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Abstract

This article presents a theoretical and empirical analysis of the recursive relationship between leadership practices and contexts to help explain the dynamics of change in a Swiss healthcare organization. Central to the paper's argument is the assumption that leadership is not only a contextually influenced, but also a context-producing practice. We develop this argument theoretically by building on the sociology of knowledge and practice theory. Empirically, we draw on three episodes of a longitudinal case study that shows the unfolding of leadership and traces the consequences of the leader's micro-actions for the context and overall change success. We discuss our insights and outline their implications for understanding and doing leadership in healthcare organizations.

Keywords

Leadership, leadership-as-practice, context, healthcare, sociology of knowledge, theory of practice

Introduction

> Leadership involves the social construction of the context that both legitimates a particular form of action and... limits the alternatives available such that those involved begin to act differently. Or to put it another way, we might begin to consider not what is the *situation*, but how it is *situated* (Grint, 2005: 1470/1471, emphasis in original).

The field of leadership increasingly recognizes the importance of context to understand (and possibly solve) 'the leadership puzzle' (Liden and Antonakis, 2009: 1587; Pettigrew, 1992).

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Context is traditionally seen as a *situation* that influences what kind of leadership will be effective. However, social constructionist research has shown that context is not just a given situation, but actively created, i.e. *situated* by leaders (Grint, 2005). The central argument of this paper is that the relationship between leadership and context is *recursive:* leadership is produced by, but also produces the context to which it refers. To make this point on a theoretical plain, we adopt a leadership-as-practice perspective (Carroll et al., 2008; Crevani et al., 2010; Denis et al., 2000, 2010; Raelin, 2011) and draw on literature concerning sociology of knowledge (Berger and Luckmann, 1966, Goffman, 2001; Knoblauch, 1995; Luckmann, 1992) and practice literature (Schatzki et al., 2001) to elaborate that context is both a resource (structure) and a product of practice and leadership a contextually influenced, but also a context-producing practice. Although scholars have outlined an agenda for contextualizing leadership practices (Denis et al., 2010), the recursive relationship has not yet received sufficient attention in leadership studies. The paper's main contribution is therefore to provide a theoretical framework that outlines how context and contextualizing are integral to leadership from a practice perspective. Accordingly, practices and context represent two sides of the same coin; they need to be considered concurrently.

Paying attention to the recursive relationship between leadership and context seems particularly promising for leadership in healthcare. Healthcare organizations are often described as ambiguous, plural and complex with respect to divergent interests, values, knowledge bases and power (e.g. Denis et al., 1996, 2000, 2001, 2005, 2010; Mintzberg, 1997). Particularly, relevance and power lies with the medical experts (Doolin, 2002; Ferlie, Hawkins et al., 1996; Glouberman and Mintzberg, 2001; Mintzberg, 1997). When organizational structures are decentralized and power relationships become ambiguous, it is usually the highest expertise that wins influence (Mintzberg and McHugh, 1985). The professionals have their own set of practices and shared values (Goode, 1957). Leadership 'from outside' of this community might find it difficult to gain relevance and acceptance and is hence challenging and prone to failure (Mintzberg, 1997; Quinn et al., 1996: 11). Yet despite its centrality, context has not yet received adequate attention in empirical healthcare leadership studies (Gilmartin and D'Aunno, 2007).

Our empirical study addresses this gap. It provides a longitudinal, context-sensitive analysis of a change initiative at a large public hospital in Switzerland. The study serves as an empirical illustration of *how* leadership practices and context reproduce each other and how they, together, shape the evolving change dynamic. The study's longitudinal approach is able to address some of the limitations that characterize single-point leadership studies that focus on the consequences in the 'here and now' (Denis et al., 2010), but which are unable to trace the evolving dynamics and recursive nature of leadership practices and context in the longer run.

