Becoming active in the micro-politics of healthcare re-organisation

Waring, Justin; Bishop, Simon; Clarke, Jenelle; Roe, Bridget

DOI:
10.1016/j.socscimed.2023.116145

Document Version
Publisher's PDF, also known as Version of record

Citation for published version (Harvard):
Waring, J, Bishop, S, Clarke, J & Roe, B 2023, 'Becoming active in the micro-politics of healthcare re-organisation: The identity work and political activation of doctors, nurses and managers', *Social Science and Medicine*, vol. 333, 116145. https://doi.org/10.1016/j.socscimed.2023.116145

Social Science & Medicine 333 (2023) 116145

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Becoming active in the micro-politics of healthcare re-organisation: The identity work and political activation of doctors, nurses and managers

Justin Waring [a,*], Simon Bishop [b], Jenelle Clarke [c], Bridget Roe [a,d]

[a] Health Services Management Centre University of Birmingham Park House, 40 Edgbaston Park Road, Birmingham, B15 2RT, UK
[b] Nottingham University Business School, University of Nottingham Jubilee Campus, Nottingham, NG8 1BB, UK
[c] School of Social Policy, Sociology and Social Research, University of Kent, Cornwallis North East, Canterbury Kent, CT2 7NF, UK
[d] University of Birmingham, UK

ARTICLE INFO

Handling editor: Medical Sociology Office

Keywords:
Micro-politics
Political activation
Political socialisation
Identity work
Healthcare work
Organisational change

ABSTRACT

The changing organisation and governance of healthcare work represents a persistent focus of micro-politics. Whilst there is a developed literature describing the micro-political struggles that occur amongst healthcare occupations, there is little understanding about how, when and why actors become politically aware and active. Framed by research on political activation and the concept of identity work, this paper reports on a narrative interview study with 65 people, specifically doctors, nurses and managers, working in the English healthcare system. The narratives show that healthcare workers become increasingly aware of and engaged in micro-political activities through incremental stages based on their accumulating experiences. These stages are opportunities for identity work as actors make sense of their experiences of micro-politics, their occupational affiliations and their evolving sense of self. This identity work is shaped by actors' changing views about the morality of playing politics, the emotional implications of their engagement, and their deepening political commitments. The study shows that political socialisation and activation can vary between occupations and rather than assuming political affiliations are given or acquired the papers highlights the reflective agency of healthcare actors.

1. Introduction

Healthcare services are, in many ways, defined by disagreement and conflict about the organisation of care. Such conflict can appear mundane as healthcare professionals negotiate the everyday routines of care (Oh, 2014; Strong and Robinson, 1990). In other instances, it can be more pronounced as actors actively seek to transform or defend established ways of working, occupational jurisdictions or authority structures (Harrison et al., 1992; Menchik, 2021; Strong and Robinson, 1990). The concept of micro-politics places emphasis on the interactive episodes of conflict, but it also speaks to the deeper political tensions that stem from social groups' competing structural interests and ideological commitments (Waring et al., 2022). We acknowledge micro-politics can relate to various ideological tensions in society at large, including conflict around class, race, or gender, but the focus of our paper is with the micro-politics associated with the changing organisation and governance of healthcare work. This centres on questions about how, and by whom, healthcare work is organised in terms of clinical decision-making, determining the routines and boundaries of care, controlling resources, and assuring technical and normative standards of work. Over the last three decades, changes in the organisation of healthcare work have produced multiple sites of micro-political controversy with the introduction of more managerial, corporate and consumerist practices that have disrupted professional practices, jurisdictions, and identities (Harrison et al., 1992; McDonald et al., 2008; Waring and Currie, 2009). In most cases, this research presents social actors as relatively formed political players or members of a given community engaged in some kind of 'turf war'. We suggest, however, that people do not enter the healthcare workplace as formed political actors, rather they become politically aware and active. This might be explained in terms of professional socialisation, but we suggest more understanding is needed about how, when and why healthcare workers become actively engaged in the micro-politics of healthcare organisation.

* Corresponding author.
E-mail addresses: j.waring@bham.ac.uk (J. Waring), Simon.bishop@nottingham.ac.uk (S. Bishop), j.clarke-2261@kent.ac.uk (J. Clarke), b.j.roe@bham.ac.uk (B. Roe).

https://doi.org/10.1016/j.socscimed.2023.116145
Received 23 May 2023; Received in revised form 22 July 2023; Accepted 3 August 2023
Available online 5 August 2023

We develop our understanding of organisational political activation as a process of identity work (Brown, 2015). We elaborate our thinking as follows. First, all identities are inherently political because, on a socio-psychological level, they are formed with shared commitments that provide a sense of internal cohesion and external differentiation (Tajfel and Turner, 2004), and on a socio-political level, because identities are constituted in relation to prevailing governing ideologies (Jenkins, 2014; Mouffe, 2011). Second, identities are not passively acquired or prescriptively given, rather they are worked upon as people try to make sense of themselves in the context of changing circumstances (Giddens, 1991). Third, people work on their identities by reflecting on their experiences of political struggles, where engagement is itself guided by their identity (Brown, 2015). And fourth, the processes of identity work shape a person's ongoing political activities in terms of how they see themselves in relation to shared commitments (Bernstein, 2005).

Following this line of reasoning, this paper compares the political activation of doctors, nurses and managers working in the English National Health Service (NHS). It analyses political activation as a process of identity work, in which experiences of micro-politics prompts reflection on one's sense of self and social identity, which in turn shapes their on-going understanding of and engagement in micro-politics.

2. Background literature

An extensive literature describes the micro-politics of healthcare work, often with a focus on the conflict that arises between occupational groups following the introduction of new ways of working, technologies or evidence-based practices (Allen, 1997; Harrison et al., 1992; Oh, 2014). This literatures places varying degrees of emphasis on the *interactive* or *ideological* aspects of micro-politics, but generally offers little explanation about how and why actors become actively engaged in such conflict.

