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## **Rolling with the Punches: Clinician Resistance in a Managerial NHS Hospital**

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### **Abstract**

The substantive area explored in this article is hospital consultants in an English Acute NHS hospital dealing routinely with increasing managerialism. Data were drawn from 49 interviews with hospital consultants, at one English Acute NHS hospital Trust. The classic grounded theory named "Rolling with the Punches" that emerged was enriched by literature relating to everyday resistance, labour process theory, institutional complexity and organisation studies by considering public and private (internal) scripts. Interpretation of the emergent theory also drew from everyday resistance narratives from rural peasantry applied to the highly qualified public sector hospital professionals. The theory reiterates the role of discursive resistance in the workplace.

**Keywords:** hospital, managerialism, resistance, NHS, workplace, resistance, professional, doctor

### **Introduction**

The National Health Service, NHS in the United Kingdom has come into its own as crown jewel of the public services. What happens in the NHS affects the entire UK. For the past 30 years, the NHS has experienced radical changes in its organisation structures and managerial regimes (Ackroyd & Thompson, 2003b; Thompson & Ackroyd, 1995). Healthcare delivery has been transformed with metrics-based performance management, electronic monitoring (Farrell & Morris, 2003), and enhanced audit and accountability (Ferlie, McGivern, & FitzGerald, 2012). Work intensity increased. Changes in the modes of control have resulted in shifting power relations between non-clinical managers and clinicians, especially hospital consultants.

There is a lack of understanding about how clinicians and non-clinical managers routinely interact (Kuhlmann et al., 2013b). These changes mean that professional agency within a managerial context should be clarified (Correia, 2013; Muzio, Brock, & Suddaby, 2013). Dissatisfaction is evident (Dickinson, Ham, Snelling, & Spurgeon, 2013; Exworthy et al., 2010; Morris & Farrell, 2007; Spyridonidis & Calnan, 2011); however, the repertoires of dissatisfaction in such a context are not well-studied (Reay & Hinings, 2009) (Bélanger & Edwards, 2013), highlighting an opportunity for exploration.

This study goes beyond a simple binary of non-clinical managers versus hospital consultants. It shows that the responses of doctors are socially constructed, situated, complex and complicit. Managerial initiatives shape, constrain and stimulate clinical practice in non-hegemonic ways and doctors find spaces to evade managerial control (Ackroyd & Thompson, 2016). Clinicians do not have grand visions of resistance, but they do whatever they can, as *bricoleurs* (Levi-Strauss, 2004), using the tensions between structures that constrain and those that enable (Giddens, 1984). This study illuminates the routine responses of doctors as they encounter managerialism in their clinical practice in an acute hospital setting.

### **Methodology: Classic Grounded Theory**

The researchers followed classic grounded theory procedures during data collection, coding, and analysis. The emergent grounded theory and its constructs were the basis of the literature review that followed. We conducted 49 interviews that were recorded in mind-map format and written up as field notes immediately after the interview. Audio recording and transcription were deemed unnecessary (Glaser, 1998), and the participants were unwilling to be recorded for fear that the recordings, with their recognisable voices, may fall in the wrong hands. In addition to the interviews, 20 observation encounters were captured, also in mind-map format. These observation sessions allowed the researchers to view the participants going about their everyday work within the research context (Barley & Kunda, 2001; Zilber, 2002). The observation sessions were those of a "complete" (or detached) observer (Burgess, 2006).

Documentary evidence from the Trust website and other relevant NHS bodies were also studied. "All is data" (Glaser, 1998, p. 8) is a basic grounded theory tenet and the data for this study came from interviews, observations, and official documents.

Data were coded line by line as they were collected (open coding), and the maxim of "all is data" (Glaser, 1998, p. 8) was kept top of mind, so everything was coded as it came up and initially captured in memos and mind-maps before being transferred to a computer database. Five questions had guided the early coding process i.e. a) what is this data about? b) what category could this code belong to? c) what is happening in the data? d) what is the main concern of the participants? and, e) what are they doing routinely to resolve their main concern? (Glaser, 1978, 1998). The core category is the emergent theoretical code from the underlying empirical data, indices, concepts, and categories.