Overall, the paper offers a contribution to knowledge on two levels: *Theoretically,* it introduces a framework that illustrates how context and contextualizing are integral to the theory and practice of leadership. The framework adds to the emerging movement of *leadership-as-practice* by addressing the recursive relationship between leadership practices and context in greater detail. Second, the paper's framework can be read as an application of the *constitutive approach* (Grint, 2000, 2005), which proposes that neither leadership nor context are objectively given, but socially constructed, whereby context and human agency (leadership) are interdependent. The focus here is not on problem-oriented contexts (Grint, 2005), but on a theoretical specification and empirical illustration of *how* leadership practices (re)produce contexts to which leaders later need to respond. Third, the practice-orientation

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of the theoretical framework adds to a *more comprehensive conceptualization of context* in leadership studies. While the paper's basic assumption of a recursive relationship between leadership and context is shared by leadership scholars working in the tradition of the 'linguistic turn' (e.g. Fairhurst, 2009), their understanding of context is largely discursive, that is, language and text-based: reality (context) is constructed through language (Grint, 2005). While the discursive construction of reality is undoubtedly important, the practice perspective points our attention to additional aspects of context construction, such as the form or the 'how' of leadership practices. *Empirically*, the paper identifies recurring leadership practices that are collectively understood by the community of medical professionals as well as the executive committee in the hospital under study. The practices can be said to reflect the dominant logic and (sub-) culture of the organization, because they convey the basic principles of how the organization functions. Our findings suggest that the actors involved are unable to reflect on the functionality of the established practices. In critical moments of decision-making or the promotion of ideas, leaders – as well as followers – fall back on routine practices that reproduce and carry forward the 'old' context of medical professionalization, instead of promoting the new, managerially oriented one. The routinized and collectively held repertoires of practices therefore represent the *most relevant* context for leadership practices in moments of change.

The paper is structured in four sections. We begin by outlining our theoretical framework and then detail the methodology adopted. Following this, three episodes are presented to show the recursive relationship between leadership practices and context. In the last section, we discuss our insights and outline their implications for understanding and doing leadership in healthcare organizations (and elsewhere).

Theoretical framework

The practice perspective

Inspired by the 'practice turn' in organizational and social theory (Schatzki et al., 2001), the value of theorizing about and studying leadership from a practice perspective has lately been emphasized (Carroll et al., 2008; Denis et al., 2010; Raelin, 2011). The practice perspective shifts the focus from how leadership is perceived or assessed by followers or leaders to the everyday, actual doing of leadership, its performance and practical activity (e.g. Alvesson and Sveningsson, 2003; Carroll et al., 2008; Denis et al., 2001, 2002, 2010; Raelin, 2011). It focuses on the micro-level activities of leaders and examines how they achieve their effects, including the (re)production of contexts, such as organizations or societies (Denis et al., 2010: 68). 'To find leadership, then, we must look to the practice within which it is occurring' (Raelin, 2011: 196).

A practice is commonly understood to be an expression of the everyday knowledge of how 'things are done around here'; it thus connects 'knowing with doing' (Gherardi, 2001). More precisely, a practice can be defined as a *historically evolved*, usually *tacit*, problem-solving or coping skill that is *held collectively* by a community. It represents a socially acceptable and functional heuristic on how to make decisions or how to come to a conclusion (Knoblauch, 2005; Orlikowski and Yates, 1994). 'The set of actions that composes a practice is organized by three phenomena: understandings of how to do things, rules, and teleoaffective structure' (Schatzki, 2005: 471; see also Reckwitz, 2002). Rules are explicit expressions that 'prescribe, require, or instruct that such and such be done, said, or the case', whereas teleoaffective structures provide information concerning, among others, the

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'emotions that are acceptable or prescribed for participants in the practice' (Schatzki, 2005: 472). The teleoaffective structure as well as the 'understandings of how to do things' are often implicitly held, routinized, and not actively reflected.