An early contribution to the field is Strauss et al.'s (1963) characterisation of the hospital as a negotiated order. This describes how the therapeutic and administrative aspects of care work are determined, less by formal rules or structures, and more through persuasion, bargaining, and uncooperative behaviours (Svensson, 1996). However, the negotiated order thesis has been criticised for its inattention to the socio-historical context, structures of power and vested interests that contextual negotiation (Allen, 1997; Bishop and Waring, 2016; Day and Day, 1977; Hall and Spencer-Hall, 1982). A more recent contribution to this perspective is Menchik's (2021) research on the management of medical authority in the face of corporate, commercial and professional pressures. He describes how the knowledge and standards of care are negotiated and determined through a myriad of stakeholder interactions and inter-dependencies across different venues, which together provide the basis of a collective occupational project that reinforces medical authority. Whilst the interactive perspective recognises that negotiations vary according to the experiences and capabilities of participants, it does not account for when and why actors become engaged in negotiations, why some might not engage, nor the broader ideological commitments that motivate their engagement.

Critical health policy and organisation research, commonly drawing on the sociology of professions, gives more explicit attention to the structural and ideological context of healthcare micro-politics. This often focuses on the conflicts that arise around specific policy reforms, with attention given to vested interests, power structures and ideologies. This is exemplified by Alford's (1975) study of US healthcare reforms that describes a continuing struggle between the structural interests of the dominant medical profession and the challenging interests of corporate rationalisers. Many studies analyse healthcare micro-politics as a conflict between the ideologies of managerialism and professionalism, where emphasis is given the strategic work of managers to challenge professional dominance and the structural power of professionals to contest, corrupt or capture management (Harrison et al., 1992; Harrison and McDonald, 2008; Light, 1994; Lozeau et al., 2002; Strong and Robinson, 1990; Waring and Currie, 2009). Here, healthcare micro-politics is often described as an interactive game for organisational control, but it is usually explained with reference to *macro*--political interests and ideologies. As with the negotiated order thesis, this research gives almost no explanation for when and why people become purposefully engaged in micro-politics or aware of their ideological commitments.

The idea that healthcare occupations act out shared interests can be located within research on professional socialisation. Returning to Strauss and colleagues, professional socialisation involves the formation of a collective identity, through which actors develop a common understanding about the purposes of work and acquire the shared values, attitudes, and interests of their occupation (Bucher and Strauss, 1961). Interests may vary between professions and sub-specialisms, and much like a political movement, professions develop identities and tactics to advance these interests. Jenkins et al.'s (2021) recent review reaffirms how medical socialisation contributes to the acquisition of, not only clinical knowledge and skills, but also the interactive norms that define professional practice and preserve professional cultures across generations. Of relevance here, these norms shape actors' responses to the wider socio-political landscape of healthcare work, and although Jenkins et al. do not expand upon how these norms might change, they do call for more research looking at socialisation as an ongoing and active process that evolves over the career. The broader literature on occupational socialisation shows it to be an ongoing and iterative process as workers move from the novice to more established membership positions (Wenger, 1998) and progress through career stages and role changes (Ashforth et al., 2000; Ibarra and Barbulescu, 2017), all of which requires experimentation with provisional identities (Ibarra et al., 1999). However, there remain questions about how, when and why healthcare professionals become aware of and active in the shared interests of their profession, or how career progression and transition into elite roles further influences political awareness and identity?

Taking up these questions, a significant development in the organisation of healthcare work has been the movement of professionals into more managerial roles. Freidson (1985) saw this as a response to the bureaucratisation of care, with administrative 'elites' maintaining the collective interests of their profession in the face of management influence. However, these 'hyrbid' roles pose problems for professional identities and allegiances, especially where elites align with corporate or managerial interests in the governance of professional work (McDonald et al., 2008; Waring and Bishop, 2013; Waring et al., 2020). Furthermore, Croft et al. (2015) show how nurse leaders occupy a liminal space between their profession and management, often struggling with their own identity work and conflicting loyalties. A further question posed by this literature, therefore, is how might occupational role transitions into leadership and managerial positions re-shape political commitments and activities?

To theorise this puzzle, we turn to research on political activation. This is a developed, but dispersed field dealing with various aspects of familial and civic political participation (Bode and Becker, 2018), social movements (Bernstein, 1997, 2005), radicalization (Doosje et al., 2016), and leadership development (Doldor, 2017). For our purposes, we highlight two features of the literature. The first is that political activism evolves over time through a staged process. Research on political radicalization describes how people become indoctrinated and activated to carry out extreme acts of terror through stages of fascination and sensitisation, cause orientation and identification, peer group identity, and activism (Doosje et al., 2016; Garcet, 2021). A similar model is presented with regards to the political 'seasoning' of business leaders, which involves stages of discovery, coping and proficiency (Doldor, 2017). Across these stages, political activation escalates in relation to a social actor's capacity (knowledge and skills), motivation (incentives and commitments) and mobilisation (encouragement to participate) (Bode and Becker, 2018). As such, we seek to understand how healthcare

professionals political activation develops through discernible stages of activation.

The second idea relevant to our study is that political activation centres on questions of identity. Social movement theories, in particular, offer relevant understanding about the importance of identity in the emergency, coalescence and mobilisation of collective action (Bernstein, 1997; Bernstein and Olsen, 2009). Bernstein (1997) elaborates the concept of political identity in relation to social movements as; first, a shared collective identity necessary for collective action; second, the expression of identity as a political strategy; and third, as the goal of action in terms of social acceptance. Of interest to our study is the way identities can be constructed through the experience of political action as a form of 'identity work' (Bernstein, 2005; Einwohner et al., 2008).

Identity work involves 'forming, repairing, maintaining, strengthening, or revising the constructions that are productive of a sense of coherence and distinctiveness' (Sveningsson and Alvesson, 2003: 1165). It implies reflexive agency as actors make sense of and reconcile their experiences to find a sense of ontological security (Giddens, 1991), helping people connect who they have been with who they are becoming in the context of social change. Identity work is itself a political project not only for internalising political expectations but for challenging dominant discourses (Berstein 2005). Research shows how healthcare professionals routinely engage in identity work in the context of organisational and occupational change which enables them to make sense of and influence their changing social position (Croft and Currie, 2015; McDonald et al., 2008; Waring and Bishop, 2011). As such, we are interest in the types of identity work healthcare actors engage in as they transition towards political activation, and in particular how this identity work might vary between doctors, nurses and managers.

