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Leadership identity construction in a medical context: 'claimed' but not 'granted'

Brian Howieson
University of Stirling, UK

Stacey Bushfield
Edinburgh Napier University, UK

Graeme Martin
University of Dundee, UK

Abstract

In the United Kingdom National Health Service (NHS), the growing number of hybrid clinical leaders has given rise to professional practice and identity struggles. Co-construction theories of leadership point to a need for leaders to engage in significant 'identity work' to construct themselves as leaders and to make legitimate claims for a leadership identity to potential followers. Our research aimed to contribute to the leader-follower literature by examining how medical leaders deal with professional identity struggles and changes to traditional work identities. We draw on data from a study of senior hospital doctors (consultant-level doctors from a variety of medical specialties in Health Boards in NHS Scotland). Our findings suggest that most senior hospital doctors in our study struggle to grant leadership identities to their medical leaders who claim such leadership identities, although they seek to see more doctors engaging in leadership. This article contributes to extant research on the influence of medical leadership roles on leader-follower identity construction.

Keywords: Leadership, Followers, Co-construction; Identity; NHS Scotland.

Introduction

The New Public Management (NPM) and state reforms of the mid-1980s in the United Kingdom (UK) contributed to the emergence of hybrid organisations. Such organisational hybridity refers to organisations that combine the managerial features and value systems of different sectors (e.g., a focus on social impact and profit generation) (Savignon et al., 2018). In the healthcare sector alone, there is a burgeoning literature on this subject (e.g., Furnival, Walshe & Boaden, 2017; Kirkpatrick, Altanlar & Veronesi, 2021; McDermott et al., 2015; Pache & Thornton, 2020). Such (healthcare) organisations are not; however, without their problems (Besharov & Mitzinneck, 2020). One suggested solution to these problems is leadership, and in the context of this article, leadership by, and from, medical doctors (Lewandowski & Sulkowski, 2018). Indeed, the involvement of doctors in managerial (i.e., hybrid) roles is proffered as a solution to reducing the friction between traditional professionalism and modern organisational paradigms (Sartirana, 2019).

In the specific case of the UK state-funded National Health Service (NHS), such hybridity has given rise to professional identity struggles and changes to traditional work identities (Bresnen et al., 2019). This is especially so in the relationship between the relatively new hybrid-leader roles created in the NHS and many senior doctors whose reference points tend to be traditional medical professionalism (Martin et al., 2020). It has been suggested that the traditional medical autonomy of doctors has been eroded because of increasing bureaucracy. In this context, leadership is often construed as woolly, full of buzzwords and a distraction from clinical endeavours. Thus, these new identities (i.e., hybrid medical roles) present challenges and dilemmas for organisations, such as the NHS (Brown 2019; Durand & Thornton 2018; Fincham & Forbes 2015; Iliffe & Manthorpe, 2018; Kyratsis et al., 2017; McGivern et al., 2015) and have become important micro-level themes in this literature on hybrid organisations.

One way of framing this relational problem of identity tensions in the context of the NHS is to begin with the leadership-followership literature. In the leadership-dedicated literature, follower theories have been developed as an antidote to leader-centric approaches. A key theme within this leadership-followership literature is that followers are, or can be, co-constructors of leadership to produce positive organisational outcomes (Uhl-Bien et al., 2014). Co-construction theories of leadership point to a need for leaders to engage in significant personal and professional 'identity work' to construct themselves as leaders and to make legitimate claims for a leadership identity to potential followers. In

turn, followers must see themselves as followers and grant their leaders claims to legitimacy (DeRue & Ashford, 2010).

DeRue and Ashford (2010) propose that a leadership identity can be conceptualised along three levels of self-construal: individual, relational, and collective. Of these three levels, the one that has been least examined is the relational level, leading Epitropaki et al. (2017) to call for greater exploration of the dynamic interplay of leader-follower identity processes and the 'claiming' and 'granting' of such identities. Consequently, we address this gap by examining relational ties between doctors and their leaders in the context of hybrid healthcare organisations and attempts by governments and healthcare employers to engage medical professionals in the running of these organisations.

Our research aimed to contribute to this literature by examining how senior doctors view and work with medical leaders in formal hybrid roles with a specific focus on the claiming and granting of leadership identities. We do so by drawing on qualitative data from a study of senior hospital doctors in the NHS (consultant-level doctors from a variety of medical specialties in Health Boards in the NHS Scotland)—an environment where leadership by medical doctors is promoted at central (UK) and local (Scotland) government level.

Our findings suggest that despite UK Government policy—the desires to see doctors play a greater role in leading change in hospitals (Department of Health & Social Care, 2016)—most senior doctors in our study do not grant leadership identities to their own medical leaders who claim such leadership identities, although accepting the need for more doctors to be involved in leadership. This, we suggest, is because of lack of trust, perceived credibility, authenticity, and visibility of their medical leaders. In line with implicit leadership theory, the medical leaders in our study were not thought to match with the views of prototypical leaders held by many of our study participants, especially with regard to effectiveness and professionalism (Schyns & Schilling, 2011).

This article makes several contributions to the study of the leadership-followership literature in the hybrid organisational context of healthcare. First, it advances our theoretical and empirical understanding of DeRue and Ashford's (2010) claiming and granting model. It does so by building on Schedlitzki et al.'s (2018) work on leader-follower relations in the 'hybrid' context of healthcare. We argue that such claiming and granting models have limitations in complex and hybrid healthcare systems because historic roles and divergence around guiding leadership-structures lead to complexities in the reciprocal dynamics of identity construction. Second, it suggests that the 'lines in

the sand' remain tightly drawn by many senior doctors, whose allegiance to a traditional version of professionalism is so deeply embedded in the past to make it a relatively stable working self-concept and inconsistent with a hybrid model of organisational control (Petriglieri, 2011).
In addressing our research aim, we proceed as follows. First, we critically examine the concept of hybrid leadership roles, co-construction theories of leadership, and identity construction. Second, we outline the research design, the qualitative data underpinning the study, and our abductive analysis approach. Third, we present our findings in relation to DeRue and Ashford's (2010) claiming and granting leadership framework before discussing the theoretical and policy implications of these findings; and fourth, we finish with a short conclusion that addresses areas that we consider are important in future research of leader-follower relations and leadership identity construction in such hybrid contexts.