The initial participants were selected purposively using the network of one of the authors of this publication, and, as data collection and analysis proceeded with detailed memo writing, emerging insights informed the choice of the next participants. It soon became clear that some analyses steered the choice of the next participants in a few different directions, leading to different concepts emerging, all of which needed to be followed up on and kept track of. This initial divergence of concept emergence added detail to the categories and progressed towards saturation of the categories. As data were collected, the new data were compared to and contrasted with data and emerging categories and themes already collected and constructed (Glaser, 1998; Suddaby, 2006).

The earlier inductive phases of coding, namely open and substantive coding were greatly iterative, and levels of coding were constantly tweaked and refined as the codes coalesced into categories relevant to the substantive area. Once this happened, we were able to become more selective and think theoretically (Glaser, 1978, 1998) in considering how the categories

could relate to one another and form explanations about how the population in the substantive area behaviourally dealt with workplace managerialism. Inductive coding ended when the core category emerged, after which selective coding was delimited by the core category. As the coding and participant selection became more theoretical, the interview questions shifted to exploring more abstract concepts with the theoretically selected participants to build and clarify the emerging theory.

Throughout the coding process theoretical ideas were written up as memos. During the theoretical coding, piles of memos about the core category and its sub-categories were sorted. Since a fundamental component of a theory is the relationships between the concepts, constructs, and categories, care was taken to make these relationships explicit. Theoretical codes can be, but are not necessarily, a basic social process (Glaser, 1998, 2013). In this case "Rolling with the Punches" is the core category; the theoretical code and is also a basic social process. The name of the theory was a phrase uttered by one of the consultants in describing his coping strategy; the term is based on a boxing metaphor "to reflect the way a fighter moves with the opponent's punch, stepping back or to the side, and, while still getting hit, avoiding the full impact of the blow; this action alludes to the continuous process of adaptation to a changing reality" (Kristensen, 2010, p. 9).

### **Rolling with the punches**

As the codes and categories surfaced from the data, the following major categories and sub-categories were formed:

#### **Phase 1: Weighing up**

Weighing up is the doctors' initial reaction to imposed managerial decisions. When managerial measures such as record-keeping and performance management were imposed on doctors, they process the requirements and work out what they might mean for their clinical practice and clinical identities. Weighing-up goes on all the time. The immediate clinical group play a significant role in how doctors understand their environment. Hence, weighing-up is an individual process with inter-subjective input.

When weighing-up, doctors seek to understand what is happening and evaluate their current mode of coping behaviours; weighing-up can, but does not always, lead to a change in behaviour. The weighing-up phase consists of two sub-categories, that is, making sense and deciding what to do.

**Making sense.** In the process of considering the new managerial requirements, doctors try to make sense of the new requirements within the context of their professional practice. If their mode of behaviour changes, it can result in erratic vacillations in a non-linear manner. A doctor might adopt contradictory behaviours to the same stimulus at different times, depending on what else is happening at the time. Different mode-shifting triggers could be present in each mode.

**Doing something.** Doctors as a group are highly individualistic. They are trained to assess and intervene as unique and complex situations emerge. To a large extent, doctors are knowledge workers, and getting them to act in solidarity can be difficult, especially on non-clinical matters, where there is not the professional practice glue which defines appropriate actions. The doctors are also not inclined to take decisions that they might view as potentially

harmful to patients. Thus, they may easily be conflicted in deciding the best course of action when two choices seem to be mutually exclusive and there are often constraints on what they could do to cope with managerialism. However, they must decide and take a specific course of action; in other words, they must do something which means choosing a response behaviour to cope with the imposed (as they see it) restrictions.

## **Phase 2: Coping behaviours**

The forms of coping taken by doctors towards managerialism include efforts to absorb the new requirement and get through the issue in the short term, a temporary stabilisation of the situation. The sub-categories of the coping mechanisms are described below.