3. The study

Narrative research attends to how people make sense of and give meaning to their experiences through story-telling (Czarniawska, 2004). Narratives are not objective truths, but subjective interpretations that can be analysed in terms of underlying meanings, beliefs and values (Czarniawska, 2004; Josselson, 2011). Although narratives are unique to a person's experience and the context of story-telling, interpretation across multiple narratives can reveal shared normative, moral and political concerns. Following these ideas, our interview study investigated how doctors, nurses and managers construct biographical narratives as a form of identity work in relation to the micro-politics of organising healthcare work.

We carried out our interview study between 2018 and 2020 with doctors, nurses and managers working, or who had previously worked, in the English National Health Service (NHS). The NHS is a comprehensive healthcare system funded largely out of central taxation and subject to wide-ranging national regulatory measures. Much like other healthcare systems, it has a developed division of labour with marked disparities in status and power between professional groups (Harrison and McDonald, 2008). Research attests to the status differences between healthcare professionals, where the likes of doctors often have greater scope to shape or resist work organisation than those with less status or influence (Allen, 1997). It is commonplace for the medical profession to be seen as occupying a dominant position relative to other occupations, and for managers, other occupations and service users to be interpreted as challenging this position through new governance arrangements, inter-professional working or consumerist agendas. The social structures of professional power provide an important backdrop to micro-politics, but they should not be regarded as absolute.

Rather than focusing on a particular reform or change agenda, our narrative study investigated participants' varied and evolving experiences of change in the organisation and governance of healthcare work. For example, some participants could reflect on changes dating back to the early 1990s or across different care settings. Nevertheless a number of relatively common programmes of change provided the backdrop for participants' experiences, including: expectations for resource efficiencies, high-profile scandals around service quality, technological innovation, service redesign, quality improvement efforts, commissioning changes, and workforce challenges. There was no clear indication from the narratives that any particular reform agenda was more significant than another, rather it seems that unrelenting change was itself the main source of political instability.

Our paper reports on narrative interviews with 65 people, recruited through established research and education networks amongst the research team. In terms of primary occupational affiliation this included: 29 managers, 21 doctors and 15 nurses. Through career advancement many doctors and nurses had moved into managerial or leadership positions at different levels of the care system, including 9 doctors with hospital or regional leadership roles, e.g. Medical Directors; and 6 nurses with leadership for quality improvement, 4 for departmental management and 5 for senior hospital leadership. At the time of participation, participants worked across a number of care settings: 27 in general hospitals, 5 in specialists hospitals, 14 in primary care, 3 in community care, 8 in regional care planning and 8 in national leadership roles. However, many had worked in multiple settings over their careers, especially during professional training, and many senior managers had experience of working across multiple type of organisations. The sample also included people with different career length including 5 with less that 10 years, 5 between 11 and 20 years, 28 between 21 and 30 years, and 19 with more than 31 years (8 participants did not provide this information or had had varied careers). See Supplementary file for participant details.

The narrative interviews followed a topic guide that invited participants to reflect upon their career and talk about prominent or memorable instances of conflict or disagreement in the changing organisation of healthcare work. No formal definition of organisational-, workplace- or micro-politics was given, but we did refer to these terms as prompts to probe their sense-making. Participants provided over 100 detailed stories, and those with longer careers talked about multiple events able to reflect upon connections between them. All interviews were recorded and transcribed.

Interpretative narrative analysis involved open reading of transcripts to understand how participants talked about the micro-politics in terms of both the structure and content of their stories (Josselson, 2011). The initial stage focused on understanding the main storylines and narrative features. Most stories focused on a change initiative, e.g. a quality improvement programme, but this would be situated in a broader context of past events and underlying motives for change. The controversies triggered by these initiatives were elaborated as a series interlinked, sequential and turn-taking activities. Subsequent coding focused on common and different ways participants talked about these interactions, but with particular attention to the way they talked about themselves in relation to these situation by focusing on 'I' or 'me' statements. We then analysed differences between occupational groups at different career stages.

It is important to reflect on the methodological limitations of the study. Participants' narratives were a construct of the interview encounter and not necessarily illustrative of the types of identity work carried out at the moments of their experiences. Furthermore, the interview exchange could be seen as a form of political work, whereby participants sought to project a particular image to the interviewer (Kvale, 2008), or fit with normative versions of one's political identity. We also recognise that more experienced participants in senior positions might be inclined to explain past actions from the vantage point of their current status. While retrospective storytelling may not convey objective accounts of the activities or emotional responses of peoples experiences of the past, the same could be said of more immediate attempts to make sense of ones experiences. We also acknowledge that participants identity and political commitments extended far beyond the organisation of care work, and related to prominent socio-political tensions related to gender, class and ethnicity (Jenkins et al., 2021), as well as

wider ideological commitments about the funding and governance of public healthcare. We do not deny the significance of these but they are beyond the scope of this paper and its focus on the micro-politics of organising healthcare work.

4. Findings

As noted above, our study did not focus on any given reform agenda and, as such, our participants provided diverse accounts of disagreement and conflict in the changing organisation of healthcare work. Some prominent issues included, for example, the re-organisation of care pathways, the utilisation of evidence-based medicine, new forms of clinical governance and quality improvement, technological innovation, the drive towards integrated working, and widespread efforts at cost control. It was also the case, however, that regardless of the specific issue or people involved, the narratives shared common features about the manifestation of disagreements that varied primarily in terms of occupational group and career stage. Of particular interest to our study was how participants reflected upon and positioned themselves in relation to these situations as a process of identity work and political activation.

4.1. Early impressions and cautious encounters

Whilst all participants saw disagreement as a normal part of everyday decision-making, in the very early career stage it was often experienced with a sense of confusion and remoteness. This is exemplified by the following trainee manager who described finding it difficult to comprehend the politics of decision-making and whether it undermines the principles of rule-based governance:

> I would say in my first placement I was often kind of really bloody confused a lot of the time. I think I deliberately kind of kept myself out of organisational politics. I felt as if there was nothing to be gained for it, if that makes sense? (Manager)

Those still in the early stages of their career tended to refer to quite generalised forms of 'office politics'. These accounts often described interpersonal disagreements and personality clashes which were generally seen as disruptive or associated with nefarious or dangerous people, rather than linked to established factions or recuring sources of conflict.