Theoretical Framing

In the context of UK healthcare, it is important to distinguish between the traditional role of doctors as informal leaders (Tavare & Lees, 2012) and the growth of 'hybrid' medical leadership roles that involve doctors taking on formal leadership or management roles traditionally done by organisational managers. The literature on such (hybrid) leadership is extensive. In the United States of America (USA), for example, Berwick (1994) and others have argued that it is crucial that clinicians take an active role in managing healthcare reform. Moreover, the Institute for Healthcare Improvement offers detailed analysis on the evolution of 'Leadership, Management, and Operations to Support Improvement' in the USA context (see: https://www.ihi.org/). In the UK, the debate on–and role of–the doctor as a leader and/or manager ensues at a pace (Razaaq, 2009; Moberly, 2014a; Moberly, 2014b; Kar, 2019; and Bamji, 2022). Thus, for example, Keijser and Martin (2020) set out a multi-domain framework for understanding and unlocking the potential of medical leaders to contribute to the effective management of healthcare services. These key domains or levels of analysis range from the macro-level healthcare ecosystem domain, through the professional domain, to the organisational and individual levels of analysis. The main thrust of their argument is that to fully understand the role of medical leaders, researchers and practitioners need to understand how individual doctors and their potential for effective hybrid leadership are embedded in these interconnected domains.

Such 'hybrid' roles date back to the NPM reforms of the 1980s and have now diffused across global healthcare systems (Fitzgerald & Dufour, 1997; Fitzgerald & Ferlie, 2000). Medical leadership has

been advocated as a means of engaging influential doctors in the healthcare reform and management and reconciling medical and managerial requirements (Buchanan et al., 2007; Kirkpatrick, Altanlar & Veronesi, 2021). Thus, increasing attention has been paid in public administration and organisational theory literature to understanding how medical doctors assume hybrid roles as they take on managerial responsibilities (Ferlie & McGivern, 2014; Noordegraaf, 2007).

Hybrid roles create identity tensions, as conflicts may arise when individuals attempt to deal with competing logics (Kippist & Fitzgerald, 2009). Similarly, medical leaders can face identity threats from colleagues, if colleagues view them as disloyal practitioners who have 'gone over to the dark side' (Llewellyn, 2001). Consequently, scholars have begun to examine the alternative ways that such hybrid roles are constructed. For example, McGivern et al. (2015) distinguish between two types: 'incidental hybrids' who represent and protect traditional professionalism, while temporarily in hybrid roles; and 'willing hybrids' who engage in active identity work and incorporate these roles into their professional career narrative. Mathilde et al. (2018) offer that opinion-making physicians, in strategic arenas, advocate to reform medical professionalism by discursively framing physicians as leaders. Bresnen et al. (2019) conceptualise three types of hybrid identities, including: aspirational hybrid managers (managers for whom moving into management had always been a guiding ambition); accidental hybrid managers (managers for whom progression into management was unintentional or even accidental); and antipathetical hybrid managers (clinicians who had been reluctant to take on managerial roles due to a perceived incommensurability between their clinical identity and managerial expectations or negative experiences of management that provoke a desire to return to core clinical competencies).

Given the potential for conflict and tensions involved in hybrid medical roles, the leader-follower tradition in the leadership literature is one way of analysing the challenges faced by medical leaders. This literature proposes that leadership is co-constructed between leaders and followers contributing to its formation, nature, and consequences (DeRue & Ashford, 2010; Fairhurst & Grant, 2010; Grint, 2000; Marchiondo et al., 2015; Shamir et al., 2007). Leadership takes place within the context of a shared group membership, where leaders (as group members) ask followers (as group members) to work on behalf of the collective (Hogg & van Knippenberg, 2003). Follower evaluations and endorsement of a leader have been found to depend on the characteristics of the leader as a group member–i.e., representing ingroup prototypicality having a shared social identity (Hogg, 2001; Haslam & Platow, 2001; Reicher et al., 2005; Chong & Wolf, 2010). Similarly, followers' attitudes and characteristics shape the group's identity and moderate leaders' influence (House, 1996; Shamir,

2007; Kellerman, 2008; Schyns & Schilling, 2011). Moreover, the socially constructed nature of the world means there are possible differences between leader and group member perspectives on the same relationship as well as lack of consensus among followers regarding the same leader (Schyns & Day, 2010). Thus, understanding how leaders and followers see and define themselves and others and understanding the complex ways in which these definitions develop, change and are influenced by leader-follower interactions and contexts are important pieces of the leadership puzzle (Epitropaki et al., 2017).