Practices are acquired by members of a community through participation in a specific context and in the process of institutionalization (Berger and Luckmann, 1966). Through continuous interaction, inter-related expectations of typical behavior patterns are established. If a sufficiently large number of actors uses these patterns to solve typical problems, they become generally accepted practices. New members of a social group observe these practices in the everyday activities of its members. This leads to the internalization of practices via the process of socialization. Eventually, these practices are so obvious that they are unquestioned and start to represent the objectified *context* for members of a community. The relationship between 'man, the producer, and the social world, his product' is a dialectical one (Berger and Luckmann, 1966). Through our practices, we create the reality (context) through which the former is influenced by the latter. 'Social reality is practices' (Taylor, 1985 cited in Schatzki, 2005: 470). Or, to put it differently, practices *are* the context to which they respond. Contexts are 'nexuses of practices and material arrangements' (Schatzki, 2005: 471). The context with its institutionalized meanings limits the possibilities to think and act (Berger and Luckmann, 1966). As a consequence, leaders are not *free* 'to do whatever they want, but neither are they *determined* in their actions by the situations they find themselves in' (Grint, 2005: 1490, emphasis added).

The power of socialization processes for new members of professional communities (Goode, 1957), such as the medical profession (Becker et al., 1961; Pratt et al., 2006; Weinholtz, 1991) is well-documented. The community provides its members with meanings, values, practices and identities which are held and understood collectively (Goode, 1957). The coordination as well as control of their professional activities is organized in *communities of practice* (Wenger, 1998), which include the standardization of knowledge with respect to work practices, such as providing treatments, doing ward rounds, or consultations.

Conceptualizing context

The understanding of context differs not only with respect to what or who constitutes it but also, on which level it is to be found. At present, leadership scholars tend to focus their attention on one particular aspect or level of context, instead of conceptualizing it more comprehensively. For example, while House and colleagues (2004) consider the national culture of a country to be the macro-context for effective leadership, others see the organizational structure or organizational culture as relevant context on a meso-level (Lovas and Goshal, 2000), while talk-in interaction is seen as a micro-level discourse context (Fairhurst, 2009). In sociology of knowledge, scholars like Soeffner (1991) and Schütz (1972) provide a framework that takes into account three levels of possible interactions among people. The three levels refer to the context levels already known to leadership scholars (for overview see Fairhurst, 2009; Liden and Antonakis 2009). What Schütz (1972) and Soeffner (1991) call macro-context is labeled by others as social Discourse or visionary leadership. The key idea of this level is to influence others through ideologies, ideas, and values, such as the New Public Management Discourse (for differentiation among *d*iscourse and *D*iscourse, see Alvesson and Kärreman, 2000). The meso-context describes indirect interactions or mediated interaction settings that are described in leadership research as leadership through

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standard operating procedures, key performance indicators (management by objectives), objects, or hierarchical structures. The basic idea is to provide leadership through objective measures and instruments that substitute personal contact. Finally, the micro-context of direct face-to-face interactions is generally referred to as micro-discourse by discursive leadership scholars. Here, the main idea is to influence interaction partners through face-to-face means, such as rhetoric, charisma, convincing content, or authority. Together, the three interactional settings form the context that, in varying degrees, structures and shapes individuals' actions. The three context spheres exist simultaneously despite their different structures and the spatial and temporal horizons of their experience. However, each level has different qualities and provides different possibilities to promote (or hinder) change. When leaders choose the 'right' level that is in line with their intention and purpose, it can serve as a resource for leadership to successfully extend its room to maneuver and influence. The level of interaction is hence a relevant quality of context that needs to be considered in a context-sensitive analysis of leadership.

In addition, sociologists add to the discursive leadership understanding of context (e.g. Fairhurst, 2009) by arguing that practices are highly symbolic and can include body performances (Reckwitz, 2002) and other para-linguistic aspects, such as the involvement of other actors, temporal structuring, or rituals (Knoblauch, 1995; Reckwitz, 2002). These symbolic aspects are understood collectively by a community. The form of leadership is therefore an important carrier of information, so that not only *what* is said, but also *how* it is said defines the context for subsequent practices.

To summarize, our theoretical framework stresses the *everyday work routines* as the site for leadership; it is interested in how leadership achieves its effects *practically* and *in situ*. Second, it argues for a recursive relationship between leadership and its consequences; leadership practices *are* the context to which they refer. Third, it raises awareness for the argument that leadership practices can draw on different context levels, whereby each level is able to provide particular advantages for leadership. Fourth, it stresses that leadership practices comprise a *symbolic* dimension and can include *para-linguistic* resources to achieve its effects. Accordingly, empirical attention should not only be paid to the *what* of leadership but also to the *how* of leadership. The focus on everyday work routines informed the data collection; the other assumptions guided the process of data analysis. We will return to their implications in the discussion.