Looking back at the early stages of their careers, many doctors described their naivety to organisational politics. This seemed to stem from their lack of embeddedness in the organisation, their focus on skill development, or being 'shielded' by senior colleagues; all of which made their later encounters with politics more startling. The following General Practitioner (GP) reflected on their training period in hospital settings where the emphasis was on skill development rather engaging in political behaviours:

> … being on rotation meant that it was difficult to really belong to a team or department and so I guess a lot of things just passed me by … you want good relationship with your colleagues and you want to develop your skills ….but you don't want to get embroiled in other things and get a reputation (Doctor)

In contrast, nurses often reflected on their early careers in ways that more readily recognised the hierarchies between professional groups and routine forms of disagreement that imbued the everyday organisation of work. The following senior nurse reflected on how they talked about inter-professional politics with newly qualified nurses, emphasising notions of culture rather than politics, but also suggesting that those who work on hospital wards become quickly socialised into status disparities:

> I don't think anyone who works on a ward is ignorant to the power differences between professional groups, it is so engrained in the culture … culture will determine how you respond to the politics, so if I was talking to a bunch of newly qualified nurses, I'd talk about culture rather than politics probably because it's more tangible. (Nurse)

Early understanding of micro-politics therefore seemed shaped by participants' professional training routes and exposure to frontline controversies around the organisation of work. For managers and nurses this was more apparent than doctors, but for all there was a reluctance to really recognise or attend to such politics because of a perceived negativity.

4.2. Awakening and taking sides

All but the least experienced participants talked about a significant moment in their career that changed their thinking about the micro-politics of healthcare work. Akin to an epiphany or awakening, these events revealed the lines of power and vested interests that guided political behaviours. As the following manager described, these events were typically precipitated by career advancement and increased responsibility for organisational decision-making, which were usually experienced earlier and more readily for managers and nurses promoted into leadership roles.

> Thinking back and I can clearly see that. I think I became aware of the politics when I moved into a directorate and could see the directorates all working in a hospital and actually when you enter senior management and you become aware of the conflict between clinicians and managers, there's suddenly an awareness.… (Manager)

Many of the participants described their political awakening as a surprise and shock, because it highlighted for them a dissonance between their idealised beliefs about how services should be organised and how change actually happened through heated conflict. For the following nurse, their promotion into leadership was expressed as a difficult transitions from the more technical aspects of clinical nursing to the more non-technical skills of inter-personal influence:

> I had an appraisal which was really interesting because up until then when you're a nurse you tend to be very technical … I had an appraisal that very much was talking about how fantastic I was at the detail of the job but that I didn't fully understand and appreciate the politics … I didn't know what that meant genuinely at that point in time so it kind of was well you know … So things like how services were being configured, how the acute, the community, mental health had to start working differently […] So that was really difficult for me because it was the first time I was coming out of this very technical world of nursing care. (Nurse)

Echoing the personal difficulties expressed above, one nurse reflected on the difficulties they encountered in trying to improve the quality of nursing practice in an intensive care unit and the emotions this provoked:

> … [I] then went to be a staff nurse on intensive care unit and it was there that I went into a post, I was a senior staff nurse. So involved running the unit … sort of matron level for quality improvement type. … There was quite a lot of the 'way we do things round there', round here, and the culture wasn't really receptive to it ….I used to get quite frustrated, quite upset over that sometimes … we just had to keep battling all the time to implement improvement. (Nurse)

Doctors' description of their political awakening was typically occasioned with their movement into specialist training or taking a permanent position at which point they became aware of the local political landscape and invested in the agendas of their peers and professional seniors. For example, we found that middle-career doctors rarely talked about individual political activities, but they would talk about

supporting the collective viewpoint of their profession in the face of management change. This could suggest a more subtle but pervasive attachment to the interests of their profession. This sense of political positioning and affiliation can be seen with the following doctor who had recently been promoted to a permanent consultant (attending) position:

> You sometimes have to ask yourself who knows the patients best who knows how to deliver the service. I'm not taking anything away from other professional groups, you know the nurses are in this too, but how can the Trust executives really understand, so we need to make sure we keep making the point that we might actually know best (Doctor)

Growing awareness of organisational politics made many participants realise they were already involved in deeper political struggles, even if only passively, by virtue of their professional membership or organisational affiliations. Some saw their awakening as 'taking sides' with their occupation or department, and coming to see the shared obligations or commitments they held by virtue of being a doctor, nurse or manager. The following senior hospital manager reflected on an encounter with a group of surgeons early in their career which revealed not only their naivety to organisational politics but also the deeply engrained conflict they now faced, which for them was clearly manifest in terms of the tensions between managers and medical professionals:

> I don't think I was ignorant to workplace politics … but I was probably naïve. I remember with my first management position … one of the first tasks was to reconfigure the surgical directorate …. I remember holding a meeting with the surgical leads and consultants … I outlined what we were planning to do … move some lists, rejig theatre times, rebalance some work to reflect changing demand. And they just looked at me, all of them, and then walked out. I just didn't know what was going on … Later one of the more senior surgeons came to my office and said something along the lines that what I was proposing was unacceptable and worse that my approach was out of line. They were willing to give me the benefit of the doubt because I was new but if I tried something like this again, they wouldn't work with me. I learnt a lot about how to not to work with doctors and how to manage with people. (Manager)

4.3. Normalisation and turning points

With career progression participants seemed to normalise the everyday micro-politics of healthcare work, in so much that it was accepted that sections of the healthcare workforce hold differing views about how best to organise work and who should be in charge of organising work. This was especially the case for those in management or clinical leadership roles (the majority of our sample) who were, in different ways, responsible for planning, changing or supervising healthcare work. As many described, dealing with competing agendas, mediating conflict and using 'soft power' was 'part of the job'. For example, the following doctor reflected on their first 'success' in leading a change initiative within their hospital which cemented their identity as an effective leader:

> We re-designed not just the ED but a lot of the front door medical services, surgical services, we took cardiology which took two groups of people that didn't talk to each other and ended up creating the new service … I'm thinking back on things that have been helpful to me yes there's something about negotiation skills, facilitation skills, how to manage meetings effectively … so how you can engineer win-wins out of meetings if you know how to set them up and do the pre-work that was really quite powerful stuff. (Doctor)

Although micro-politics might become normalised, the majority of participants also described a difficult event or turning-point in their career that required them to re-evaluate their thinking about the politics of healthcare work. For some, these turning-points exposed their lack of political acumen and a deficiency in their leadership capabilities that needed addressing. The following manager reflected on the difficulties of implementing a new workflow management system in their hospital which was strongly resisted by professional groups. They recognised being over-confident in their formal authority and their lack of political foresight, which for this participant became the focus of their leadership development:

> So in terms of me falling fowl of politics, I think naivety and arrogance. I think the arrogance part was I thought I knew what I was doing in my job, and I thought that if I did the job, if I did a good job in the way that I thought was best, that would be enough. So that was the combination of naivety and arrogance. (Manager)

Some experienced these turning-points as professionally or personally damaging. The following nurse leader who had progressed into a senior quality improvement role reflected on an the moral distress they experienced when trying to implement change in the face of resistance from frontline staff:

> [It's] uncomfortable a lot of the time and again I think it depends, whether things are going well or things are going badly and I've worked at this organisation for a long time … But I think to actually be working within the organisation, … with regards to organisational politics, sometimes it feels as if you're literally being torn limb from limb. (Nurse)

Healthcare professionals who had moved into leadership or management roles also described these turning-points as revealing their precarious position of being caught between the expectations of their profession and the wider organisation. Most talked about continuing to share their longstanding professional commitments and to describe themselves as doctor or nurse, but they also recognised that their new roles made them responsible for delivering the operational and strategic objectives of the wider organisation. Some talked of leading changes in care pathways or quality improvement initiatives that placed them in the 'firing line' of controversy to the extent that they became the focus of their professional colleagues' opposition, with their loyalties called into question. Others, however, saw their ability to mediate between these competing interests as demonstrating their diplomatic skills and validating the importance of their leadership role (Jones and Fulop, 2021). As the following clinical leader described, their turning-point was significant for showing how they could maintain relationships with professional colleagues, and at the same time deliver reforms expected by management strategy:

> I was very aware that my colleagues would think I had 'turned to the darkside' and was only trying to introduce the surgical pathways to improve things like theatre utilisation or reduce waste, or meet government targets, rather than deal with the things that bothered them. But I suppose what I did was balance these views, to create some kind of fit or alignment (Doctor)

4.4. Strategic necessity and personal mastery

Participants with senior clinical leadership or executive management roles provided more polished accounts of their micro-political activities. For these people, dealing with the politics of workforce change was a routine feature of their role, and their ability to deal with resistance and conflict was central to their identity as an effective leader.

> I think you get a bit of political nous with experience and it's about, I suppose it's about understanding well the internal politics… Because a lot of that I think is unspoken, you just learn it with experience and you learn to read between the lines a bit more. It's stuff that's not necessarily overt, but you pick up on that more discreet intelligence, soft intelligence should I say. (Manager)

Some described a virtuous circle whereby accumulated experience of politics facilitated mastery of political capabilities and successful leadership of change which, in turn, supported their image as a 'politically savvy' leader. This sentiment was found across all senior level managers, nurses and doctors, suggesting some degree of convergence in their attitude towards politics, but still divergence in the motivation for their engagement.

> I think it's seniority, I think it's the maturing ….I think it's probably the seniority and the experience and probably just the years of dealing with it ….I realised years back that I have become a diplomat. I have to be so diplomatic and I think that is a key skill for me. I am diplomatic on a daily basis… to ensure that people continue to be engaged and continue to work together (Manager)

A further point of convergence for most senior leaders and executives, whether based at local, regional or national levels of the NHS, was a sense of commitment towards the delivery of strategic policy goals and dealing with groups that retard change. As described above, for clinical leaders this often meant dealing with members of their own profession, which often problematised their allegiances. Some described how, unlike their frontline colleagues, they could see the 'big picture' of broader healthcare, economic or political issues and so it was important to lift themselves out of the quagmire of frontline micro-politics. This is reflected in the following account from a regional-level nursing director who talked of needing to influence multiple constituents to 'get them doing stuff'.

> … the need to be savvy politically, internally to know how you play the board, to know how you play our consultant body because you are not their shop steward you've got to get them doing stuff. (Nurse)

For this group, dealing with the liminality (Croft et al., 2015) even duplicity of their position became part of the diplomatic work (Jones and Fulop, 2021) of clinical leadership. The following clinical leader reflected on needing to 'cajole' both managers and doctors when developing the case for a new surgical unit:

> I had to deal with both sides, neither the Trust managers or the surgical heads seemed willing to accept the case … it took a lot of cajoling and showing them the evidence, and building the case, and getting support from outside the hospital (Doctor)

Although most senior leaders and managers recognised their positional authority, it was common for them to emphasise their personal characteristics as enabling them to lead; thereby giving more credit to their own personal qualities. This seemed especially important for managers, for whom political mastery was closely linked to their leadership identity:

> … one's got positional power which is very rarely used, but everyone knows it's there … but one prefers to use influence and argument and logic and empathy and all that, that's my preferred style of working whereas when one works, as you're describing, laterally or upwards you've got to use relationships … people know that you've done that … [and] has some soft and invisible cache which one has to use very judiciously and respectfully, but there is a soft power. (Manager)

Senior-level participants offered subtly different value judgements about their role in the politics of organising healthcare work. Nursing leaders, in particular, advocated for political behaviours that were moral, ethical and values-based. In this sense, there is 'good' or authentic politics that can counteract more dysfunctional and immoral behaviours. The following nursing director of a large teaching hospital described their involvement in the politics of leading change as being driven by their commitment to *doing the right thing:*

> I will only do things that I know are right and proper, and that at the end of the day I can put my hand on my heart, and even if something wasn't quite right, it was done with the best of intent, and it wasn't a call, to be malicious or anything like that. (Nurse)

In contrast, managers often took a more pragmatic or instrumental view which centred on whether they were able to deliver change, regardless of the techniques of managing resistance:

> Power and politics are neutral … They can be used for good or they can be used for ill. It's a reality of every relationship within an organisation and it's incredibly important to engage with it. Those that don't find themselves lost and stuck and not making any progress … I can feel very, very comfortable, I expect many can be, while I'm using power or politics for what I see as ethical reasons that are valid, the goal of the organisation, for the people that we're serving. (Manager)

5. Discussion

Our study examined how doctors, nurses and managers become aware of and active in the micro-politics of organising and governing healthcare work. Whilst the wider literature offers many detailed accounts of the political tensions experienced during periods of change (Harrison and McDonald, 2008), there remains little understanding about how and why individual actors become embroiled in such politics. Guided by the literature on political activation, we explore how healthcare actors described their experiences of becoming politically aware and active in terms of their evolving sense of self and social commitments.