DeRue and Ashford (2010) proposed a theory explaining the development of this leadership relationship that is composed of reciprocal and mutually reinforcing identities as leaders and followers, is endorsed, and reinforced within a broader organisational context and is dynamic over time. These authors argue that leadership and followership identities are dynamically co-constructed — through an interactive and reciprocal identity 'claiming' and 'granting' process — at three levels of self-construal: individual internalisation; relational recognition; and collective endorsement. At the individual level, individuals come to incorporate the identity of a leader or follower as part of their self-concept. In other words, they must believe or 'claim' that they are leaders (or followers) and demonstrate the appropriate skills and attributes. Indeed, prior theory suggests that the designation of these personal attributes 'to the self' is not simply a cognitive, intra-individual assessment; rather, it is embedded in specific contexts where an identity is asserted and ascertained during social interaction.[1]

Relational identities are based on relationships between the individual and important others (Brewer & Gardiner, 1996; Lord & Brown, 2001). Leadership identity is thought to be stronger when it is relationally recognised or 'granted' by important others through the adoption of reciprocal role identities as leader and follower (Cunliffe & Eriksen, 2011). Most importantly, leadership and followership cannot be constructed in cases where claims and grants are not reciprocally supported. In other words, although one might have a title of a 'Manager', they may not actually be a 'leader' if their employees (subordinates) do not grant them a leader identity and claim for themselves a follower identity (DeRue & Ashford, 2010). In this sense, leadership 'is not something the leader possesses' (Hollander, 1993: 29), rather it expresses a recognised relationship among individuals. Relational identity processes suggest that — in addition to individuals' internalising a leader or

[1] See also, for example, Dr S MacLeod 'tweet' of 3rd February 2017 (@sheona_macleod): *"Jim Mackay says you are all leaders as doctors, it's not optional #rcpeTrainees17"* [Note: Jim Mackay is NHS Scotland Postgraduate Dean, Director of Education and Quality].

follower identity — a leadership identity will be stronger when it is relationally recognised through the adoption of reciprocal role identities as leader and follower, i.e., for leaders, when others take on a reciprocal follower identity.

Collective identity involves being seen within the broader social environment as part of a social group; for example, leaders or followers (Brewer and Gardiner, 1996; Lord and Brown, 2001). It is argued that the more an individual is collectively endorsed as part of the group 'leaders' or the group 'followers', the more those related identities will be reinforced and the stronger and more stable that identity construction will be (DeRue & Ashford, 2010). Collective endorsement might come from other individuals or the social context more broadly. Such collective endorsement is about being seen within the broader social environment as a part of a social group.

In summary, DeRue and Ashford (2010) offer a constructionist view that identifies leadership and followership as co-constructed in an interactive and reciprocal identity 'claiming' and 'granting' process. If such reciprocal and mutually reinforcing identities are inherently social—and both leader and follower identities are available to anyone—then the process by which certain people become socially constructed as leaders, and other people as followers, becomes particularly important to understand. DeRue and Ashford root their description of this process in what is called 'identity work' in the literature (Sveningsson & Alvesson, 2003). Identity work refers to 'people being engaged in forming, repairing, maintaining, strengthening, or revising' their identities (De Rue & Ashford, 2010: 630). It is undertaken both by individuals projecting an image and by others mirroring back and reinforcing (or not) that image as a legitimate identity (Epitropaki et al., 2017).

DeRue and Ashford (2010) and others (Moorosi, 2014; Humphreys et al., 2015; Marchiondo et al., 2015) have conceptualised leadership identity development as a 'dynamic dance' — an ongoing process of the social construction of the leader and follower identities. Identities emerge, develop, and are shaped through ongoing social interactions, in which leader and follower identities are claimed and granted or, indeed, rejected by others. When individuals claim the identity of leaders and are granted that identity from other individuals, they legitimately gain a leadership identity. These identities mature as they are endorsed at the dyadic/relational level as well as at the group or collective level (DeRue & Ashford, 2010). In summary, identity work is undertaken both by an individual projecting an image and by others mirroring back and reinforcing (or not) that image as a legitimate identity. This broader, multi-party process is leadership identity construction.

Building on DeRue and Ashford's (2010) model, Epitropaki et al. (2017) adopt a multi-level view and map existing literature on three levels of analysis of leader identity work (intrapersonal, interpersonal and group) as well as three levels of self (individual, relational and collective). A clear conclusion that emerged from their review is that although identity processes on the group level have received significant attention from social identity researchers, other levels remain relatively unexplored. Likewise, Denis et al. (2015) argue that the current literature on hybridity often operates at a macro (organisational) level, but it also has important 'local' implications for work teams and individuals (meso- and micro-levels). Thus, the current research is particularly interested in the micro-level 'hybrid' roles — framed by both professional and managerial logics, practices, assumptions, values and beliefs — which have diffused across healthcare systems globally, including the medical manager role in the UK (McGivern et al., 2015).

Since the publication of DeRue and Ashford's (2010) 'claiming' and 'granting' model, further research in this area has been conducted around (e.g.): the role of leadership development programmes in identity construction (Moorosi, 2014); the role of context in initiating the leader identity construction process (Humphreys et al. 2015); leadership identity construction and decision-making (Marchiondo et al., 2015); and Schedlitzki et al. (2018) who offer a critical exploration of organisationally-assigned leader-follower relations and discuss the implications of the absence of a follower discourse on leader-follower relations and identity construction. In addition, in a hybrid context, there is increasing published research on identity work in healthcare organisations; for example, McGivern et al. (2015) and Kyratsis et al. (2017).

A search, however, of major databases (Business Source Complete, Science Direct and Scopus) found only a limited number of studies that examined leadership identity construction in a hybrid context, such as the UK state-funded healthcare system with senior hospital doctors.[2] Overall, our review of the relevant literature echoes the view of Epitropaki et al. (2017: 114) who state: 'the absence of empirical work (on leadership identity construction) is striking. With the exception of the Jackson and Johnson (2012) and the Marchiondo et al. (2015) studies, we were unable to locate empirical studies on the interpersonal level'. Thus, we conclude there is need for more empirical work at this level on the theoretical tenets of the leader and follower 'claiming' and 'granting' identities process.

[2] For the interested reader, notable literature from the nursing and midwifery professions includes Croft et al., 2015; Currie et al., 2010; and Divall, 2015.

