Good shepherds? The role of professional-managerial 'hybrids' in the evolving governance of medical work

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Abstract

The governance of professional work increasingly involves the purposeful enrolment of professional members into 'hybrid' leadership or management roles. Questions remain as to whether these 'hybrids' serve the interest of their profession or management in the organisation of expert work. Drawing upon Michel Foucault's elaboration of 'pastoral power', this paper considers how hybrids shepherd the conduct of their professional colleagues. Informed by analysis of six studies, the paper traces hybrids' pastoral practices in constituting and governing their professional colleagues' subjectivities. Our analysis offers new understanding of the relational dynamics of power in the organisation and governance of professions, and further demonstrates the distinct practices of shepherding and governing social conduct.

Introduction

The organisation and governance of professional work is often the focus of reform. Changing political expectation, consumer demands, financial imperatives, organising trends, scientific breakthroughs and technological innovations all pose questions about how professional work should be organised and governed. Yet the institutions of professionalism are resilient and resistant to change, especially where change originates from external policymakers, managers or other non-professional groups (Currie and Waring 2009).

Recent efforts to re-organise professional work has involved the purposeful enrolment of professional actors into 'hybrid' managerial and leadership positions. These 'hybrids' have attracted scholarly attention because they appear to blur professional and managerial practices, identities and ideologies (Bejerot and Hasselbladh 2011; Denis et al. 2015; McGivern et al 2015; Bresnen et al. 2019; Giacomelli, 2020; Denis and Germain, 2022; Waring, 2024). Situated between their profession and wider work environment, hybrids engender change from *within* rather than *over* professional communities as a form of 'organised professionalism' (Noordegraaf 2011). As such, hybrids have prompted research around the nature of their work, identities, and role in the social organisation of expert work. Indeed, a key related question is whether hybrids act as conduits for management reform within professional work, or work to maintain professional interests, and buffer against new forms of external managerial control.

In this paper, we focus on hybrids' roles in the changing organisation and governance of healthcare, specifically in the re-organisation of medical work. Over the last three decades, the healthcare services of many high-income countries have been the focus of near constant reform. Guided by broader developments in public policy and governance, especially the rise

of New Public Management (NPM), and more recently progressive or networked governance, healthcare services have, in turn, become more managerialised, been subject to competitive market forces, and faced reorganisation through collaborative networks (Ferlie et al. 2013).

These reforms have profoundly impacted the governance of medical work, which many have interpreted as challenging the long-established discretion and authority of medical professionals. Yet, research shows that the medical profession is adept at strategically negotiating, co-opting, or resisting reforms, especially where managers threaten doctors' existing practices, identities and jurisdictions. It is within this context that the explosion of new medical-managerial and clinical leadership roles is located.

We focus specifically on these hybrids' roles in a succession of organisational reforms in the English healthcare system. The paper combines and re-analyses the findings of six in-depth qualitative studies that, over an 18-year period, examined a series prominent reform agendas in areas of clinical risk and quality assurance procedures, care pathway and service redesign, clinical appraisal, healthcare networks, quality improvement, and integrated care. Across these different reform agendas, we trace the ways hybrid medical-managers interpret and reframe reforms, and interact with and influence their medical colleagues to engender new ways of working.

The distinctive contribution of this paper is its engagement with Michel Foucault's concept of 'pastoral power' (Foucault 1982, 2007, 2011). We consider how hybrids 'shepherd' the subjectivities of their professional colleagues by redefining what it means to 'be' professional, and by supporting professionals to govern their own conduct in a way that accommodates policy expectations.

Hybrids and the governance of professionalism

Research on hybrids has developed along at least four complementary lines. The first locates hybrids in the context of broader institutional changes (Noordegraaf 2011), especially changing political and corporate agenda that combine professional, market and bureaucratic logics (Kitchener 2000; Reay and Hinings 2009; Wallace et al 2023). The second examines how hybrids interface between the profession and the managerial organisational setting, often supporting the implementation of strategic change (Burgess and Currie 2013; Llewelyn 2001; Ferlie et al. 2013). The third examines how those who hold, and aspire to hold, hybrid positions develop distinct and sometimes liminal identities because of their precarious position at the interface between their professional and managerial peers (Bresnen et al. 2019; Croft et al 2015; McGivern et al 2015; Spyridonidis et al 2015; Nzinga et al. 2019; Martin et al 2021; Howieson et al 2023). The fourth, and most relevant to our paper, considers how hybrids represent new expressions of power and authority in the organisation of expert work, and especially the question of whether hybrids represent the interests of management or their profession (Currie et al. 2015; Jones and Fulop 2021; Kirkpatrick et al. 2023; Wallace et al 2023), or mediate these competing interests (Numerato et al. 2012).