Our study finds that healthcare actors do not enter the workplace as formed political players, rather they become aware of and active in organisational politics based on their accumulating experiences and deepening commitments. Drawing on the literature on political activation (e.g. Bode and Becker, 2018), healthcare actors' political activation develops through incremental stages. To a large extent, the transition between these stages reflects actors' increasing exposure to the everyday micro-politics of work brought about by career progression organisation. Following an initial period of uncertainty or naivety, healthcare workers' growing involvement in decision-making leads to an awakening to the engrained politics of healthcare work which in time leads to the normalisation of organisational micro-politics. Following Lave and Wenger (1991), these early stages in political socialisation and activation are significant for two reasons. First, they suggests that healthcare workers' growing awareness of organisational politics coincides with a deepening sense of occupational or organisational belonging in terms of having a more legitimate membership role in the workplace. Second, such belonging and deepening political awareness reveal to healthcare workers that they share the concerns and interests of their membership group, which positions them on one 'side' or the other of a given dispute. However, the incremental stages of political activation do not always lead to ever-deeper ideological commitment. With career progression many healthcare workers experience a difficult turning-point that causes them to re-evaluate their willingness to engage in political disputes, whilst those who move into hybrid professional-managerial roles can find their commitments and loyalties called into question (Croft et al., 2015; Waring, 2014). Career progression into senior leadership roles requires sustained engagement in and mastery of politics (Doldor, 2017), where being an effective political operator is integral to the leadership identities of managers, nurses and doctors alike.

Our study offers some response to Jenkins et al.'s (2021) call for more research on the processes of professional socialisation over the career and how such socialisation shapes actors' interactive norms with regards to their political landscape. The processes of 'political socialisation' described in our study shows that only the foundations of political awareness and activation are located within formal education and training pathways, with the more significant developments in political awareness and activation occurring through ongoing career progression

and transitions. As noted, however, the transition into leadership roles, together with the possibility for more negative experiences can problematise political activation and present dilemmas for political affiliation.

Our study also finds important differences in healthcare occupations' political activation. It seems that nurses and then managers more quickly become awakened to and active in micro-political disputes. For nurses, awareness of status and power disparities, more broadly, seems part of their shared cultural fabric, which develops through early professional socialisation and is reinforced through day-to-day inter-professional working (Fackler et al., 2015). For nurses, navigating the contradictions of having more clinical experience but remaining subservient to doctors is a central element of their work (Allen, 1997). In general, managerial work is more directly concerned with processes of organisational planning and change, which routinely provoke opposition from professional groups eager to determine the character of their own work (Waring and Currie, 2009). As such, their involvement and mastery of politics becomes an integral feature of their career development (Doldor, 2017). For managers, there was less obvious occupational commitment to other managers given their heterogeneity as an occupational group across the different types of service organisations, and so their commitments seem to be anchored to the processes of managing work in line with organisational strategy or health policy. For doctors, the extended processes of clinical training and limited embedding within the clinical workplace seems to delay the processes of early activation. And when awareness and activation does occur for doctors, it seems more closely tied to the activities and agendas of their senior colleagues within the local context. As such, role models and peer groups become important aspects of doctors political activation. The movement of nurses and doctors into leadership roles deepens their understanding of politics, but as shown by Croft et al. (2015) it more strongly places nurses in a precarious position between the demands of their colleagues and the organisation. For both nurses and doctors, the progression into hybrid roles can de-stabilise and call into question earlier professional commitments and obligations. It might be argued that those who embraced these new lines of commitment illustration a stage of re-politicisation or even conversation.

Our study findings highlight the reflexive agency involved in political socialisation and activation, which offers a counter-balancing to more structural perspectives that suggest healthcare actors' acquire their political commitments and interests in an un-reflexive way. In seeking to explain the factors that shape this reflexive agency, we elaborate three relatively common aspects of participants' identity work.

The first relates to the interplay between morality and identity, which evolves in the context of changing experiences and sensibilities (Stets and Carter, 2012). Early in their careers, healthcare workers often regarded political behaviours as inappropriate or undermining normative values. As participants moved into more established insider roles (Lave and Wenger, 1991), their attitudes towards micro-politics became refracted through deepening occupational or organisational commitments, whereby political behaviours were viewed not only as normal but also more appropriate when associated with the interests of their own community. For some more experienced and senior participants, the morality of organisational politics was neutralised, whereby leadership identities are anchored in the ability to manage political turmoil, and so questions of morality were re-cast in terms of their success in dealing with conflict.

The second aspect of identity work relates to the role of emotion and emotional work (Freeden, 2013; Hochschild, 1979). Our participants described political activation in highly emotional terms, especially the shock of their awakening, the distress of their turning-point and the pride of their achievements. Reflection on and the management of emotion seemed integral to the processes of identity work as participants made sense of their understandings of workplace politics and their role within it. This seemed closely linked to participants' moral judgements, where negative emotion could reinforce the view of political behaviours as being immoral and nefarious, and vice versa. The social movement literature highlights the role of emotion in forging commitment to group interests and mobilising collective action (Ruiz-Junco, 2013), and we suggest further research is needed in this regard, especially the role of other actors in shaping the emotional and ideological commitments actors have towards organisational change.