Our study attempts to fill this gap by examining the dynamic interplay between leader and followers' identities in a dyadic context (between-persons' identity work). At this interpersonal level, leadership and identity research is focused on the relationship in the 'space between' the leader and the followers and in the ways in which they shape each other's identities. Regarding the levels of self, our research is located at the *relational self* that is derived from connections and role relationships with significant others. Thus, our research question is to evaluate the effectiveness of claims of leadership identities in an environment where leadership by medical doctors is promoted at central (UK) and local (Scotland) government level.

Research Methods

The Context: Leadership Identity Work in Healthcare

The hybridisation process in NHS Scotland has involved the cumulative effect of multiple rationales of decision-making and organisation, including professional, NPM, public value, and mutuality logics, which have been layered — one on top of another — over time (Bevan et al., 2014; Harris et al., 2014; Howieson, 2016; Keisjer & Martin, 2020). As part of this, the Scottish Government and elite medical bodies, such as the Academy of Medical Royal Colleges and Faculties in Scotland have been active in promoting the discourse and practices of medical leadership by co-opting senior doctors into leadership roles to help (re)engage medical professionals with their employing organisations (Berghout et al., 2018). This changing context makes it an excellent case to examine how fluid rationales, systems and principles of governance have contributed to leadership identity construction.

Given our research question evaluating the effectiveness of claims of leadership identities, we chose to study senior hospital doctors (known as consultants) in the NHS in Scotland (hereafter known as NHS Scotland). NHS Scotland is part of the UK NHS. The NHS — one of the world's largest hybrid organisations employing 1.7 million staff — is well-known for embodying multiple rationales in its decision-making and constitution (Harris et al., 2014) despite having a workforce ostensibly bound together by an ideological mission of delivering high quality patient care to all free at the point of delivery (Department of Health & Social Care, 2021).

Data Collection

In this article, our analysis focuses on qualitative data from a mixed-methods study of hospital consultants in NHS Scotland. The study was guided by the interpretivist paradigm as it sought to explore and understand (in-depth) how senior doctors in Scotland interpreted and gave meaning to their experiences of work in relation to changes in the NHS over time. These data were collected in two stages. The first stage involved in-depth, semi-structured interviews with 68 hospital consultants. A qualitative maximum variation sampling approach (as described by Miles and Huberman, 1994) was employed, whereby in-depth interviews were completed with consultants at different career stages in all 14 regional Health Boards in different medical specialisms in large and small hospitals. The aim was not to generalise to the population of consultants but to generalise to the theory on how consultants from differing medical specialties viewed their experiences of work. Participants were approached via an email from the British Medical Association and most participants self-selected to participate following this initial invite. Additional participants were recruited through a combination of referrals from existing contacts and direct recruitment. Interestingly, only nine of the interview participants had held (either in the past or at the time of the interview) a formal management or leadership role. The interviews used a semi-structured protocol, informed by questions on consultants' careers to date, their experiences of work, identification with their jobs, clinical teams, employers, and NHS Scotland itself. Interviews were mainly conducted face-to-face in the hospitals in which the consultants worked and lasted typically between 60-90 minutes. All interviews were professionally transcribed.

The second stage of data collection arose from an online survey that was distributed to 3740 consultants via email invitation. This survey sought to gain a sense of the extent to which the views and themes identified in the interviews represented the wider consultant population in Scotland. In this article we do not discuss the full quantitative analysis of the closed questions but do include selected statistics in the discussion to show commonalities across the two data sources and to demonstrate how the data across both methods were triangulated. Our qualitative analysis does include the responses to the final open question that asked consultants for any further comments on their experiences of working as a consultant in Scotland. From the 1058 responses to the survey, we received 430 replies to this general open-text question.[3] We acknowledge that these types of data have been questioned because of its lack of focus on context and reduced conceptual richness due to the typically short answers. Short length of answers, however, was not an issue in this case with most

[3] Despite our best attempts to recruit a representative sample, we do accept that the questionnaire and, in particular, the comments may be subject to self-selection bias, i.e., the doctors who were most 'unhappy' may have been most motivated to complete this question.

replies ranging between one and four paragraphs, and often, written in a highly reflective mode. Thus, following the advice of O'Cathain and Thomas (2004), we saw the answers to the open question in the survey as an opportunity for a larger sample of senior doctors to give further voice to their views and as complementary to the rich data gathered during the interviews.

Data Analysis

Our analysis and theorisation were iterative. In a bid to bring qualitative rigour to the analysis, we followed the advice of Gioia et al. (2012). First, we moved from the narrative data to Empirical Themes (in general retaining participant terms), which are referred to as 1st Order Concepts. This involved the research team open coding (Strauss & Corbin, 1998) the interview transcripts using NVivo 11 (QSR International, 2015) to identify initial themes from within the data (Grbich, 2013). This first cycle produced numerous empirical themes. The second cycle involved seeking similarities and differences among the many themes and condensing them into 32 more manageable and meaningful 1st Order Concepts (Saldaña, 2015). The third cycle involved examining the data more deeply using axial coding to identify connections between the Empirical Themes and grouping them into more abstract 2nd Order Themes, which are stated as Conceptual Categories. In this 2nd order analysis, the focus was on 'codeweaving' (Saldaña, 2015: 276) and exploring how the emerging themes might help us describe and explain senior doctors' experiences of work. A similar process was completed to code and analyse the free text comments and the resultant 2nd Order Themes were in broad alignment with those from the interviews.

After the initial stages of analysis, we then began working back and forth between the data, emergent themes, concepts and the relevant literature. At this point, the research process transitioned from *inductive reasoning* to a form of *abductive research* in that data and existing theory were considered alongside each other (Alvesson & Kärreman, 2007; Gioia et al., 2012). Several of the 2nd Order Themes related to the doctors' perceptions of individuals in hybrid medical leadership roles and their engagement with, and trust in, management. This led us to revisit DeRue and Ashford's (2010) framework of leadership identity construction and to formulate the specific research question, which guided the remaining analysis and is the focus of this article:

> How effective are claims of leadership identities in an environment where leadership by medical doctors is promoted at central (UK) and local (Scotland) government level.