Interest in the social power of hybrids originated in earlier sociological debates on professional re-stratification (Freidson 1985). Freidson (1985) countered the idea that corporatisation and bureaucratisation were leading to a decline in professional power by arguing that many professions were adapting to these changes by becoming, in themselves, more segmented and hierarchical. Freidson identified the emergence of professional 'elites' responsible for production of knowledge and administration of work. Although these elites

might restrict the autonomy of individual professionals, Freidson saw re-stratification as protecting the collective interests of the profession in the context of bureaucratic change. However, others authors, such as Coburn and colleagues (1997), questioned the notion that re-stratification serves the interests of the profession primarily. Instead, they suggested that elites might prioritise the interests of the state or management by helping to manage 'rank-and-file' professionals in 'hard-to-reach' areas (Coburn et al. 1997), effectively delegating the work of management to an elite professional stratum.

In the context of contemporary debates around 'organised professionalism', it has been further suggested that hybrids have a role in promoting more standardised, accountable and productive forms of professional practice and identity (Noordegraaf 2011). For example, Waring (2014) interprets hybrid roles as sitting at the relational interface between a profession and its wider organisational and governance landscape. From this perspective, Waring elaborates different elite positions with regards, for example, to policymaking, regulation, research and quality. However, the literature remains divided as to whether elites and hybrids work to protect the interest of their profession in the face of change or to mobilise management interest in medical work. It is possible too that both activities are at play across to differing extents and in different combinations across different reform contexts.

For this paper, we contribute to these debates by offering a distinct theoretical lens on the role of hybrids as the conduits of managerial interests and in fostering a new expression of professional self-governance. In developed these ideas we turn to Foucault's works on governmentality and pastoral power.

Governmentality and Pastoral Power

In broad terms, Foucault's work considers how 'regimes of truth', as articulated through an assemblage of discourses, technologies and institutions, define the subjects of which they speak, and in so doing position these subjects in relations of power with others and themselves (Foucault, 1982). Professions and experts play an important role in Foucault's analysis of disciplinary power and government beyond the state (Rose and Miller 1992). His earlier works show, for example, how the emergence of 'scientific' knowledge, and corresponding professional institutions (e.g. psychiatry), were integral to the classification, surveillance and discipline of abnormal subjects (e.g. psychiatric patients) (Foucault 1994, 1991, 1980).

Foucault's later work on governmentality looked further at how the contemporary 'art of government' is realised, less through sovereign or disciplinary power, and more through the freedom enjoyed by subjects in governing their own behaviours (Foucault, 1980, 2007). The 'conduct of conduct' (Dean 2010) – the way in which this freedom is framed and governed indirectly through the operation of discursive power – occurs through state and non-state technologies that inscribe and normalise behavioural imperatives *within* individual subjects at the levels of their identities and behaviours (Dean, 2010; Lemke, 2001; Rose and Miller, 1992). Foucault's analysis of neoliberal governmentality shows, for example, how experts guide and cultivate entrepreneurial self-governing subjects through a variety of technologies and strategies of calculation (Foucault 2007). This 'subjectification' involves the constitution of subjects who are actively concerned with governing their own ethical behaviours (Foucault, 2011).

In tracing the historical development of modern governmentality, Foucault (2007) elaborated the concept of 'pastoral power' to describe how certain actors play a critical role in the formation of obedient, self-governing subjects. Derived from his reading of Christian texts, Foucault described how religious teachers 'shepherd' the moral conduct of their 'flock' through instruction, hearing confession, avowal of faith, and the promise of salvation. Crucially, pastoral power is a *relational* practice through which individuals, and communities, are supported to internalise moral or political discourses, and to draw upon these truths when governing their own conduct:

> "What the history of the pastorate involves, therefore, is the entire history of the procedures of human individualisation in the West... a prelude to what I have called governmentality through the constitution of a specific subject, of a subject whose merits are analytically identified, who is subjected in continuous networks of obedience, and who is subjectified through the compulsory extraction of truth." (Foucault, 2007: 184-5)

Foucault developed his understanding of pastoral power not only as a historical and religious regime of discipline, but also as a precursor to and foundation of governmentality (Golder, 2007). Foucault (1982) saw the 'modern pastorate' – contemporary, non-religious authorities prominent in the governing of life in the era of neoliberalism, including for example psychological and clinical professions and professionals – as offering salvation, not in the next life, but in the current life through the promotion of desirable, healthy or prosperous lifestyles.

Recent academic attention has reinvigorated Foucault's notion of pastoral power in analyses of contemporary governmentality. Some authors, for example, conceptualise pastoral power in terms of the ways new forms of power, enabled by technological advancement, act on contemporary subjects. Others find analytical insight in the idea of the pastor as the embodied subject of governmental power. For example, Martin and Waring (2018) have suggested that pastoral power is key to the realisation of governmentality, constituting the subjectivities of individuals and communities through the work of identifiable pastoral actors.

Professions as pastors

Relating these ideas to the professions, many studies have used the concept of pastoral power to analyse the role of *professionals as pastors* (in relation to subjects outside the profession). However, there has been growing interest in the role of *pastors within professions*, i.e. the role of professional pastors in shepherding the conduct of their peers. From this perspective, they advance a notion of professionalism that involves adhering to modes of work and identification that increasingly reflect the expectations of employers, managers or customers.