**Stabilising temporarily.** This is a mode of behaviour that is adopted by many newly-qualified hospital consultants. Invariably, they struggle with the non-clinical issues associated with the transition from being a registrar (trainee hospital consultant) to a fully qualified specialist consultant. They work extra hours, often under unrelenting pressure, to get the job done; being trusted as a clinically reliable doctor is important. However, their stress levels increase and their work-life balance suffers. The next step is that the doctors resist the managerial imposition.

**Resisting.** Resisting means opposing managerialism in various, usually subtle, ways. Given professional and social constraints, hospital consultants do not go out to the picket line, but are hard at work. Overt resistance is disguised, and takes two main forms; *subverting* and *quibbling*.

By *subverting*, the hospital consultant will use the managerial system against itself. A doctor who is frustrated with efficiency measures and cost savings could use the clinical governance processes to highlight the dangers posed a lack of readily available bedside equipment. The subversive uses the clinical governance logs to record clinical concerns, and managers are obliged to respond since the recorded concern is now effectively in the public space and cannot be ignored.

*Quibbling* means raising hair-splitting concerns. Whilst the subversive attacks managerialism using large measures, the quibbler does very many small things to achieve the same goal. The quibbler uses the knowledge that managers must achieve targets within specified time frames and seeks to undermine them, slowing down specific managerial initiatives and frustrating managers, as they themselves are frustrated.

**Limiting the impact.** Doctors eventually come to terms with the reality of the managerial impositions and take steps to limit its impact on their lives. They say, in effect, "we are where we are. I have to do the best to insulate myself." There are two ways of limiting the impact: *lying low* or *faking it*.

*Lying low* involves avoiding and staying out of sight of colleagues and managers in trying to find ways around the managerial initiatives. Despite the move towards multi-disciplinary teams (MDTs), there is still enough room in the one-to-one doctor-patient encounter for avoiding tactics to be at least partially effective.

*Faking it* is about keeping up appearances by being in the right place, at the right time and saying the right things. This is a positioning tactic and is arguably less obvious than lying low.

Faking is a mode of behaviour for the consultants to buy enough time to remove themselves from any unwelcome attention and cement their position in the professional environment. Many hospital consultants are skilled in adopting this pattern of coping behaviour.

The unending chain of managerial initiatives creates opportunities for various coping behaviours. The relationship between managerial events and behavioural responses on the part of the doctors is ongoing and iterative, as though they were engaged in an unending and somewhat erratic dance, continuously jostling for a superior position relative to one another.

### **Phase 3: Adjusting to/Living with**

Adjusting to/living with is a mode where an uneasy state of equilibrium is established, although it may be of short or long duration. The behaviour is essentially that of compliance, or at least apparent compliance. For these doctors, the managerial hospital is a reality which they are exhausted from fighting and they take respite in one or more of four tactical positions: *going with the flow*, *complying substantially*, *complying fully* and *waiting it out*.

**Going with the flow.** Going with the flow is evident when individuals keep aligned with whatever seems easiest at the time, with the appearance of being cooperative; yet these behaviours may simply be to take attention off themselves so that they may engage in more self-serving activities such as significant private practice interests. Going with the flow is like faking it, but they feel no obligation to position themselves strategically. Justified self-interest can be a strong motivator.

**Complying substantially.** When doctors comply with a heavy heart, they do enough to get the managerial job done, but without any enduring commitment or belief in the value of the project. They do their work and go home.

**Complying fully.** Complying fully is a pattern of behaviours is used by those hospital consultants who are meeting the demands of the managerial hospital, almost completely and without resistance. However, motivations for doing so might differ. Some comply fully because when things go wrong (possible malpractice litigation), as increasingly happens, they find refuge in having followed protocols and clinical guidelines. Other consultants do what the managerial project demands; however, following protocols and managerial directives often results in things taking longer than expected. Thus, complying fully can be like quibbling although the latter is a resistance pattern of coping behaviours. Complying fully takes more time than is necessary with every step of the managerial process whilst still being fully compliant. Both tactics set out to achieve the same goal (slowing down the managerial project) but the orientations of the subjects differ depending on the agency of the specific protagonist.