Empirical case

Research context

Expert organizations, such as hospitals, depend on and aim at producing new knowledge. This manifests itself in the continuous specialization of the various sub-disciplines. Expert specialization is both the secret of success for medical progress and the reason for further differentiation (Lega and DePietro, 2005). Until the 1990s, the Swiss healthcare sector was characterized by stable growth and sufficient resources. Most of the large public hospitals were therefore organized along the scientific differentiation of the medical disciplines in so-called silos (Mintzberg, 1979). The different medical clinics (silos) were largely autonomous, and the definition of their key day-to-day activities, the target groups, and processes emanated from the professionals' work routines and expert knowledge. The pressure to cut costs and to foster greater integration among the medical disciplines grew only slowly. By the year

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2000, however, most public hospitals in Switzerland were involved in New Public Management (NPM) initiatives, which focused on process orientation and introduced management thinking and reasoning. This was true also for the university hospital that we studied. In 2004, political pressure had increased and the still newly appointed hospital management (executive committee) of the university hospital decided on a strategic initiative whose aim it was to overcome the traditional division of tasks (and power) and to introduce a modern, more process and management-oriented organization. More precisely, they commissioned the re-organization of the structure of patient care and the introduction of new treatment centers, in which all experts who were required for a particular treatment were to work together, instead of being separated by the traditional (professional) boundaries of the medical clinics (such as surgery, internal medicine, etc.). The key agent in this strategic project was the project leader, a professor of surgery with an MBA, who had recently been appointed to the executive committee. He was the initiator and 'driver' of the strategic change.

Data collection

The paper is based on an intensive, real-time, longitudinal field study of a change project which follows the methodology of a single case study (Yin, 2003). It traces the developments along the entire process and across all hierarchical levels (Chakravarthy and White, 2002). Our initial research interest lay in understanding the dynamics of large-scale change in public hospitals. Our research question was: How is change accomplished? Data collection was undertaken over a period of 24 months (2004–2006), using a range of qualitative methods, including direct observations of executive committee meetings, project team meetings, and other team meetings relevant to the change initiative; semi-structured interviews and 'naturally occurring talk' (Silverman, 2001) with the executive committee members, the project leader, the physicians involved in the project (the chief physicians, residents, and interns), and the administrative and support staff. In addition, documents, such as relevant minutes, reports, strategic papers, and emails, were collected. More than 100 meetings were observed throughout the fieldwork, with the second author taking verbatim notes on what was said and discussed and by whom, as well as on the overall setting and atmosphere, the way people were seated, and other non-verbal clues. A total of 25 official semi-structured interviews and about 20 naturally occurring conversations were recorded. In the interviews, the participants were asked to recount what was currently happening, how they perceived specific decisions or actions, and to explain why something (a decision, a plan, an idea) did or did not work out. In other words, the main interest lay in reconstructing people's subjective experience of leadership and change. The interviews included repeat interviews with the key informants, such as the project leader.

One of the challenges for qualitative, ethnographic research is to obtain access to the field and to observe people in their everyday life without disturbing them (Van Maanen, 1982). Field access was granted to the second author, who had just joined the hospital as a part-time consultant when the pilot phase of the change was being initiated. His job was to support the project leader and to provide him with managerial knowledge. Since he was new to the hospital, the second author was not yet a 'native' and therefore not blind to everyday routines (Tedlock, 1991). His participation during the observations varied between a 'passive' and 'moderate' stance. During the first phase, he mostly observed what was happening in order 'to follow closely the daily and intimate processes of [managerial] work, while at the same time to remain an ''inside' outside observer ... to follow in every detail what the [managers] do and how and what they think' (Salk, 1986: 12). Later in the

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process, he would volunteer to take on administrative tasks, such as writing the minutes. At no time did the second author involve himself actively in the discussion with the chief physicians or the executive committee.