We suggest that hybrids might have an important role in the re-constitution of professional subjectivities, acting as 'conduits' of governmentality (Martin and Waring 2018). Bejerot and Hasselbladh (2011) interpret the introduction of quality registers within the Swedish healthcare system as a form of governmentality in which medical leaders – acting as pastors – re-align professional practices with the expectations of quality improvement. Similarly, Ferlie and colleagues (2012; 2013; Ferlie and McGivern 2014) use the concept of pastoral power to interpret the role of professional leaders in mobilising new evidence-based practices within the English healthcare system.

Waring and Martin (2016; see also Martin and Waring 2018) look at the role of professional leaders in the coordination of professional networks, tentatively identifying four 'pastoral practices'. The first involves 'constructive practices', where pastors translate governing rationalities into a form that is meaningful to the professional community. The second involves 'inscription practices', where pastors encourage individuals to internalise behavioural norms. The third involves 'collective practices', where pastors relate individual behavioural expectations to the shared norms of the community and foster moral censure of deviance. The fourth involves 'inspection practices', where pastors engage in ongoing surveillance of individual and collective behaviours. Waring and Martin's model has been applied to the case of public health interventions in Papua New Guinea (Shih et al. 2017), quality improvement methods in Kenya (McGivern et al. 2017; 2020), strategies to promote patient adherence to prescribed medicine use in the English healthcare system (Waring and Latif 2019), and self-care (Jones, 2018). In this paper, we engage with these ideas to analyse how medical-managerial hybrids work to reconstitute the subjectivities of medical doctors in the context of different healthcare reforms.

The case of medical-managers in the English healthcare system

Although hybrids have been studied across a variety of professional settings, including law, accounting, teaching and social work (Exworthy and Halford, 1999; Giacomelli, 2020), much of the literature is derived from empirical studies of healthcare professions (e.g. Bresnen et al. 2019; McGivern et al. 2015). As part of global health reforms, and possibly as a result of the difficulties of managing medical work, policies have increasingly enrolled doctors into hospital management roles. This includes, for example, medical directors on hospital

executive boards, clinical directors involved in departmental administration, and other specialist roles in the management of research, medical education, public health quality improvement and service change (Llewellyn 2001; McGivern et al. 2015; Jones and Fulop, 2021).

A recent development in this regard has been the re-articulation of 'medical management' through the language of 'clinical leadership' (Martin and Learmonth 2012). This offers a more inclusive and distributed approach to the allocation of managerial responsibilities, with diverse professionals encouraged to assume responsibility for changing professional practices and cultures. Bresnen et al. (2019) identify the implications of different clinical and managerial orientations for hybrid identities (see also Waring 2014).

In recent years, there has been an upsurge of interest in the motivations and identities of healthcare hybrids, as a way of shedding new light on enduring questions of power (Bresnen et al. 2019; Croft et al. 2015; McGivern et al. 2015; Spyridonidis et al 2015). This suggests that some hybrids strategically develop a managerial identity to advance their career and influence their peers, whereas others occupy a more liminal and precarious positions in trying to balance competing pressures and maintain some distance from management. For example, McGivern et al (2015) talk of 'incidental' and 'strategic' hybrids, while Bresnen et al. (2019) describe 'aspirational', 'ambivalent' and 'agnostic' hybrid identities. Recent studies have extended research on hybrids, examining their role in managing health services in low-and middle-income countries where, due to severe resource constraints, hybrids must navigate between official, professional and practical norms (Nzinga et al, 2019). Research has also explored hybrids' roles in promoting entrepreneurship in health care (Hodgson et al, 2022; Sofritti, 2022) and how 'entrepreneurial' hybrids are affecting the implementation of new

digital technologies (Bernardi and Exworthy, 2020; Hoang and Perkman, 2023). Hybrids also play key roles in integrated care systems (Jones et al 2022; Waring et al 2023).

While such research illustrates a focus on the identities or subjectivities of hybrids themselves, we suggest there is a need for more theoretically informed research on the way subjectivities function as locus of power, and the ways in which hybrids, as pastors, are active in shaping new professional identities and practices.

Methods

Our paper draws upon the findings of six separate qualitative studies of workforce and organisational change in the English National Health Service (NHS) carried out between 2005 and 2023. In different ways, these investigated the roles and contribution of medical-managerial hybrids in prominent organisational reform agendas, including i) risk and quality assurance procedures (Author), ii) care pathway and service redesign (Author), iii) clinical appraisal (Author), iv) health care networks (Author), v) quality improvement (Author) and vi) the introduction of regional integrated care systems (Author). Although each study had a particular focus in terms of reform and was undertaken in a different setting, all addressed the role of hybrids in implementing and sustaining change. Moreover, they together provide a wide-ranging longitudinal picture of medical-managerial hybrids over an 18-year period.