**Waiting it out.** Waiting it out is also a compliance-oriented behaviour and is effectively being present physically but not present mentally or emotionally. Doctors can become incrementally demotivated with change fatigue. They are waiting out their time until retirement, and simply do their work, support their colleagues clinically but do not contribute much more than that. It is part of an exit strategy, although it is a tragedy when the exit may be two or more decades away.

### **The Grounded Theory: Rolling with the punches**

Data analysis led to the emergence of dealing with managerialism as the main concern for hospital consultants. Doctors believe that patients come to hospital for treatment by clinicians, and managers should not interfere with the doctor-patient relationship or the clinical decision-making process.

However, doctors perceive that managerialism detracts from their professionalism and they respond by behaving in a variety of ways to avoid, minimise, or otherwise deal with this perceived interference in a manner reminiscent of the avoiding actions taken by participants in the sport of boxing. The name of the theory was chosen based on the boxing metaphor, rolling with the punches, which "reflects the way a fighter moves with the opponent's punch, stepping back or to the side, and, while still getting hit, avoiding the full impact of the blow; this action alludes to the continuous process of adaptation to a changing reality" (Kristensen, 2010, p. 9).

Rolling with the punches begins with a *weighing-up* process in which the doctor reflects on the managerial imposition (*making sense* of the situation) and decides what course of action to take in response (*doing something*). Most of the doctors cope initially by *stabilising temporarily* to maintain the status quo, before taking steps to either *resist* by means of *subverting* or *quibbling*, or to *limit the impact* of the managerial action by either *lying low* or *faking it*.

Sooner or later, most doctors will adjust to the reality of the managerial requirement and act to live with the situation (*adjusting to/living with*). They most frequently choose one of, *going with the flow*, *complying substantially*, *complying fully* or *waiting-it-out*. Each of these phases, behaviours or steps do not happen in a unidirectional manner as described here, but are mutually constitutive and constantly iterate, creating a complex web of actions, interactions, responses, behavioural adjustments and retaliations.

### **Literature review and discussion**

The literature review was delimited by the grounded theory. Hence, literature was consulted only to the extent that it contributed to a better understanding of the emergent grounded theory.

#### **Phase 1: Weighing up**

Managerialism has significantly changed the acute NHS hospital (Farrell & Morris, 2003; Flynn, 1999) with a possible reconfiguration of the doctor-patient encounter and the subjectivity of doctors. That is when weighing-up is needed (Ancona, 2012). Doctors act without having a clear, or grand, vision of the future in mind (Klein, 1999) with situated responses (Smets & Jarzabkowski, 2013).

Rolling with the punches as a conceptual model suggests complicity between managerialism and medical professionalism. Professional resistance seems to be on a compliance-resistance continuum (Vinthagen & Johansson, 2013). Hospital consultants cannot step outside of the managerial framework and must find spaces to turn the managerial logic in their favour. Their everyday clinical behaviours must be institutionally validated so the doctors continuously (re)frame the relationship between managerialism and medical professionalism in their everyday practice.

Doctors are not culturally insensitive (Garfunkel, 1984) mindlessly following the managerial cultural scripts (Blomgren & Waks, 2015; Waring, 2014). The managerial project

and clinical professionalism make potentially conflicting demands on the hospital doctor. The observed behaviours are underpinned by interpretation, agency, effort, and intentionality. Agency (Emirbayer & Mische, 1998) frames the routine behaviours that can either facilitate or impede managerialism. Weighing-up is the connective link between the different modes of everyday resistance behaviours i.e. stabilising temporarily, resisting, limiting the impact and living with/adjusting to. Despite the duration of the managerial project, everyday resistance has largely kept the acute NHS hospital as a professional bureaucracy (Dickinson et al., 2013).