We then 'mapped' 2nd Order Themes (Conceptual Categories) to the relevant propositions offered by DeRue and Ashford (2010)–working back and forth between the data and the theoretical propositions. At the analysis stage, we considered that of the 11 propositions offered by DeRue and Ashford (2010), four were most relevant to our study. Finally, we interrogated these propositions considering the narrative data to arrive at 'Problems with this Proposition'. In using this approach, we were cognisant of the advice offered by DeRue and Ashford (2010: 641), namely, to gather 'rich, in-depth accounts of the individual cognitive processes and relational processes that underlie the claiming and granting process' to gain insight into the development and evolution of leader-follower relationships and identities in a hybrid organisational context. We also sought to acknowledge any deviating views and compare the views of those with and without experience of formal leadership. This 'movement' from theory to narration to theory interrogation is shown in Table 1.

Findings

In the first column of Table 1, we present four propositions from the 11 propositions that were offered by De Rue and Ashford (2010), namely propositions 1, 5, 7 and 9. These propositions were selected because they were most relevant to our data set. In the subsequent columns, we consider these in relation to our data analysis, including illustrate quotes/statements, empirical themes and conceptual categories. For proposition 5, we suggest that we have four corresponding 2nd Order Themes (Conceptual Categories).[4] We then point to problems with the four propositions and set out some possible theoretical directions. These are explained and examined in the subsequent discussion.

[4] Hence, Proposition 5 is offered four times in column one of Table 1.

De Rue and Ashford (2010) Propositions	Typical Quotes/Statements	Empirical Themes: 1st Order Concepts	Conceptual Categories: 2nd Order Themes	Problems with this Proposition	Theoretical Directions
Proposition 1: The construction of a leadership identity occurs when claims and grants of leader and follower identities are endorsed with reciprocal grants and claims.	*If I have a leader, I like to be able to know that I trust the leader to make decisions that I don't know the ins and outs of - whereas with my medical colleagues who go into management I'm not sure that I do trust them to make decisions that I would approve of if I knew the ins and outs of it and that means that they're not really trusted leaders to me.* *I think the clinicians involved in management were amongst the least trustworthy people I dealt with.* *I had a clinical governance issue that I wanted to highlight to Senior Managers, and they completely blocked it.* *I'm very sceptical of doctors that choose to become managers… I do not have sympathy for the lack of courage of both medical and non-clinical managers in standing up to unachievable tasks and targets. My experience of medical and non-clinical management is one of repeated half and incomplete truths with a disregard into patent care until their job is on the line and then they run for cover. Targets and money nothing else* (Free Text Response). *With a few exceptions, the medical managers in my service … have an agenda that is based on hiding from clinical duties and financial enrichment via the merit award system* (Free Text Response).	Trust, scepticism, integrity, self-interest	Lack of trust in and credibility of Medical Managers	Claims of leader identities not endorsed and granted.	Importance of trust in the reciprocal identity construction process. Organisational factors that contribute to this lack of trust.
Proposition 5: The greater the clarity, visibility, and credibility of	*I think the power relations have changed very much in favour of those who are in management roles whether they be clinical managers or non-clinical compared to the power and authority that I have.*	Difficult to distinguish between medical managers and non-clinical	A manager is a 'manager' irrespective of professional	Credibility of Consultant when they become	Importance of divergent leadership-structure

claims and grants, the more likely those claims, and grants will be reinforced via reciprocal grants and claims.	*Senior medical managers are more influenced by political expediency than clinical need and important decisions are constantly being ducked to avoid political embarrassment.* *I wouldn't recognise the Chief Executive, or the Medical Director. I don't know who they are. I think, you know, they can't really give that leadership, when we don't know who they are.*	managers, target-driven, political influence, target culture, lack of visibility, overwhelming managerialism.	background	Medical Managers. .	schemas
Proposition 5: The greater the clarity, visibility, and credibility of claims and grants, the more likely those claims and grants will be reinforced via reciprocal grants and claims.	*I think is that those clinicians who do become managers are selected for the personality traits and for the ambition that aligns itself with what the management perceived essential specifications are for the job. So if they advertise for a lead for one clinical area within the service we as the clinicians in the service know that the person who has applied for that job is perhaps the least appropriate person to be managing the service, but they are the most likely person to get the job because they will fit in with what the specification is, as perceived by the management. Because they are people who are driven to deliver on management targets, and they are people who are divorced and, in many cases, alienated from colleagues before they even get that job.* *I think certain clinicians should go into leadership but not necessarily the clinicians that apply for the leadership roles.* *Inappropriate individuals have been given authority over services they know little about, act in an inappropriate authoritarian way, insist on the application of flawed dogma, do not understand job planning, and have increasingly expected consultants to take on a middle grader role in addition to their consultant role.* *I do not feel respected by medical and non-medical managers …they have been unresponsive to my concerns about patient*	Effectiveness, selection of managers, lack of support, unresponsive, lack of respect.	Medical Managers not actually good at management	Credibility and visibility of Consultant when they become Medical Managers.	Paradox of wanting more doctors in leadership alongside scepticism around the effectiveness and identity motives their own medical leaders