Each study also had similar methodological features, including comparative organisational case studies (Stake 1995) and the use of qualitative semi-structured interviews that focused on the career biographies of hybrids, the emerging roles of hybrids with regards to the change agenda in question, and the views and responses of professional and managerial co-workers (see Table 1). More significantly, aggregating these studies offered a data set of a size and

scope rarely achieved through qualitative studies on their own, totalling 91 in-depth interviews with hybrids and further 410 interviews with co-workers. It also allowed comparison between hybrids in terms of their distinct histories, roles and positions within healthcare organisations, and their relationships with different stakeholders.

We acknowledge that the aggregation and re-analysis of data derived from independent studies raises methodological and ethical issues. On a methodological level, it is important to consider differences in the underpinning theoretical and methodological positions in study design, and the extent to which data produced for one purpose can be used for another. For this article, the primary studies investigated similar topics of inquiry and were informed by similar theoretical debates, as set out above. They also adopted broadly similar biographical narrative approaches to data collection, and interpretative data analysis. Some of the studies were more ethnographic in design and involved additional forms of observational data, and where relevant, this has been used to provide supplementary insight to this comparative paper.

On the question of ethics, it is important to note that participant consent typically relates to the primary study and not necessarily the onward use of data in other studies. An ethical judgement is therefore required that involves balancing the potential for new insight from re-analysing data against the harm to participants, at all times ensuring the principles of confidentiality agreed in the primary research remain intact (Richardson and Godfrey 2003). In this case, we found no substantial risk to participants from the re-analysis of data. The analysis did not require the disclosure of data or confidential information to any new parties; only anonymised data were shared between the authors. We also note the growing expectations within the research community that anonymised research data, qualitative as

well as quantitative, should, where feasible and ethical, be made available for aggregation and secondary analysis (for example through online repositories) to derive maximum value from publicly funded research. Our approach is consistent with this trend (Ziebland et al. 2021; Weller et al. 2023).

Unlike a review paper or meta-ethnography, where reported findings are subject to synthesis and re-analysis, our study returned to the primary empirical data for each study and involved a new phase of independent and comparative analysis informed by the theoretical ideas outlined above. This followed an iterative process of interpretative data analysis (Corbin and Strauss 2014), that was also informed by the principles of abduction (Timmermans and Tavory 2012). Thus, we used pre-existing theories and empirical observations to orientate analysis, empirical observations to confirm, recast and question existing theory, and new and alternative interpretations as the foundations for theoretical elaboration (Timmermans and Tavory 2012). In practice, this iterative dialogue used the existing research on hybrids together with the concept of pastoral power as a framing device, but with the intention of challenging and revising these frames through the comparative analysis of qualitative data.

Each author independently reviewed and coded the primary data from the studies they led in terms of the pastoral practices and relationships of hybrids. All authors then reviewed these codes and illustrative extracts of data to explore their coherence and consistency and to identify replication, similarities and differences across the six studies. Through reviewing the aggregated primary (empirical) codes, all authors contributed to the elaboration of second- and third-order (thematic) codes with the intention of elaborating existing theory (See Table 1). We then related these aggregated themes and concepts back to the primary data to ensure consistency of interpretive approach, and then identified similarities and differences across

the data sets that might provide a basis for explanation. Finally, the data themes were categorised in line with Waring and Martin's (2016) framework of pastoral practices: constructive, inscription, collective and inspection.

Findings

Constructive practices

Our first theme focuses on the idea that hybrids are constituted through national and organisational policy as a medium for the construction of organisational discourses into professional work. Extending Waring and Martin (2016), this involved a series of activities for prioritising and translating the intent, style, and evidence of organisational and managerial discourses so they might more easily appeal to, be accepted by and, ultimately, be internalised by their professional colleagues. It illustrates a 'downward' process working between 'senior management' and 'frontline' professionals.

This translation work focused on securing the endorsement of professional colleagues: first, of the organisational change agenda; second, of the need for change in professional practice; and third, of their own position as hybrid within the division of labour. For example, policy developments in quality improvement saw doctors in one study taking on new leadership roles in which they worked to translate current quality improvement methodologies, such as Lean, into operation frameworks aligned with their professional peers' interests. Similarly, the recent introduction of regional integrated care systems saw senior medical leaders taking on cross-organisational positions where they contributed to the translation of national policy into regional plans for change, paying attention to their professional colleagues' interests and

values. Thus, hybrids were at the nexus of multiple competing agenda, that they needed to align. For one participant, this was encapsulated in 'management-speak':

> "Language is always an issue. You know, 'management-speak'. It puts the back up most of my [professional] colleagues. I have to be careful with how things are communicated." (Clinical Director for Stroke)

> "I think if you include the word 'policy' in anything then the shutters come down almost immediately [among my professional colleagues]. Guidelines are almost as bad, but policy implies it is blanket and you have to do it." (Lead clinician for intensive care)

The volume and variety of policy change means that hybrids often needed to filter and prioritise which initiatives were most relevant and acceptable to professional peers. In the case of quality improvement reforms, for example, hybrids had to select from initiatives related to infection control, daily team briefings or handover checklists, by taking into account which were most relevant to the needs of their department and acceptable to their medical colleagues. In reaching decision, hybrids looked outside the organisation to consider the recommendations of relevant professional societies, thinking this provided legitimacy, or reviewed the clinical evidence base for the proposed change, knowing this would be important to their colleagues. In other words, the prioritisation and translation activities were concerned with aligning change with professional agenda, whilst also working to mollify potential tensions between professional and managerial perspectives.