Weighing-up, which goes on all the time, can lead to any of the modes of coping behaviour.

## **Phase 2: Coping mechanisms**

**Stabilising temporarily.** This study confirmed the difficulties of newly qualified hospital consultants in the transition to duty consultant (Brown, Shaw, & Graham, 2013; Morrow, Burford, Redfern, Briel, & Illing, 2012). They find themselves managerially unprepared to be the senior clinician. Younger consultants work hard but also seek a better work-life balance (Dacre, 2008; Thomas, 2014). Their goals involve getting through work and not overtly resisting the managerial project. Their agency is not projective but mainly practical-evaluative (Emirbayer & Mische, 1998). They get through their work lists (which are determined by management) in ways that maintain the existing ways of getting work done. They weigh up what management wants versus the accepted clinical practices of their senior colleagues in their areas of speciality. Therefore, they do not merely follow cultural scripts (DiMaggio & Powell, 1991; Garfunkel, 1984), but effortfully work towards accomplishment of the task at hand (Smets & Jarzabkowski, 2013). Thus, practical-evaluative agency has iterative consequences and clinical priorities ultimately prevail.

Despite concerns with the distinction between the public and hidden modes of coping, particularly resistance (Scott, 1989) one could still use the points of difference as an analytical tool. The public script of the newly qualified consultant is one form of compliance with the requirements of the managerial system. The hidden transcript is the shared understanding within the immediate clinical speciality of the doctor, determined largely by the senior hospital consultants in the department. This is the text that legitimises the public behaviour of the newly qualified consultant. Stabilising temporarily is an early, hidden mode of everyday resistance. For newly qualified consultants, disguise is an important survival tool. Their mode of coping behaviour serves to strengthen the professional bureaucracy rather than support managerialism.

**Resisting.** The concept of routine resistance can easily be found in situations where interpersonal power is present (Correia, 2013; Scott, 1989; Thomas & Davies, 2005). This study answers the question of how hospital doctors routinely resist whilst still accomplishing everyday work with patients.

This grounded theory study confirmed that a small number of doctors resist managerialism by framing the relationship between managerialism and medical professionalism as incompatible. This is an intentional and active process (Emirbayer & Mische, 1998; Smets & Jarzabkowski, 2013) in a drive to be true to clinical professional values, which have been shown to be resilient (Crilly & Le Grand, 2004; Currie & Suhomlinova, 2006).

*Subverting* is the delinking of a managerial technology from its stated purpose (Hirsch & Berniss, 2009; Levay & Waks, 2009). Doctors confirmed subversion as found in the literature

(Ferlie et al., 2012; Miller & Rose, 2008) and use managerial tools for clinical purposes. Where they cannot turn the managerial logic around, doctors engage in discursive resistance and attempt to discredit managerially-inspired clinical protocols and clinical guidelines as "cookbook medicine" (Timmermans & Berg, 2003, p. 19).

Subversives adopt mainly a practical-evaluative agency, as they do not have an option but to get through the managerially controlled work lists as well as attending to their patients. They do not support the change of the hospital from a professional bureaucracy to a managerial hospital. Their agency has iterative consequences and the professional bureaucracy prevails.

*Quibbling* agency is mainly practical-evaluative, but with no projective dimension, thus having iterative consequences. There is enough in a day for the quibbling resistor to stall the managerial transformation programme.

Resisting is a pattern of situated non-dramatic responses to managerial power in the manner described by Scott (Scott, 1985, 1990). The public transcript affirms managerial status but doctors use institutional spaces within which to conduct ambiguous acts of resistance. The hidden transcript that sustains these individual acts of defiance is an alternative clinical professional subjectivity (Noordegraaf & Steijn, 2014; Spyridonidis & Calnan, 2011; Spyridonidis, Hendy, & Barlow, 2014).