Data analysis

The data analysis basically involved two steps. In the first step, we tried to make sense of our data by organizing and ordering it. To achieve this, we followed a narrative strategy (Langley, 1999) and wrote a 'change story' from the raw data, summarizing everything that had happened. We not only included the different events, activities, and choices, but also the different levels (hierarchies) involved, as well as the overall temporal sequence (Langley, 1999). In addition, we tried to pay particular attention to the overall cultural context within which the events and social practices unfolded (Prasad, 2005). The change story was done to address our original research question which was interested in how change was 'happening'. When we tried to understand why it had played out the way it had, we realized that a closer look at the leadership practices and their relationship to context were central. We then consulted diverse literature to help make sense of our data (see the theoretical framework above). We paid particular attention to the work by Denis and colleagues (2010) and their characterization of leadership practices. Hence, in the second step of the data analysis, we focused our attention on the recursive relationship of leadership practices and context, and tried to understand how the co-production developed over time and affected the overall change dynamic. The research questions with which we addressed the data were: (a) How is leadership accomplished? (b) How do actors perceive the context? (c) How is the context influenced by the leadership practices and vice versa? and (d) How does the ongoing co-production of the leadership practices and context shape the overall change dynamic? In the process, each author separately carried out open coding (Strauss and Corbin, 1998), paying particular attention to the leadership activities and contextual aspects. A leadership practice was defined by us as a re-occurring pattern of influence tactic or decision-making behavior that was critical for the unfolding dynamics. Following the separate analysis, we compared our first order quotations and observations and tried to group those that related to similar aspects into second order themes. These themes resulted in a list of leadership practices and context interpretations which were used to present the empirical case in three episodes (see Table 1 for overview of leadership practices and main context themes that derived from our analysis).[2]

Findings

As outlined above, the context of our study was a strategic change initiative put forward by a professor of surgery newly appointed to the executive committee. He was given the task to improve the medical processes and was considered a medical and management expert due to his medical training and subsequent MBA education. The professor of surgery introduced the concept of 'treatment centers', in which all relevant professionals were to work together, instead of being separated by professional silos. In a pilot phase, the *treatment center for musculoskeletal system* was to be implemented. We present data from this pilot phase and structure it in three episodes – each episode is defined by a characteristic leadership challenge that needs to be addressed in order for the process to move forward. The three episodes span different time periods (episode one 12 months, episode two 5 months, episode three 2

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Table 1. Summary of the three episodes, their key challenges, context attributes and leadership practices.

Episode	Key challenge	Context	Leadership practices	(Re)produced context
Episode 1: To get them all on board (January 2004 to January 2005)	The project leader has to win over the executive committee and the physicians. He has to make the initiative as relevant as possible to them, but in different ways. A key challenge is that the physicians fear a shift in the balance of power.	Resource scarcity NPM Discourse Thinking inside the box Equals, no privileging Balance of power No one interferes in the work of a colleague Agreement as long as no resources are affected	Abstraction and temporal disconnection Reframing the relevance for medical profession Personalization Granting autonomy (personal power) Creating facts	No resource allocation Everyone agrees, but no one is really committed Agreed upon structure recreates culture of 'thinking inside the box' as well as chief physician's autonomy and power Difficulty to make joint decisions and take on joint responsibility
Episode 2: Defining a detailed concept (February to June 2005)	Decisions will have to be made about the structures and processes, but in such a way that no downgrading of individual protagonists or specialization subareas can be inferred.	Personalization Equals, no privileging (balance of power) Thinking inside the box No interference and no 'telling other physicians how to do things'	Mitigating Delaying decisions Respecting disciplinary boundaries	No definition of clear structures and power relationships Additional resources needed High uncertainty New project leader is young chief physician
Episode 3: A plunge into cold water (July to August 2005)	The challenge is to actually transform the selected treatment center and to have it running reasonably.	Standardized and pre-structured medical work routines Work ethics	Reliance on the self-organization of the professionals (along hierarchies and 'patient-paths')	Organizing around personalities (personalization) Eventually 6 instead of 4 teams Chaotic consequences for IT and administrative staff

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months); together they comprise a period of 20 months (January 2004 to August 2005). For each episode, we will outline the 'given' context, the leadership practices that answer the context, and the context 'echo' of these practices that, in turn, constitute the new context for the subsequent leadership practices in the next episode. Table 1 provides an overview of the three episodes including the key challenge for leadership, the (re)produced context, and the leadership practices.