"You have to find the things that your colleagues care most about. It's not good going on about a new commissioning model, it means nothing to them, but if you talk about how the resources flow into the department, and what we can to do get more resources so we have more staff or whatever." (Clinical Director for Stroke)

"Evidence is really powerful. If someone is really questioning a new procedure or decision or whatever, it can be so effective to refer to a body of evidence or a trial." (Improvement Lead for Surgery)

Inscription practices

In carrying out construction work, hybrids engaged with their professional peers through communication and engagement practices to 'inscribe' discursive expectations into the identities of peers. Significantly, these activities seemed concerned with reconstituting the collective practices and identities of their professional peers in line with the policy ambitions. One strategy for reframing policy in ways deemed acceptable to professional colleagues was invoking the notion of the 'good doctor'; suggesting that alignment with management policy also aligned with their professional duties to patients and colleagues. As outlined above, hybrids often turned to professional guidance or research evidence to justify these moralistic frames.

"Doctors want to be "good doctors" – loyal to their profession rather than organisation but need to be part of an organisation too to earn a living." (Medical Director)

> "I like to think that my colleagues are inclined to do a good job for its own sake, but if we need to change what they do, then we need to think creatively about [what] motivates them." (Clinical Director for Surgery)

Several of our studies found that hybrids used a variety of departmental meetings, training events, and other public forums to articulate changing expectations for medical professionalism, especially in areas like patient safety and quality improvement. Here, notions of 'good' were linked to new procedures for improving patient experience, safe practice, or clinical effectiveness, usually with the subtext that 'being good' required participation in these procedures. It often seemed that hybrids were trying to 'sell' or justify change to their colleagues without the use of formal authority or mandate:

> "And you have to do big selling to your colleagues, that we need to use this to our advantage, focus on patient experience, use targets to improve that and your lives." (Network and Clinical Director for Sexual Health Services)

> "I don't think it is a government target, I think that if I had my granny waiting in [the emergency department] over 12 hours, I wouldn't be happy. So, we need to try and find a solution." (Medical Director and Intensive Care Specialist)

Some hybrids described training as being concerned with empowerment and delegation, or sharing responsibility with frontline doctors, but typically with the aim of securing their engagement in prescribed change projects.

> "I have to delegate tasks to some of my colleagues. Most of the time, it's something they have an interest in or a project they want to get involved in…. the team development work is a good example." (Clinical Governance Lead for Anaesthetics)

> "It's about empowering and enabling. I don't want to tell people how to do their jobs, I want to help them see that there are better ways of doing it." (Clinical Director for Emergency Medicine)

Through these engagement strategies, hybrids articulated and fostered values and norms around 'good' technical and moral practice that they hoped would be shared amongst the wider peer group and which aligned professional practice with changing organisational expectations around service management and improvement.

Many hybrids, especially those in general management positions, described their role as a buffer between the wider organisation and their professional community. This often involved dealing with the frequent changes and ambiguities in service management, but in ways that created a sense of consistency and clarity for their professional colleagues. For example, medical leaders involved in the implementation of care pathway and service redesign worked to show colleagues that many seemingly remote and backstage changes in work processes were aimed at improved the flow of clinical practices. In general, hybrids often engaged their colleagues by seeking to provide reassurance and certainty, in the face of ambiguity and fear.

> "The external environment is very turbulent… you've got to give people a consistent message … [but] it is opaque. The rules are commonly ambiguous and they change rapidly from time to time so, my role in many ways is to try and work out for what the consistent elements are within the rules and articulate them." (Medical Director)

Collective practices

Across their different management domains, hybrids described a variety of activities concerned with fostering desirable forms of individual and group behaviour. Extending Waring and Martin's (2016) framework, this involved fostering both individual and collective responsibility for professional behaviour. In the area of quality improvement, for example, this was concerned with doctors' involvement in improvement processes, such as Plan-Do-Study-Act cycles, and in patient safety with enhancing doctors' participation in incident reporting. With regards to the introduction of regional care systems, it involved fostering new forms of collaborative and inter-professional working, often based upon the idea that these represented more appropriate, even more professional, ways of working.

Based upon the engagement activities described above, these aspects of hybrids' work typically centred on the collective practices of doctors. Collective practices were reliant as much on lateral relationships among peers as on the more vertical relationship between the hybrid and her/his professional colleagues.