Although weighing-up is described as an initial step, it reappears constantly as doctors evaluate new situations and requirements as they arise, and change their responses depending on specific circumstances.

**Limiting the impact.** This study confirmed that some doctors coped by trying to find ways around managerialism and limiting the impact. These impact-limiting behaviours came predominantly in the form of *lying low* or *faking it* tactics.

*Lying low* is an avoidance tactic (Endler & Parker, 1994; Lazarus & Folkman, 1984, 1987)--an effortful and intentional response (Giddens, 1984). Since doctors have to complete their work-lists as set out by managers, their agency is primarily practical-evaluative (Emirbayer & Mische, 1998) with inverse-decoupling (Levay & Waks, 2009) of the relationship between the managerial initiative and actual clinical practice. Lying low is about finding spaces from which to resist whilst being in the shadows. In this tactic one could have someone becoming a clinical manager with the objective not to advance the managerial project, but to defend the clinical project (Dickinson et al., 2013; Waring & Currie, 2009).

In *lying low*, agency is mainly practical-evaluative with iterative consequences, with some projective agency. The latter is often only to gain credibility with management in order not to draw attention to what is fundamentally a defence of clinical logics. So, effort, intentionality, and agency are geared to find ways around managerialism. Clinicians sometimes seem to have no choice but to cede ground to managers with the emergence of hybridity.

*Faking it* is a positioning tactic. The fluidity of the professional identity (Ashforth & Johnson, 2001; Waring, 2014) allows for a wide range of acceptable behaviours. Two issues remain non-negotiable. First, doctors cannot put patients at risk. Second, they must complete their work-lists as prepared by managers. Hence practical-evaluative agency primarily underpins their behaviours. Since they are faking it, they aim at keeping managerialism and medical

professionalism apart and decoupling (Levay & Waks, 2009) the managerial technology from its purposes. So, when it comes to job planning and clinical audits (McGivern & Ferlie, 2007) and quality enhancement (Levay & Waks, 2009) they adopt the managerial initiative and discourse and do enough to be seen by management as being cooperative. They then get notice of any future as they see the right people, sit in the right meetings and say the right things – without necessarily walking the walk.

### **Phase 3: Living with/Adjusting to**

Ultimately long-term adaptation is necessary in some form. In this mode there are four predominant types of behaviour: *going with the flow*, *complying substantially*, *complying fully*, and *waiting it out*. A different combination of agency, intentionality and effort underpins each of the tactics thus reframing the relations between managerialism and medical professionalism.

*Going with the flow* is a pattern of coping behaviours that blurs the boundaries between managerialism and medical professionalism resulting in a hybrid professionalism (Blomgren & Waks, 2015; Noordegraaf, 2016).

Agency is mainly practical-evaluative (Emirbayer & Mische, 1998) with iterative consequences as well as a degree of projective agency. Such projective agency makes them somewhat attractive to management but causes tensions with their colleagues (Spurgeon, Clark, & Ham, 2011). Because the doctors do not fully commit to the managerial project, the non-clinical managers are suspicious (Greener, Harrington, Hunter, Mannion, & Powell, 2011), and trust is somewhat shaky. The managers see hybrid professionals as operating in the managerial zone but with a salient professional identity within other nested identities (Ashforth & Johnson, 2001; Spyridonidis & Calnan, 2011; Spyridonidis et al., 2014). The doctors sit on the clinical-managerial fence and self-identify as two-way windows (Llewellyn, 2001). However, doctors often feel ill-prepared for the management tasks that they do assume (Ham, Clark, Spurgeon, Dickinson, & Armit, 2011; Spehar, Frich, & Kjekshus, 2012). *Going with the flow* behaviours could be said to be the practicing of soft bureaucracy (Courpasson, 2000) with practice-situated improvisations (Smets & Jarzabkowski, 2013).

*Going with the flow* involves sitting on the fence in a very public way and can be a challenge to both their clinical and non-clinical management colleagues. Hence, it can be a lonely space to occupy.