First episode: To get them all on board (January 2004 to January 2005)

In the beginning, the key challenge for the project leader is to gain the support for his initiative from both the executive committee and the physicians. He has to make the initiative as relevant as possible to both groups, but in different ways. The executive committee can be won over by referring to common management discourse: the project leader is able to build up legitimacy for his project by identifying an acute management deficiency in the hospital and the absence of an explicit strategy. He argues that the hospital should focus on its 'core competencies', rather than being a 'convenience store' of treatment options which is not very patient-oriented and which shows no clear competitive advantage (Prahalad and Hamel, 1990). This is, in principle, well-received by the executive committee. However, the situation is quite different for the physicians who are generally skeptical about change, especially when it involves a shift in the balance of power.

Context. The context situation that the project leader is dealing with in the first episode can be described as follows: There is a general consensus among the executive committee to *establish stronger management orientation* in the hospital. At present, the organization is still organized by medical sub-disciplines in so-called silos. The organizational structure is seen as responsible for patient-unfriendly processes and resource wastage. Each sub-discipline is closed to outsiders and outside economic needs. The logic of each sub-discipline can be described as *inside the box* thinking. The physicians act largely autonomous and are not used to someone interfering in their daily work routines. Officially, the medical sub-disciplines are equally important and the power subtly divided.

Leadership practice: abstraction and temporal disconnection. According to the initial idea, the executive committee has to agree on core competencies they want to promote as part of the hospital's official strategy. However, the notion of 'core competency' is controversial. It implies a distinction between valuable and less valuable domains within the organization. Although it is easy for the executive committee to define what they are good at, it is far more difficult to make official what they are *not* good at:

> But to date - and I mean the past 15 years - we have not been able to define what we currently do NOT do well anymore. It's very difficult for us to define this.
> (Member of the executive committee)

The hospital management's dilemma between wanting to change something and retaining interdisciplinary power relationships threatens to result in indecisiveness. To prevent this, the project leader develops creative neologisms in order to raise the contentious issues to a level of abstraction at which consensus is possible. In a multi-page proposal addressed to the

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hospital's executive committee, the notion of core competencies, which is seen as a strategic element, is separated from the concept of treatment centers.

> The core competency notion is *avoided*: the required content discussion of the organization's core competencies is separated from the structuring of the competency and control system. (Project leader)

Another method to avoid the failure of the initiative and to win the executive committee for his idea is to select a therapy field that – due to its scope – is a natural candidate for a core competency. Conversely, the much more difficult decision regarding the abandonment or downgrading of therapy fields (so-called non-core competencies) is omitted.

> The determination of the non-core competencies, in other words, the specialist fields that will become less strategic in the future, will be subjected to a decision at a later stage. (Project leader)

Context production. The actual strategic decision about which domain is important and for what reason, and how many resources should thus be newly allocated is therefore temporally disconnected from the project and remains undecided for the present. The reason for this is that the chief physicians in the executive committee will only agree if their specialist field is not reduced, if no new focal points are introduced, and – above all – no shifts in resources (and power) occur. Despite these conditions, the project leader receives the official assignment from the executive committee and is authorized to initiate the project.

Leadership practice: (re)framing the relevance for the medical profession. While the project leader sells the initiative to the executive committee by means of market arguments and economic concepts, it is clear that this will not inspire the professionals (Dutton, O'Neill and Lawrence, 2001). Instead, he goes for a subtle reframing (Goffman, 1974). He portrays the treatment center as an opportunity for (a) professional training and development, (b) greater patient orientation, and (c) innovation. These themes are at the heart of most chief physicians' decision-making processes, because they concern their basic responsibilities: patient care, research, and teaching. The project leader argues that the center would overcome the current fragmentation and free up resources that could be used as investment in innovations.