A prominent example of these collective practices was in the use of performance data in professional group or departmental meetings to reinforce collective standards, based on organisational imperatives. This involved focusing on individual performance that appeared to deviant from (expected) collective norms, and in so doing, encouraging broader patterns of self-reflection, and behaviour change across the whole group. This revealed an important

triangular relationship between the hybrid, their professional peers, and external performance data.

> "If you can give people a regular set of data as to how they are doing, they will behave to maximise their position…. In a sense it's an analogy to some kind of football or rugby, if they really understand where the goalposts are, and they really understand where the boundary lines are, and they really understand how you score points, and they can see the points being scored they will score them." (Medical Director)

Hybrids routinely used organisational data in collective forums, such as departmental meetings, to review performance against established targets, such as cancelled operations or re-admission rates. Although outwardly concerned with departmental performance, hybrids would often link these measures to individual medical professionals or care teams, encouraging doctors to analyse their own contributions to collective conduct. What appeared especially significant was the way hybrids acted as the 'guardians' of the data, controlling their use and presentation towards the ends of improvement.

> "If you ask me what is the one thing that gets people to change, data. Data. I need data on what people have been doing and whether it's any good and I want data showing that a new way of working is better." (Clinical Director of Emergency Department)

Across the six cases, hybrids fostered a collectivisation of responsibility, moving the locus of surveillance from the hybrid to the wider professional community. For example, when hybrids facilitated performance review meetings, such as clinical audit or root cause analysis,

they usually established the broad parameters of performance, sharing relevant data, but also encouraged rank-and-file colleagues to scrutinise the data themselves and reach conclusions about how to improve, intervening in the deliberations only selectively.

> "The clinical audit committee meets once a month and goes through all the significant cases and any incidents. Colleagues will be asked to talk through particular issues as a way to explore what might have been done differently." (Clinical Director for Acute Medicine)

Across the cases, it was clear that hybrids understood and made of use of the competitive culture of their profession, manifest in their strategic use of peer pressure to guide group behaviours.

> "[Doctors'] perception of themselves, their views on how their colleagues perceive them, it was a very powerful motivator… to perceive them as being good … Consultants… will change their behaviour very quickly if it becomes clear to them that their consultant colleagues have lost confidence in them." (Medical Director)

Such encounters nevertheless had to be carefully managed by hybrids, to ensure that data were being understood and used in the 'correct' way:

> "Naming and shaming has been discussed. The plan was to do individual feedback to people just via an email, just RAG [red/amber/green] rate and essentially stating the bits they did well and suggesting areas that potentially could be improved and in a fairly soft way. […] The problem is some people almost treat is as a badge of honour

if they are one of the ones named and shamed. Sometimes it can actually backfire on you." (Lead clinician for intensive care)

Inspection practices

In concert with the collective practices described above, hybrids also used a range of more individualised 'inspection practices', reminiscent of the confidential confessional rituals, to ensure values were appropriately internalised and adhered to by individual professionals. These activities took place in private, away from the larger meetings of peers that constituted collective practices. Hybrids described, for example, meeting colleagues on an individual basis to discuss performance issues. These ranged from more regular review meetings to discuss career development or annual appraisal, to 'special' meetings concerned with questionable or problematic conduct. It is noteworthy that relative to the other aspects of their work, hybrids talked less about their interactions with individual doctors, especially in regard to 'problem' colleagues. These encounters were regarded as confidential, and maintained the norms of professional collegiality, which hybrids continued to uphold (Rosenthal 1995). Seen another way, they might be understood as having a confessional quality, in which the Seal of the Confessional prevented the details from being disclosed.

One area where hybrids did talk about these private encounters was in relation to doctors' annual appraisals, in which a doctor's performance 'in the round' was the focus of discussion, usually with an emphasis on professional development and progression. Thus, hybrids undertook 'inspection practices' necessary to ensure that standards were being maintained, and that new behaviours and identifications continued to be embraced. However, hybrids used these encounters, in conjunction with wider departmental or performance

review processes, e.g. clinical audit meetings, to reinforce their own professional status and keep a check on individual 'stray' doctors:

> "People need to see there is a right way of doing things and dealing with the [organisation], it's no good being difficult all the time. I want to show people that you can get more of what you want working with the system than always fighting it." (Clinical Director of Stroke)

> "[Appraisal] reinforces the authority of the seniors. They have a duty to do this and to look over the team and see who is doing what and how it's working, which again I think is one of the strengths of having it local within the organisation. At the end it's the local team leaders to carry the buck." (Medical Director)

Relational contingency and resistance

As might be expected given their in-between, even liminal, position, a significant issue for many hybrids was their standing and reputation within their immediate clinical community (McGivern et al. 2015). Although clinical directors might have formal organisational authority, it did not necessarily follow that they commanded the respect of their colleagues. As shown in the wider literature, becoming a hybrid role could even be seen as 'joining the enemy' (Croft et al. 2015) or 'turning to the dark side' (McGivern et al. 2015).