	care and service delivery. *Many of my answers are coloured by my experience of medical management over the past 3-4 years, which has been extraordinarily bad … I have felt disillusioned, disempowered, and not listened to when trying (with colleagues) to raise concerns about patient and staff well-being.*				
Proposition 5: The greater the clarity, visibility, and credibility of claims and grants, the more likely those claims and grants will be enforced via reciprocal grants and claims.	*The higher up the greasy pole of management one goes the less understanding of grass roots you have. Clinicians should remain active and not be solely managers.* *Medical managers have no interest in clinical quality or outcomes. See their role as obedience to the Health Board. They are non-thinking individuals.* *I think they've all become just management lackeys, if you like, and they forget the things they should be standing up for.* *It does seem to happen that people who get more involved in management toe the party line more, which is a shame, and that is why I think senior people who have a true gravitas and experience are less likely to do that. They have been around long enough to see how it all works, but, and have their own opinion.* *The moment medical colleagues of mine get involved in management they seem to lose all interest in improving working conditions and their motivation to work in management appears questionable and at worst driven by their own personal gain.* *They seem to lose all sense of the problems we are affected by and rather than standing up for the specialty, they actively look for opportunities to increase our workload even–more than likely, to fit some targets by managers.*	Personal change, identity, claims to identity, crossed 'line in the sand', change in roles/priorities, towing the party line.	Personal 'change' as doctors become Medical Managers	Credibility and clarity of Consultant when they become Medical Managers.	Interplay of different levels of leadership and challenges inherent in combining clinical and managerial identities
Proposition 5: The greater the clarity, visibility,	*Managers, medical and non-medical, worked to help consultants to be more effective in their work until about 15 years ago Now all they seem to do is put hurdles in the way of effective, efficient*	Negative views, lack of courage, lose their humanity,	Negative view of elite Medical Managers	Credibility and Visibility of Consultant	Temporal nature important

and credibility of claims and grants, the more likely those claims and grants will be reinforced via reciprocal grants and claims.	*management of patients.* ***Participant X:*** *I'm there to represent the Division of Psychiatry and some of them [various medical managers, the various clinical directors] I really find it quite shocking these people seem to have lost their humanity really. …I think the fundamental reason for that is that people have forgotten actually the basic principles, the core things that they should be doing.* ***Interviewer:*** *How do you suggest that this situation be improved to allowed consultants to do their own jobs more effectively?* ***Participant X:*** *Right, sack the medical director. Employ somebody who has got his or her roots in humanist values of decency, of care for staff*	puppet of managers, visibility.		when they become Medical Managers.	
Proposition 7: The more consistency people see between their own attributes and their own implicit theory of leadership (followership), the more they will claim a leader (follower) identity.	*And then the management chip gets implanted in them, and they forget about being a doctor… associate medical director and up… they then cease to be like doctors and then become part of management.* *They just move across [to the dark side] because they have their own targets that are set for them.*	Visibility, identity change.	Perception of doctors as they become managers.	Said Medical Managers do not 'look like' Consultants	Investigate how medical leaders navigate this image risk
Proposition 9: The more individuals perceive instrumental,	*There's a suspicion amongst some of us (particularly younger) consultants that some of the senior medical hierarchy will go with the flow or with the policy because they will be rewarded later on. At a local level this can be with discretionary points or awards, but you see it even at high levels. Many doctors who*	Desire for reward/recognition/ Power	Status	Relationship with claiming leadership and instrumental, interpersonal,	Negative associations with such motives and leadership in

interpersonal, and image rewards associated with leadership, (a) the more they will claim a leader identity and (b) the more they will grant a follower identity.	*help a government report will get an OBE, or if you sit on a certain committee and support government policy you'll get a knighthood. As a result, I think many younger consultants feel their medical leaders and bosses do not represent them. They get so high up in the system that rewards them that they become part of the management system rather than representing doctors. There are even some joke terms for this; 'Gongitis', 'knight' fever and 'lorditis' (a reference to Lord Darzi). For some people it seems to become very seductive - working for managers, the government or within 'corridors of power'. They seem to enjoy this more than clinical work with colleagues. They are seen as having 'gone native'. … It's another part of the 'network' that operates with the medical profession. If you're not part of it, you don't get promoted or rewarded. Only those who are prepared to toe the line are appointed and rewarded.*			and image rewards.	general may be putting off others.

Table 1: Theory to Narration to Theory

Discussion

Table 1 considers the data in relation to four of the 11 propositions from De Rue and Ashford's (2010) model of the leadership relationship that proposes leadership is effective when individuals take on reciprocal and mutually reinforcing identities as leaders and followers, is endorsed and reinforced within a broader organisational context and is dynamic over time.

DeRue and Ashford (2010) state that any identity can be conceptualised along three levels of self-construal: individual internalisation, relational recognition and collective endorsement. We consider that all doctors have an individual internalisation as a leader, as evidenced by the practitioner literature (see, e.g., The Royal College of Physicians of London training event *Doctors as Leaders– Organisational Leadership*[5]; British Medical Journal *Doctors as Leaders* (BMJ, 2009) and the General Medical Council *Guidance on Leadership and Management for Doctors*[6]).Nevertheless, at the relational level, our findings suggest that most doctors do not see their own careers advanced by aspiring to or engaging in, formal medical leader roles. Somewhat paradoxically, however, they wished to see more doctors in senior leadership positions, with interviewees making statements like: '*the growth of clinical leadership roles is an excellent idea'* and 77% of our survey respondents agreeing with the statement '*we need more clinicians in senior leadership positions in this Board'*. Yet, as illustrated in Table 1, doctors were sceptical of the effectiveness and identity motives of their own medical leaders. This was supported by our quantitative findings with only 32% of respondents agreeing that medical managers tended to do an effective job in improving service delivery. Thus, we contend that our data show there is a tenuous relationship between the consultant body and their own medical leaders, with relational recognition and trust in the competence, integrity and benevolence of those moving into medical leadership very weak. In addition, our findings did not support the idea of collective endorsement in this professional setting, so as De Rue and Ashford (2010) suggest our data do not support two of the three tests of leadership identity construction required for a 'working consensus'.