*Complying substantially* is compliance in a qualified way, demonstrating practical-evaluative agency without any commitment to shifting their professional priorities towards managerial criteria. So, their agency has iterative effects. If they are obliged to adopt managerial technologies, they do so with a heavy heart and discursively justify their choices (Anderson, 2008; Mumby, 2005), at least to themselves. They do their work, comply as required, and often complain. Frustrations are usually kept private or shared outside the workplace; the doctors do not readily reveal their true feelings at work.

*Complying fully* is the coping behaviour of a handful of hospital consultants, those with a future-orientated intentionality (Emirbayer & Mische, 1998). These consultants believe that the doctor as a practitioner only is out-dated and not practical, that the new medical professionalism should incorporate transparent accountability (Power, 1999), metrics-based performance management (Farrell & Morris, 2003), and self-management (Miller & Rose,

2008); in fact, it is a strategic hybrid (McGivern, Currie, Ferlie, Fitzgerald, & Waring, 2015) that is necessarily a salient part of their new professional identity. Those who are complying fully engage in significant discursive justification to legitimise their hybridity.

Projective agency is important for this group as they are committed to a reconfiguration of the medical profession and are happy to get the job done. However, their projective agency still operates in a healthcare delivery environment characterised by wicked problems and complexity (Nelson et al., 2003; Shiell, Hawe, & Gold, 2008). Even their enthusiasm for change does not suggest a grand vision of an alternative medical professionalism but mere situated improvisations (Smets & Jarzabkowski, 2013) that congeal on the margins of the discourse of medical professionalism.

Nearly half the respondents are *waiting it out* and this group comprises the most experienced hospital consultants. Some may have been strategic hybrids at some time earlier but the role has exhausted them (McGivern et al., 2015), and they disengage, hungering for the time when clinicians operating had a high degree of clinical autonomy. Their agency and behaviour might be congruent with those consultants who are going-with-the-flow, but given that they are often mid-career or nearing retirement consultants, their efforts, intentionality and agency differ.

Many doctors have become incrementally exhausted and have adopted a detached state of mind which may have led to marginalisation (British Medical Association, 2013). The consultants do their work in established ways without significant regard for management control systems, metrics-based performance management and competitiveness (Farrell & Morris, 1999, 2003). Having a detached state of mind takes effort and discursive justification. It is hard to look the other way when one has so much more to give to a system that does not value clinical input as it should.

### **Conclusion**

Rolling with the Punches is a complex theory of routine resistance as hospital consultants navigate the fine line (Clifford, 1981) between managerialism and professionalism. Our research suggests that resistance is a complex phenomenon with multiple modes and levels of expression. Close examination of the discourse, justifications and behaviours of the participants gave us an insight into a subtler understanding of resistance within a context where the maxim "first, do no harm" is non-negotiable.

Managerialism has shifted power relations within the acute hospital. Trust and collegial professional integrity have been replaced by audits, accountability, performance metrics, and quasi-competition. These managerial methodologies pose substantial challenges to the hospital as a professional bureaucracy. Managerial decision-making in the complexity of the healthcare delivery system pressurise professional discretion and many consider that the managerial operating logic of the hospital challenges medical professionalism.

Doctors are trained to put the welfare of patients above all else. Hence, resistance potentially putting patients at risk is difficult for doctors to contemplate. Acting in solidarity with other hospital doctors is almost alien to them. Hospital consultants seldom have the political awareness and skills to resist managerialism efficiently, but this does not mean that they do not resist.

What is clear is that doctors care about patients. Managerialism is an issue when it interferes with that clinical orientation. Thus, doctors constantly reframe the relations between the two main logics of managerialism and medical professionalism (Greenwood, Raynard, Kodeih, Micelotta, & Lounsbury, 2011; Smets & Jarzabkowski, 2013). They are not on a picket line but the hospital consultants often resist managerialism in the small crevices in managerial technologies at the clinical frontline (Barley, 2008), yet at the same time integrating that very managerialism into their everyday behaviours (Noordegraaf, 2016).