> "You have got to be able to command the confidence of the various different groups. You've got to establish your credentials." (Associate Medical Director and Neurosurgeon)

> "I think definitely as you go through clinical management and you go up the chain, there is a distancing from your clinical colleagues because you have to take on the corporate ethos, fact…Yes, selling out and the archetype of that is obviously the medical director who cannot win." (Network and Clinical Director for Sexual Health Services)

> "I'm the poacher turned gamekeeper, as one of my colleagues puts it… seen as fraternising with the enemy" (Clinical Director for Anaesthetics)

Across the different cases, hybrids described a continued allegiance with their profession, framing this in intriguing terms: as a matter of 'protecting' it from managerial excesses, but also 'saving' it from itself. For example, those working in the area of quality improvement repeatedly talked of their responsibility to safeguard the standards of their profession, whilst those engaging in the leadership of regional system change similarly talked of advocating for their individual profession's unique contribution to integrated care. On the one hand, their developed understanding of organisational systems made it possible to navigate policies and use management opportunities towards professional ends. Returning to their translation activities, they described their work in reinterpreting management initiatives not just in terms of securing professional support, but also turning them to clinical advantage, giving clinical colleagues scope to take control of change processes. Hence, work to engage professional colleagues in change processes were also about subjecting those change processes to clinical influence—albeit in a way to some extent constrained by managerial imperatives:

> "You see what you might think of as silly things, from the Department of Health in terms of targets, projects which generate funds, and we say, "oh, we'll do that"

> probably in the back of your mind thinking this is a bit silly, but we'll say we'll do that, because then we'll get the money in and then we can always spend the money on something else. And that's what I see as game playing." (Clinical Director for Anaesthetics)

> "Rather than argue about your targets why not try to be a bit clever about them. When the government said we need to modernise … say, great idea why don't we do it like this? And use the politics to your own advantage. We will modernise in the following way and it will make things better for patients." (Medical Director and Intensive Care Specialist)

Another commonly articulated idea was influencing the wider organisation and management agenda, thereby shaping managers' mindsets.

> "Getting things done within the system, using the system to get it done. Not in a way railing against the system but trying to use the system to your own ends." (Medical Director and Intensive Care Specialist)

In short, hybrids' work was not limited to simply ensuring the smooth passage of managerial agenda by reframing them in ways acceptable to professional colleagues. In translating policies in ways more likely to align with but also influence professional identities, they simultaneously refashioned and transformed aspects of the policies themselves, ensuring that they were influenced by professional standards, and securing some form, albeit constrained, of professional oversight and responsibility in the realisation of managerial expectations.

Discussion

Informed by Foucauldian theory, and re-analysing six qualitative studies, our paper offers new understanding of how medical-managerial hybrids work to re-constitute the subjectivities of their professional colleagues. Clearly there are variations across the six cases, including the specific change agenda and work contexts under study. For example, the focus of hybrids work in leading quality improvement projects or assurance activities are distinct from those involved in the reconfiguration of care pathways or the implementation of regional networks and care systems.

That said, there were common features of their relational work with professional peers. Building on Waring and Martin's (2016) model of pastoral practices, our analysis elaborates these common activities in terms of how hybrids translate and construct new discourses of professionalism, and how they engage and communicate these discourses in ways that not only resonate with, but also redefine the expectations and subjectivities of, the medical professional. Hybrids engage professional colleagues in collective and individualised activities to promote and reinforce changing expectations through the use of external data sources and, more significantly, by fostering peer pressure and community sanctions for inappropriate conduct.

Professions' capacity to resist and subvert management change is well documented, with hybrids often positioned as a 'buffer' between management and the profession (Waring 2014). A question posed by research in this area is whether such strategies are aimed at aligning professionals with organisational imperatives, softening organisational imperatives in the interests of the profession, or creatively mediating the two (Gleeson and Knights

2006). Our combined studies suggest that whilst there is some degree of mediation to safeguard core professional interests, hybrids are also concerned with aligning their professional colleagues with the changing organisational imperatives around risk management, quality improvement or service redesign, among others.

Thus the 'appeal' of (and to) new forms of medical professionalism by hybrids appears to convey the interests of management and policy-makers (Evetts 2003) – but in ways that might not always be obvious to professional co-workers. That said, we also recognise the way hybrids mediate between interests and create settlements seen as involving change in peripheral aspects of professional work, de-coupling substantive managerial changes, and so maintaining core aspects of professional identity. Accordingly, hybrids may instead be seen as engaging in practices to preserve their wider profession's central position and power in more managerialist organisational contexts.