Hybridity in the NHS has arisen because traditional medical professional autonomy has been overlaid by bureaucratic, market and state logics (Martin et al., 2020; Keisjer & Martin, 2020). This 'hybridity' has given rise to professional identity struggles and changes to traditional work identities. Only nine of

[5] See: https://www.rcplondon.ac.uk/education-practice/courses/doctors-leaders-organisational-leadership.
[6] See: https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/leadership-and-management-for-all-doctors

the 68 consultants who participated in this study had held a formal leadership role, but most had adopted informal leadership responsibilities within the clinical setting during their tenure.[7] Thus, they find themselves in the position of being expected to lead clinical teams while also follow those in formal leadership roles (Gronn, 2009). DeRue and Ashford (2010) propose that leaders and followers do identity work and claim such identities — others grant. Individuals then project an image and others mirror back and reinforce (or not) that image as a legitimate identity. In terms of identity construction, we consider that identity work being undertaken by medical leaders to claim a leadership identity is ineffective.

Those participants with formal leadership experience tended to take a more sanguine view of their colleagues in formal leadership roles and focused more on the constraints of leading in the healthcare context and the bureaucratic challenges and frustrations that they had experienced in such roles. However, they did not position themselves as followers; instead, they spoke of the informal leadership that they now enact. Negative connotations surrounding the role of 'follower' (relating to being passive, low engagers and needing to be told what to do), which do not align with the traditional professional power enjoyed by senior doctors may, in part, explain a reluctance amongst our participants to claim such a role. The contemporary literature argues that effective followership does not involve individuals blindly following a leader, but rather it requires followers who meaningfully contribute to tasks through independent, critical thinking. Skilled followers are active participants who push forward ideas, question leaders, adapt to changing circumstances and have a strong sense of responsibility and motivation (Leung et al., 2018). So perhaps there is an argument for development in this area. However, as noted in the first row of Table 1, a key theme prominent across our data surrounded a perceived lack of trust of managers. This together with the varying implicit leadership theories surrounding healthcare (hierarchical /distributed) and the historic power dynamics, suggest that leader-follower relations in this context can be both complex and fraught with conflict.

Turning to De Rue and Ashford's framework, we consider first Proposition 1, 'The construction of a leadership identity occurs when claims and grants of leader and follower identities are endorsed with reciprocal grants and claim.' In relation to this, our data emphasised the importance of trust in facilitating the claiming of followership and granting of leadership identities. Phrases, such as '*least trustworthy', 'half-truths'* and *'devious and untrustworthy'* signify a lack of trust in medical managers

[7] Although these nine doctors had held leadership roles, all participants were treated homogeneously.

amongst the participants. This lack of trust means that the senior doctors are often not granting medical managers 'leader' identities, nor are they claiming a follower identity.

Second, and reflecting on Proposition 5, which states 'the greater the clarity, visibility, and credibility of claims and grants, the more likely those claims and grants will be reinforced via reciprocal grants and claims,' our results do not evidence a relationship that is reciprocated or mutually reinforcing. Noticeable phrases include: '*I wouldn't recognise the Chief Executive, or the Medical Director' and 'Medical managers have no interest in clinical quality or outcomes. See their role as obedience to the Health Board. They are non-thinking individuals. I think they've all become just management lackeys, if you like, and they forget the things they should be standing up for.'* This, in part, answers our research question that was to evaluate the effectiveness of claims of leadership identities in an environment where leadership by medical doctors is promoted at central (UK) and local (Scotland) government level. Certainly, extant Government policy in the UK would like this relationship to develop. Although medical leaders (i.e., 'willing hybrids') are doing identity work and, therefore claiming leadership identities, our findings suggest that it is not always being 'mirrored back'. In De Rue and Ashford (2010) terms, claims to leadership identity are not being granted.

Our data offer no evidence of the clarity of claims; however, there are issues with medical leaders' visibility (i.e., they are 'distant') and credibility (i.e., their medical peers do not see them as authentic). This, we consider, has significant implications for Government policy in this field. Moreover, it raises doubt over the extent to which Proposition 1, 'The construction of leadership occurs when leader and follower identities are endorsed with reciprocal grants and claims', holds in this context. This lack of granting of leadership identities is, we suggest, due to a lack of trust in — and credibility of — medical leaders. Moreover, and remaining at this general-level, questions remain as to the extent to which this relationship is endorsed within the broader organisational context.[8] There is also little evidence to show doctors are claiming follower identities. In this respect, there is no leader-follower relationship suggested by DeRue and Ashford (2010). This has, we suggest, significant implications for positive organisational outcomes.

Third, for Proposition 7, 'the more consistency people see between their own attributes and their own implicit theory of leadership (followership), the more they will claim a leader (follower) identity.' Lord (1985) proposes that by the time people begin working in organisations, they have developed

[8] As our study, however, was cross-sectional, we make no claims about the dynamic nature of this relationship over time.

varying assumptions and beliefs that form an implicit theory about what leaders and followers 'look like' and how leadership unfolds in groups. We make no claim to describing a stereotypical doctor; that being said, we contend that our findings suggest an association with implicit leadership theory. In other words, do the respondents consider that the medical leaders no longer actually 'look like' what doctors (i.e., the respondents) perceive doctors to look like?

Fourth, and in respect of Proposition 9, 'The more individuals perceive instrumental, interpersonal, and image rewards associated with leadership, (a) the more they will claim a leader identity and (b) the more they will grant a follower identity.' In terms of motivational risks and rewards, we do accept that there is some instrumentality at play here with medical leaders who have motivations to be rewarded. In addition, we make no claim to the relationship between risk and 'less claiming' and claiming a follower identity. But, from the respondents, there is clearly concern with doctors who seek formal reward. For example: '*They get so high up in the system that rewards them that they become part of the management system rather than representing doctors. There are even some joke terms for this; 'Gongitis', 'knight' fever and 'lorditis'.* It would seem that our sample does not like to grant claims to peers who are 'in the game' of being rewarded.