Context production. To win all relevant groups over and avoid conflict, the project leader makes different promises to different groups of people and creates divergent expectations. The project leader reproduces the *balance of power* context by avoiding open conflict and by adhering to existing norms. He is obviously willing to pay the price for 'muddling through' (Lindblom, 1959) in order to take the initiative one step further.

Leadership practice: personalization. To communicate with the two target groups in different ways is only possible, because the project leader is the *only* person who spans these hierarchical levels and keeps them together. The practice of personalization, that is, taking on *personal responsibility,* also suggests that the initiative *belongs* to the project leader. He *is* the initiative and has total responsibility, as a surgeon has for an operation. It implies that no physician is going to interfere. Respect for the professional colleagues (and the project leader is, after all, a surgeon) and their medical focus is mandatory. As mentioned above, the professional culture does not allow 'star disciplines' or 'core competencies' at the cost of

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others. The personalization is also evident in the workgroups which are set up to involve those who are affected by the change in the planning process. To avoid a conflict-laden start, he refrains from including the chief physicians to keep the different interests apart. Instead, he invites the senior physicians of the different sub-disciplines and the nursing staff to participate in the workgroups. The project leader dominates these meetings at will. He has complete procedural control and is the only one with a complete overview of the project. The inclusion of middle hierarchies generally proves fruitful with regard to content. However, when a senior physician starts criticizing the proposals, the project leader simply does away with him by no longer convening the workgroup to which the senior physician belongs. No one objects to this practice. The project leader is therefore able to *create social situations* that have considerable influence on peoples' scope for maneuvering (Knoblauch, 1995). The production format of the workgroups downgrades its members to 'knowledge suppliers'. Eventually, the project leader takes on the planning work himself. He justifies this with the remark that 'nothing that would have been really sustainable was proposed in the workgroups'. In the end, it is the academic publication by Nonaka and Takeuchi (1995) that provides him with the convincing idea (and justification) to further develop the initial organizational chart into a matrix structure. Looking back, he justifies his approach as follows:

> We obviously have a lack of management capacity. This manifests itself in that expert panels come to meetings unprepared and offer prejudices rather than well-reflected arguments. This led, I have to honestly admit, ultimately to the structure that I proposed. The structure is based on an academic publication that I read. (Project leader)

Context production. An important context factor in expert organizations is the difficulty of making joint decisions (March, 1991) and assuming joint responsibility (Bate, 2000). The leadership practice *personalization* is responding to this context in a perfect way and therefore becomes a recurring practice throughout the development and implementation of the initiative. Of course, personalization does not remedy the problem, but rather reinforces it. Joint decisions are not made and no-one (except the project leader) feels responsible. Officially, everyone agrees but no-one really feels committed because they are not involved (it is not *their* initiative, but *his*).

Leadership practice: granting autonomy to avoid conflict. One can ask why a complex matrix organization with free-flowing knowledge (Nonaka and Takeuchi, 1995), which is contrary to the physicians' hierarchical model, becomes a quintessential factor for the initiative's approval. But with the new matrix structure (see Figure 1), the project leader is able to deal with two essential obstacles: accommodating all leading physicians in a *suitable managerial function without loss of face* as well as *avoiding a clear hierarchy* among *equivalent experts*. The *autonomy* as well as the culture of *thinking inside the box* is thus re-created by means of an organizational structure that actually intended the contrary.

Nevertheless, the physicians with a horizontal management function do not trust the situation. They are worried that, in the end, the leaders of the medical teams (vertical functions) will be the 'real chiefs' who are likely to dominate the horizontal functions because they have the important resources. In the context of scarce resources, the physicians in a horizontal management function do not want to run the risk of being at the mercy of their colleagues. The project is therefore once again about to fail. But the project leader is willing