The third aspect of identity work relates to participants' evolving commitments to shared occupational or organisational interests. Idealised professional or public service commitments were important to all participants at all career stages, but over time these intermingled with other concerns. Participants' political awakening involved the realisation that they were themselves enrolled in political controversies by virtue of their occupational membership. Although shared occupational commitments strongly influenced participants' sense of self, these could be qualified or off-set by more personal interests manifest around career advancement. This was especially the case for managers for whom career advancement was often linked to delivering change, and for clinicians that had moved into hybrid professional-managerial roles. These hybrid positions place professionals at the interface of competing interests and agendas (Waring, 2014), and as shown by McGivern et al. (2015), hybrids can be intentionally strategic in their identity work to reconcile competing demands and support their career advancement. For some this involved aligning their identity with more with personal leadership ambitions within and beyond their organisation, e.g. in policy advisory roles (McGivern et al., 2015). More research is needed on the specific political identities of these hybrid roles, especially where there is scope to play-off or align competing interests to show commitment to multiple parties, e.g. profession and organisation, and at the same time, advance personal interests for career advancement (Currie and Croft, 2015). What seems less clear, in particular, is the way in which other actors, especially peers, mentors or leaders, actively shape actors' reflective identity work. The social movement literature shows, for example, how movement leaders are instrumental in aligning interests and mobilising activities, but how this plays out for hybrids, and other healthcare professionals, is less clear.

In conclusion, we return to our earlier reflection that little research considers how and why healthcare actors become aware of and actively engaged in the micro-politics of organising healthcare work. Our findings resonate with the wider literature on professional socialisation whereby workers progressively internalise shared interests and commitments through continued and deepening community engagement (Niemi and Hepburn, 1995; Wenger, 1998). We understand this 'political seasoning' (Doldor, 2017), as an on-going process of identity work. This identity work helps people make sense of the politics of organising healthcare work and, importantly, their shared political commitments and inclinations for political action. We suggest this identity work involves working through three linked issues: changing views about the morality of politics, the emotional consequences of political encounters, and deepening (and shifting) political commitments and interests. This identity work reveals variable levels of reflexive agency across participants' careers, but also the persistence of structural constraint manifest in the variable social positions and lines of power experienced by different occupational groups (see also McDonald et al., 2008). That is, some groups are more directly confronted with political disputes and their role within them, albeit with variable scope for action, whilst for others political engagement comes later but with greater scope for action. Furthermore, the study suggest actors' moral judgements and political interests are not entirely prescribed nor passively accepted, but are interweaved into their identity work in light of their accumulated experiences and emotional responses. That is, social actors' commitments to broader macro-political interests are far from given, but are contingent upon the interweaving influence of individual and shared interests, personal experience and ongoing moral deliberation.

Credit author statement

All authors we involved in the conception of the study, data collection and analysis, and the drafting and editing of the manuscript.

Funding

This study was fu nded by the UK National Institute for Health Research (NIHR) [Health Services and Delivery Research) [NIHR 16/52/04]. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

Ethical statement

The study received favourable ethical review by the University of Nottingham Research Governance Committee (Business School).

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

Data will be made available on request.

Acknowledgement

The authors acknowledge Georgia Black, Mark Exworthy, Naomi Fulop, Jean Hartley and Angus Ramsay who contributed to the design and conduct of the wider NIHR study from which this paper is drawn.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.socscimed.2023.116145.