Reflections for Practice

Our findings suggest that despite UK Government policy — the desires to see doctors play a greater role in leading change in hospitals (Department of Health & Social Care, 2016) — most senior doctors in our study do not grant leadership identities to medical leaders who claim such leadership identities. This, we suggest, is due to a lack of perceived credibility and visibility of the said medical leaders. In addition, and in terms of implicit leadership theory, the medical leaders were not thought to compare to the views of prototypical leaders held by many of our study participants with regards to both effectiveness and professionalism (Schyns & Schilling, 2011).

Overall, identity co-construction theories of leadership point to a reciprocal need for leaders to undertake identity work to construct themselves as leaders and to make legitimate claims for a leadership identity to potential followers who, in turn, have to grant the claims to these leaders. Our findings suggest that this co-construction process has been largely unsuccessful with consultant doctors in NHS Scotland, with neither leaders nor followers being successful in making such claims or granting those claims of/to the other party. Simply put, medical leaders may 'claim' leadership, but they are not always 'granted' leadership by their colleagues. Indeed, most consultants in our study

saw medical leaders in a negative light. There was a strength of feelings towards doctors who had 'crossed a line in the sand' and this research suggests that consultants resisted the claims of these new hybrid medical leaders (i.e., willing hybrids) to a leadership identity (DeRue & Ashford, 2010). This unwillingness to 'grant' medical leader identities appeared to originate from a general lack of trust in managers. This *unwillingness* resonates with Savage et al. (2020). In their 'Conditions that can either facilitate or impede the influence of medical leadership on organisational performance', they offer analysis that explains many of our findings, i.e., impeding conditions. For example, in Perceptions of Management, they offer that managerial and clinical logics are challenging for physicians to reconcile. Management, perceived as an administrative domain, and the medical domain have distinct cultural differences. In detail (p4): 'When clinicians take on managerial roles, they are perceived to occupy a no-mans-land, often not meeting the expectations and authority vested in them. Many are concerned with losing their credibility among their peers and becoming outsiders, with management referred to as the 'dark side"'.

Future Research

De Rue and Ashford (2010) is a contemporary, United States-conceived theory that suggests individuals range from conceptualising leadership as a process than can be shared and mutually enacted among group members to one that is hierarchically structured such that there is only one leader in a group and leader and follower identities are mutually exclusive. Such individual difference in leadership structure schemas will shape when claims are reciprocated with grants and when grants are reciprocated with claims. Although we accept this (shared and mutually enacted and hierarchically structured) binary divide between leaders and followers, we suggest that the schemas within a hybrid organisation are more complex and multi-layered (Keisjer and Martin, 2020). In the context of this study, this binary divide is arguably problematic and too simplistic. It will be important, therefore, to consider alternative structures for hybrid organisations to understand claiming and granting. More generally, however, it is important to advance theory on the interplay and clinical relationship between hybrid leaders and followers in the UK/European cultural context.

DeRue and Ashford's model suggests that the greater the perceived status and rewards of the leader role in an organisation, the more likely there will be competitive leader claims. We observed this in part, but we also observed negative associations with personal rewards as a motivation and with the role of leader in general that participants suggested 'put off' some potential good hybrid leaders for taking on formal leaderships. This complexity would benefit from further study. The antecedents of

claiming and granting leadership and followership identities span multiple levels of analysis, including individual perception, social and relational processes, and supportive collective (organisational) structures. This study has been focused on the relational level and on senior doctors' recognition of medical leader identities. We have suggested that historic power dynamics together with an institutionalised lack of trust in 'management' amongst doctors creates barriers to the effective reciprocal claiming and granting of leadership identities in this context. Future studies could look to capture together the individual, relational and organisational factors that shape the hybrid leadership construction process. Investigating how individual medical leaders navigate the interpersonal and image risks associated with taking on a leadership role in this context and how they deal with resistance from colleagues to adopt follower identities would be useful (Bamji, 2022) as would examining the organisational factors that contribute to whether an individual is relationally recognised and collectively endorsed as a leader.

Finally, given the potential for conflict and tensions involved in hybrid medical roles, the leader-follower tradition in the leadership literature is only one way of analysing the challenges faced by medical leaders. The clinical leadership literature is vast and further theoretical development–especially in a European context–may seek to further draw on the practitioner literature (The King's Fund, 2019) to understand leader-follower interactions and contexts. It may also seek to draw on the institutional literature (e.g. Berghout et al., 2018; Keisjer & Martin, 2020; Petriglieri, 2011) to round out DeRue and Ashford's (2010) seminal contribution.

Conclusion

DeRue and Ashford (2010) and others have called for more in-depth qualitative studies to understand the form and nature of claiming and granting in leader-follower relationships. This research as attempted to gather in-depth accounts of the individual cognitive processes and relational processes that underlie the claiming and granting process.

Our research is located at the *relational self* that is derived from connections and role relationships with significant others. Thus, our research question is to evaluate the effectiveness of claims of leadership identities in an environment where leadership by medical doctors is promoted at central (UK) and local (Scotland) government level.

We consider that it advances theoretically, empirically, and managerially, DeRue and Ashford's (2010) claiming and granting model. We argue that such models have limitations in complex and hybrid healthcare systems. Second, it suggests that the 'lines in the sand' remain tightly drawn among many senior doctors, whose allegiance to a pure version of professionalism is so deeply embedded in the past to make it a relatively stable working self-concept (Petriglieri, 2011).

DeRue and Ashford's (2010) model was an attempt at a universal solution but in the context of hybrid organisations our study suggests limitations. More work is clearly required to understand the claiming and granting process in organisations with logic multiplicity.

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