Institutionally complex (Greenwood et al., 2011), highly fragmented, and complex organisations like hospitals (Goodrick & Reay, 2011) require agency to routinely get by (Kraatz & Block, 2013). The sense-making process in agency explains contingency of their routine resistance behaviours at the clinical frontline. The routine resistance behaviours of the hospital consultants show that the hospital remains a contested space with a professional bureaucratic bias (Dickinson et al., 2013), despite the huge investments in managerial reforms. Institutional and organisational complexity creates room for agency and misbehaviour (Thompson, 2016). However, it should be noted that the fluidity of micro-institutional behaviours show that managerialism and medical professionalism are not definitively incompatible (Besharov & Smith, 2013; Noordegraaf, 2016; Noordegraaf & Steijn, 2014).

The hospital consultants routinely frame relations at the intersection of competing logics at a micro-institutional level (Reay & Hinings, 2009; Smets & Jarzabkowski, 2013) in the tradition of everyday resistance (Scott, 1985, 1990). We know that the managerial hospital aims to shape both the subjectivities of the hospital consultants and the work environment. Rolling with the punches is a theory of how their routine resistance reclaims that subjectivity and reshapes the social environment in the process of accomplishing routine work. This is the arena of the micro-politics of resistance (Thomas & Davies, 2005).

The ideas on agency, the social construction of meaning (Berger & Luckman, 1967; Blumer, 1971; Giddens, 1984) overlap with Scott's (1985, 1990) ideas on transcripts and discursive resistance. This paper supports the idea that employee resistance is not dead (Ackroyd & Thompson, 2003b, 2015; Thompson, 2016). By focusing on the viewpoint of employees one gains insight into how they make sense of the complexities of the workplace (Thomas & Davies, 2005; Weick, 1995) and how the messiness created by pulling in opposing directions is managed in everyday, informal and spontaneous ways (Knights & McCabe, 2000).

The managerial hospital concentrates organisation power in the hands of mainly, but not exclusively, non-clinical managers. Hospital consultants also have power in the form of clinical expertise and social status, and the ebb and flow of power between clinicians and non-clinicians is evident. This classic grounded theory study gives a conceptual account of everyday behaviours of hospital consultants in a managerially-run acute hospital. It shows that resistance by hospital consultants is taking place and explains why and how the hospital remains largely a professional bureaucracy (Dickinson et al., 2013).

This study illuminates the gaps in understanding between doctors being neither "cultural dopes" (Conroy, 2010, p. 61) nor heroic change agents (Battilana & D'Aunno, 2009). A close examination of the diverse responses of doctors answers the call for a more nuanced account of the complexity of professional agency (Hwang & Colyvas, 2011, 2014).

### **Directions for future research**

Organisational misbehaviour is alive and well. One needs to look in the right places and pay close attention to the empirical context (Ackroyd & Thompson, 2015; Thompson, 2016). A focus on individual agency is needed because macro-logics do not determine frontline behaviours (Barley, 2008). By starting to look at the organisation from the perspectives of the medical staff, as we have done in this paper--rather than management--we might get a better idea of everyday resistance in organisations.

Other professional groups, within the same empirical context, could be studied. This should be interesting because hospital consultants are the most powerful clinical group within the hospital. How do other, less powerful professionals react to the managerial transformation of the acute hospital? Then, one could have a comparison between the findings of this and the new study. The comparison could have implications for theory and practice.

One could also do a study of professionals in other empirical contexts who are subject to managerial transformation. A formal theory of professional coping under managerial transformation could emerge over time.

### **Practice implication**

Managers generally have an idea that doctors resist change but do not always have a nuanced understanding of the phenomenon. This study could assist practitioners in this regard.

### **Originality**

This study develops links between classic grounded theory, routine resistance in the workplace, management studies, and organisational development. It contributes to the emerging stream of micro-institutional research as to what is happening within organisations as they respond to external pressures.

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