References

Alford, R., 1975. Health Care Politics. University of Chicago Press, Chicago.
Allen, D., 1997. The nursing-medical boundary: a negotiated order? Sociol. Health Illness 19, 498–520.
Ashforth, B.E., Kreiner, G.E., Fugate, M., 2000. All in a day's work: boundaries and micro role transitions. Acad. Manag. Rev. 25, 472–491.
Bernstein, M., 2005. Identity politics. Annu. Rev. Sociol. 31, 47–74.
Bernstein, M., 1997. Celebration and suppression: the strategic uses of identity by the lesbian and gay movement. Am. J. Sociol. 103, 531–565.
Bernstein, M., Olsen, K.A., 2009. Identity deployment and social change: understanding identity as a social movement and organizational strategy [1]. Soc. Compass 3, 871–883.
Bishop, S., Waring, J., 2016. Becoming hybrid: the negotiated order on the frontline of public-private partnerships. Human Relat. 69 (10), 1937–1958.
Bode, L., Becker, A.B., 2018. Go fix it: comedy as an agent of political activation. Soc. Sci. Q. 99, 1572–1584.
Brown, A.D., 2015. Identities and identity work in organizations. Int. J. Manag. Rev. 17, 20–40.
Bucher, R., Strauss, A., 1961. Professions in process. Am. J. Sociol. 66, 325–334.
Croft, C., Currie, G., Lockett, A., 2015. Broken 'TWO-WAY windows'? AN exploration of professional hybrids. Publ. Adm. 93, 380–394.
Currie, G., Croft, C., 2015. Examining hybrid nurse managers as a case of identity transition in healthcare: developing a balanced research agenda. Work. Employ. Soc. 29, 855–865.
Czarniawska, B., 2004. Narratives in Social Science Research. Sage, London.
Day, R., Day, J.A.V., 1977. A review of the current state of negotiated order theory: an appreciation and a critique. Socio. Q. 18, 126–142.
Doldor, E., 2017. From politically naïve to politically mature: conceptualizing leaders' political maturation journey. Br. J. Manag. 28, 666–686.
Doosje, B., Moghaddam, F.M., Kruglanski, A.W., de Wolf, A., Mann, L., Feddes, A.R., 2016a. Terrorism, radicalization and de-radicalization. Curr Opin Psychol 11, 79–84.
Doosje, B., Moghaddam, F.M., Kruglanski, A.W., de Wolf, A., Mann, L., Feddes, A.R., 2016b. Terrorism, radicalization and de-radicalization. Curr Opin Psychol 11, 79–84.
Einwohner, R., Reger, J., Myers, D., 2008. Idenitity work, sameness and difference in Social Movements. In: Reger, J., Myers, D., Einwohner, R. (Eds.), Identity Work in Social Movements. University of Minneapolis Press, Minneapolis, pp. 1–18.
Fackler, C.A., Chambers, A.N., Bourbonniere, M., 2015. Hospital nurses' lived experience of power. J. Nurs. Scholarsh. 47, 267–274.
Freeden, M., 2013. Editorial: emotions, ideology and politics. J. Political Ideol. 18, 1–10.
Freidson, E., 1985. The reorganization of the medical profession. Med. Care Rev. 43, 11–35.
Garcet, S., 2021. Understanding the psychological aspects of the radicalisation process: a sociocognitive approach. Forensic Sci Res 6, 115–123.
Giddens, A., 1991. Modernity and Self-Identity: Self and Society in the Late Modern Age. Polity Press, Cambridge.
Hall, P.M., Spencer-Hall, D.A., 1982. The social conditions of the negotiated order. J. Contemp. Ethnogr. 11, 328–349.
Harrison, S., Hunter, D.J., Marnoch, G., Pollitt, C., 1992. Just Managing: Power and Culture in the National Health Service. Macmillan, London.
Harrison, S., Mcdonald, R., 2008. The Politics of Healthcare in Britain. SAGE Publication, London.
Hochschild, A.R., 1979. Emotion work, feeling rules, and social structure. Am. J. Sociol. 85, 551–575.
Ibarra, H., Ashford, S., Gersick, C., Dutton, J., Ely, R., Gabarro, J., Gargiulo, M., Johanson, L., Murnighan, K., Rafaeli, A., Schein, E., Sutton, R.-E., Walton, R., Weick, K., 1999. Provisional selves: experimenting with image and identity in professional adaptation I thank. Adm. Sci. Q. 44, 764–791.
Ibarra, H., Barbulescu, R., 2017. Identity as narrative: prevalence, effectiveness, and consequences of narrative identity work in macro work role transitions. Acad. Manag. Rev. 35, 135–154. https://doi.org/10.5465/amr.35.1.zok135.
Jenkins, R., 2014. Social Identity. Routledge, London.
Jenkins, T.M., Underman, K., Vinson, A.H., Olsen, L.D., Hirshfield, L.E., 2021. The resurgence of medical education in sociology: a return to our roots and an agenda for the future. J. Health Soc. Behav. 62, 255–270.
Jones, L., Fulop, N., 2021. The role of professional elites in healthcare governance: exploring the work of the medical director. Soc. Sci. Med. 277.
Josselson, R., 2011. Narrative research: constructing, deconstructing, and reconstructing story. In: Wertz, F. (Ed.), Five Ways of Doing Qualitative Analysis: Phenomenological Psychology, Grounded Theory, Discourse Analysis, Narrative Research, and Intuitive Inquiry. Guildford Press, London, pp. 224–242.
Kvale, S., 2008. Doing Interviews. SAGE Publication, London.
Lave, J., Wenger, E., 1991. Situated Learning. Legitimate Peripheral Participation. Cambridge University Press, Cambridge.
Light, D., 1994. Countervailing powers. In: Johnson, J., Larkin, G., Saks, M. (Eds.), Health Professions and the State in Europe. Routledge, London, pp. 25–41.
Lozeau, D., Langley, A., Denis, J.-L., 2002. The corruption of managerial techniques by organizations. Hum. Relat. 55, 537–564.
McDonald, R., Harrison, S., Checkland, K., 2008. Identity, contract and enterprise in a primary care setting: an English general practice case study. Organization 15, 355–370.
McGivern, G., Currie, G., Ferlie, E., Fitzgerald, L., Waring, J., 2015. Hybrid manager-professionals' identity work: the maintenance and hybridization of medical professionalism in managerial contexts. Publ. Adm. 93, 412–432.
Menchik, D., 2021. Managing Medical Authority. Woodstock. Princeton University Press.
Mouffe, C., 2011. On the Political. Routledge, London.
Niemi, R., Hepburn, M., 1995. The rebirth of political socialization. Perspect. Polit. Sci. 24 (1), 7–16.
Oh, H., 2014. Hospital consultations and jurisdiction over patients: consequences for the medical profession. Sociol. Health Illness 36, 580–595.
Ruiz-Junco, N., 2013. Feeling social movements: theoretical contributions to social movement research on emotions. Soc. Compass 7, 45–54.
Stets, J.E., Carter, M.J., 2012. A theory of the self for the sociology of morality. Am. Socio. Rev. 77, 120–140.
Strauss, A., Schatzman, L., Bucher, R., Ehrlich, D., Sabshin, M., 1963. The hospital and its negotiated order. In: Freidson, E. (Ed.), The Hospital in Modern Society. Free Press, New York.
Strong, P., Robinson, J., 1990. NHS under New Management. Open University, Buckingham.
Sveningsson, S., Alvesson, M., 2003. Managing Managerial Identities: Organizational Fragmentation, Discourse and Identity Struggle.
Svensson, R., 1996. The interplay between doctors and nurses – a negotiated order perspective. Sociol. Health Illness 18, 379–398.
Tajfel, H., Turner, J., 2004. Social Identity Theory of Intergroup Behavior. Psychology Press, London.
Waring, J., 2014. Restratification, hybridity and professional elites: questions of power, identity and relational contingency at the points of 'professional-organisational intersection.'. Soc. Compass 8, 688–704.
Waring, J., Bishop, S., 2011. Healthcare identities at the crossroads of service modernisation: the transfer of NHS clinicians to the independent sector? Sociol. Health Illness 33 (5), 661–676.
Waring, J., Bishop, S., 2013. McDonaldization or Commercial Re-stratification: corporatization and the multimodal organisation of English doctors. Soc. Sci. Med. 82, 147–155.
Waring, J., Bishop, S., Black, G., Clarke, J., Exworthy, M., Fulop, N., Hartley, J., Ramsay, A., Roe, B., 2022. Navigating the micro-politics of major system change: the implementation of Sustainability and Transformation Partnerships in the English health and care system. J. Health Serv. Res. Pol., (online). https://doi.org/10.1177/13558196221142237.

Waring, J., Currie, G., 2009. Managing expert knowledge: organizational challenges and managerial futures for the UK medical profession. Organ. Stud. 30, 755–778.

Waring, J., Roe, B., Crompton, A., Bishop, S., 2020. The contingencies of medical restratification across inter-organisational care networks. Soc. Sci. Med. 263, 113277.

Wenger, E., 1998. Communities of Practice. Cambridge University Press, Cambridge.