Yet hybrids are also a heterogeneous group. At individual level, they may be for and against reforms because they reflect, to a greater or lesser extent, their personal interests or sense of professional identity (McGivern et al 2015; Bresnen et al. 2019; Martin et al 2021: Kirkptrick et al 2023). However, they may also support or resist the enactment and implementation of different managerial discourses (e.g. relating to quality improvement versus making efficiency savings) because these are aligned, or not, with the collective identities, epistemologies, norms and political interests of the profession as a whole (Fischer et al 2016; McGivern et al 2016; Ferlie et al. 2018; Giacomelli, 2020). Thus, differences between individual hybrids, between the professions of which they are members, and between the agenda and discourses they are asked to advance may affect the activities pursued by hybrids.

The empirical detail developed through the combination of our six studies provides some empirical validation to the constructs put forward by Waring and Martin (2016), which have also been found in studies of pastoral power in other national contexts, including high- and low-income counties (Shi et al. 2018; McGivern et al. 2017; 2020; McGivern, 2024). Our analysis extends Waring and Martin's (2016) framework by illustrating how constructive practices involve translating management discourse into terms acceptable to the medical professional community. It also shows how the internalisation of expectations relies upon framing strategies and the use of evidence, professional guidelines and data, and how creating routines for collective regulation relies upon hybrids' understanding of pre-existing group norms, especially tensions between collegiality and competition.

These studies also show how hybrids face relational contingencies that challenge both their ability to influence their professional colleagues, and in turn, their own standing within the organisation. These often relate to the illegitimacy of hybrids amongst many of their professional colleagues, which provides a basis for questioning their motives and approach. Where hybrids' positions were perceived as illegitimate, professional colleagues were more willing to reinforce established professional modes of working as a form of counter-conduct (Foucault 2007). In this sense, the hybrid clinical leader is not viewed as the 'good shepherd' but rather as 'wolf in sheep's' clothing' and so the professional flock were unwilling to acquiesce to managerial governmentality where they did not accept its value for the profession or for patients. This highlights the contingent and precarious position of hybrid leaders sitting at the relational interface of their profession and the wider organisation (Waring 2014). Governing at this interface requires creative balance in the form of dual-directed cycles of influence, in which the shaping of professional subjectivities in line with management expectations needs to be matched by corresponding activities in representing

and safeguarding the underlying values and morals of the profession in the face of those who might seek to erode them. Where hybrid orientation is balanced more towards the organisation or management at the expense of the profession, then the pastoral position can become the focus of resistance. And where hybrid orientation is balanced more towards the profession in opposition to management change, there is the possibility of the hybrid position being constrained or withdrawn by the organisation.

A significant theme developed in our analysis is the idea that contemporary governmentality relies heavily on collective forms of self-surveillance, confession and censure. Although modern governmentality beyond the state is often related to more individualised forms of self-governance through the 'technologies of the self' (Foucault 1982), it is important to re-emphasise the role of the collective (and of the interaction between the individual and the collective) in shaping and reinforcing individual subjectivities, where the behaviour of the 'I' must be consistent with the common 'we'. Pastoral power functions across these levels, attending to both the individual (stray sheep) and the community (flock), and the alignment between the two. This aspect of pastoral power might be regarded as a kind of 'technology of the collective'. For example, our hybrids facilitated public (rather than private) confession ("exagoresis") and censure of inappropriate conduct among professional colleagues, often taking a limited or backstage role in proceedings, instead encouraging peers to take responsibility for regulating each other's behaviour. And yet, these collective forms of self-regulation continued to be orchestrated and monitored by hybrid and reinforced through forms of individual scrutiny and confession.

Foucault's ideas about pastoral power rely on the metaphor of the shepherd and the flock, with the shepherd guiding the flock to salvation by internalising and propounding a new

external discourse. In the case of hybrids, however, the shepherd is drawn from the flock, being regarded as a kind of first amongst equals. This means that they must simultaneously be a part of and apart from their medical community, and their position as hybrid remains contingent on the acceptance of their professional community as much as managers (Waring et al 2021).

At the same time, the additional expectations placed on these roles by non-professional actors means that they are simultaneously working to steer the flock and constitute new forms of professionalism that align with policy imperatives. This requires a complex balancing act in which they must not appear to depart excessively from the expectations of their profession in the advancement of managerial agendas or their own career development. In other words, they must try to retain their position as the 'good shepherd', rather than being regard the 'wolf in sheep's clothing'.

Our analysis has strengths and weaknesses. Strengths include the breadth of studies and datasets from which it draws, including the way in which our analytical approach allowed us to use these data to challenge, enrich and shed light on one another. A related strength is the time period covered by the studies—as noted above, a period of constant change in UK and other high-income healthcare systems—and the variety of reforms, innovations and clinical contexts they examined. On the other hand, the studies derive exclusively from a single national context, and focus solely on the medical profession. Given the differences of status, professional norms and collective identity of other professional groups within and beyond the healthcare context, study of the pastoral work of hybrids from other professions would be of value. Finally, although some of the studies included the collection of other forms of data, we have focused on qualitative interview data in this analysis. This approach is consistent with

the focus on understanding the active work of pastors in seeking to act on those around them, but also carries well known limitations and biases, for example around social desirability and recollection.

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