reaction, motivated by both idiosyncratic personal interests and agendas for institutional change or preservation (Lawrence et al., 2009).

The core focus of institutional work is on highlighting the awareness, skill and reflexivity of individual and collective actors; generating an understanding of institutions as constituted in their more or less conscious actions; and finally, in identifying an approach that remains firmly rooted in "action as practice" (Lawrence et al., 2009: 7). In trying to understand these practical actions and how they impact on institutions in terms of their creation, maintenance and disruption, it 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) and hence, using institutional work as a central theoretical framework, the core focus of this research is to study how these actors, in their practices and actions, engage with and respond to changes in the institutions of medical education and the medical profession.

Methodology

Between October and December 2012, the author interviewed 21 individuals involved with the development of changes to medical curricula that focussed on leadership and management training within the context of a specific project. They were identified through a purposive sampling approach and were contacted by the author to take part in face-to-face, semi-structured interviews at a time and location of their choice. The interviews each lasted, on average, one hour and were audio-recorded and transcribed professionally. This approach is located in a constructivist-interpretivist paradigm where there are multiple, constructed realities and was chosen because the research question aimed to explore the experiences and meanings participants had of the change process, as well as what actions they took and practices they adopted whilst engaging with and responding to the project.

The research participants worked at several different organisations, each with some responsibility for service improvement, medical education, regulation or professional advocacy. Some participants worked at the same organisations but often in different occupational roles: doctors, project administrators, senior managers, independent management consultants, academics. Participants were asked about their role at the time of engagement with the project, how and why they got involved, whether they had a specific organisational remit or agenda to propose, who they worked closely with and whether there were any particular incidents of note during the project, as well as being asked to reflect on their role and the project's outcomes.

A thematic coding approach was adopted (Bryman, 2008; King, 2004; Barbour, 2008) where a number of transcripts were examined to identify key concepts and categories. Codes were initially constructed using concepts from the relevant literature and the author's own prior knowledge and experience, to which were added codes that emerged during the coding process itself. NVivo 10 qualitative software was used for recording, storing and managing the codes. The coding process is ongoing. From this, concepts within institutional work were drawn on and using an abductive style (Cunliffe, 2011) this resulted in the following preliminary findings.

Preliminary findings and discussion

Participants in this study experienced change through a varying numbers of perspectives. They were largely enthusiasts, albeit some with reservations about the process of engagement and conscious of the need to engage with the change before it was pressed upon them:

> "...the potential for serious radical change and that was exciting. You know, it wasn't just tinkering, it wasn't just developing a nice course on leadership, it was radically going to change things, or have the potential to change things." (#14)

> "… there was a sort of, an aside, sort of statement or an aside route that went beside all this to decide all this which was if we don't do it ourselves somebody else will do it to us, so if you want to be in control of your own destiny then you have to get up there and do something." (#02)

Some valued the process of consultation and engagement in terms of how it was carried out, as well as its reach and duration and how it laid the ground for broad acceptance by the wider profession.

> "...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. Er it's critical isn't it, you know, and he'd see half the group nodding...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

er in this area because that will inform, if you like, the finish. So, if you like, we were getting that sort of um endorsement, which made it, which made it a lot easier when somebody like Y or whoever, was then contacting that college. .. So we had that sort of um endorsement, that opportunity to link it back all the time." (#21)

They recognised the value of influential players knowing each other in terms of how their prior rapport helped to achieve organisational and institutional buy-in and momentum for the change:

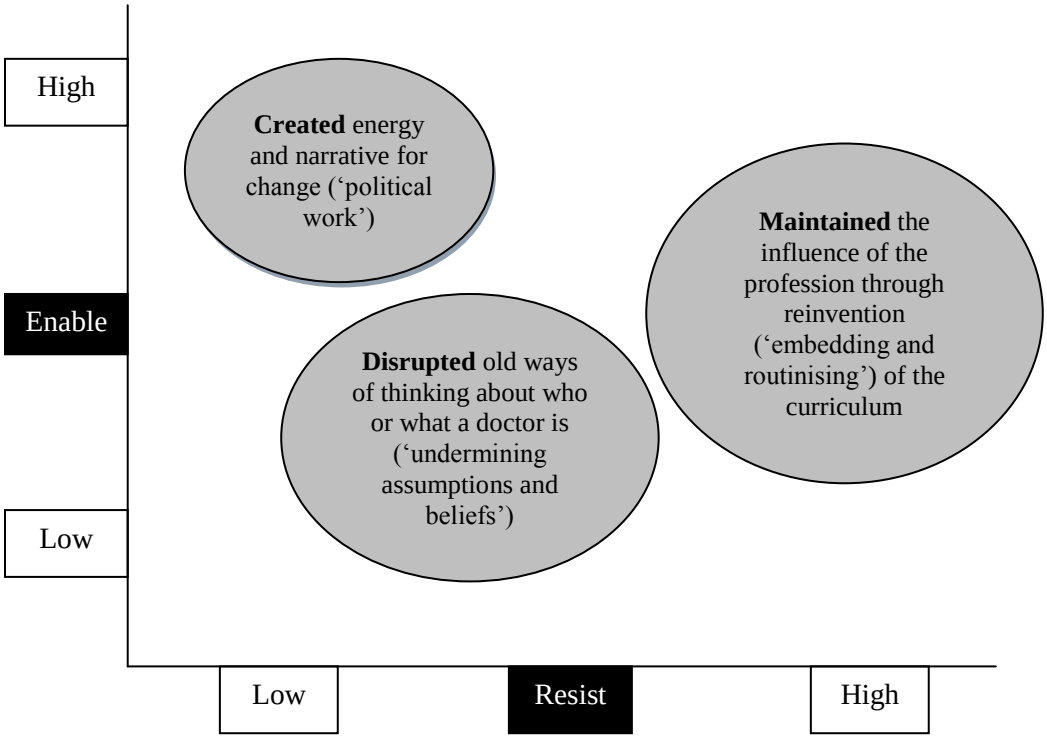
> "…it was very much the … mafia when I was down in the Department of Health, and whether you like it or not these things matter. I mean you try your best not [*emphasized*] to make them matter but if you are wanting something done you use all your contacts you can…that's how you get things done. You don't get, nothing is ever done in a committee, a committee ratifies all the decisions you have made beforehand, does it not?" (#02)

This demonstrates some political insight into the 'behind scenes' processes of change, rather than through formal or official channels. Some recognised the importance of their involvement in terms of representing a particular view or organisation:

> "... We needed it from day one to the end of professional life time, and I guess, maybe I, maybe the [organisation] contributed to that overview. Put it the other way round, if the [organisation] had walked away from it and had not been involved it would have been, it would have made it more difficult to complete the project and would have had less impact." (#16)

Conclusions

This paper has focussed on the experiences of individuals as they engaged with the medical profession in relation to creating and developing changes in leadership and management training. Whilst findings are limited at this stage, in an attempt to make a 'conceptual leap' and bridge the gap between empirical data and theory (Klag and Langley, 2013), some insight can be developed as to the relationship between enabling and resisting change on the one hand and the theoretical concepts of institutional work, which are outlined in the following model. The challenge for this work, as coding and analysis continues, is to develop this further.



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