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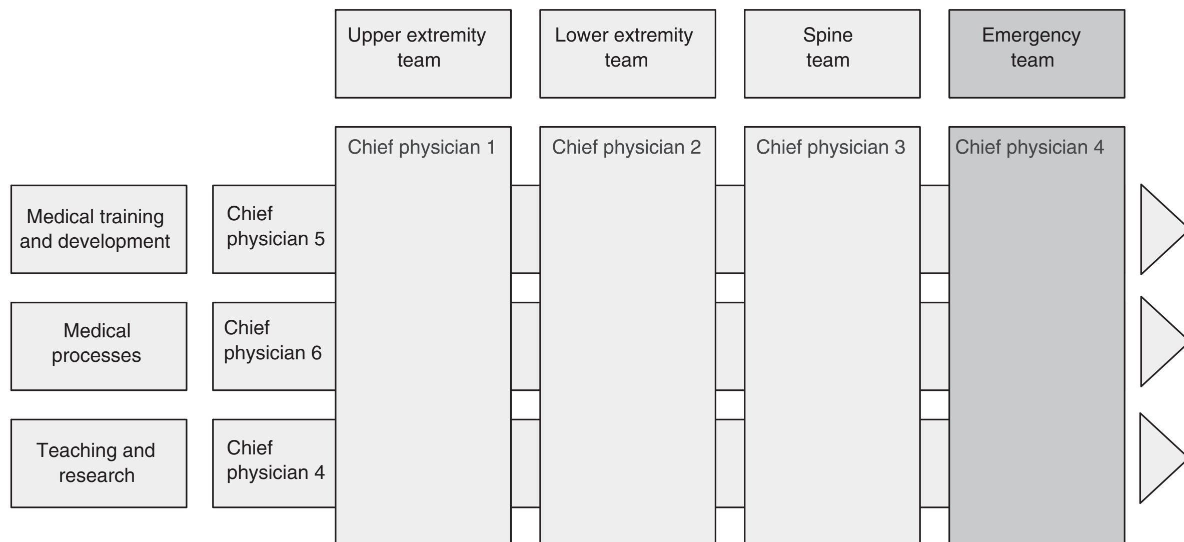

Figure 1. The new matrix structure with four teams and three cross-sectional functions.

to resort to extreme measures and suggests that the executive committee appoints all six physicians to the position of chief physician.

> To eventually be able to proceed with the treatment center, we promoted each treatment center manager to chief physician. If we had not done this, we would never have received approval from these physicians. It is a compensation for the worry of a loss of personal power. (Project leader)

Context production. The physicians' threat to resist the new structure is so grave that the project leader and the executive committee have to appoint all center managers to a permanent chief position, which includes established rights (autonomy, personal power) in order to proceed with the ostensible change. Figure 1 shows the final matrix structure that consists of three cross-sectional functions (medical training and development, medical processes, teaching and research), and three medical teams (upper extremity, lower extremity, spine) as well as the emergency team to which the physicians of the other three teams rotate.

Leadership practice: creating facts. The chief physicians' appointments are confirmed under enormous time pressure just before Christmas, making an implementation of the new structure in January no longer realistic. The project leader fears that a long transition period runs the risk of starting the discussion about positions and managerial authority anew. To stabilize the decision in favor of the treatment center, he therefore decides to *create facts* and to implement the center on paper. In other words, the center is formally implemented after the chief physicians' appointments. In the professional culture of physicians, decisions are usually neither questioned nor reconsidered. As a consequence, the materialization and visibility of the center leads to an actual stabilization of the initiative. Nevertheless, the newly proclaimed treatment center does not yet affect the employees' everyday working routines and their understanding of the new structure is ambiguous.

> No, I don't think so; I don't know how much has been communicated. I am not sure it is communicated in a way so that everyone can understand the new structure. ... Even though

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> most of them would like to know what the future holds. Whether the new management structure has really been grasped is difficult to say, but I have a feeling that it hasn't. (Intern)

Conclusion episode one. By means of his leadership practices, the project leader succeeds in obtaining formal authorization for the change initiative. To overcome the physicians' reluctance, he accepts a downgrading of the initiative from a 'strategic project' to a 'restructuring' project. The advantage of this is that it is easier for the project leader to subsequently obtain approval. As long as no resources are allocated, the project is of no real interest to anyone – not even the physicians who will be affected by the change. In the communication with the executive committee and the surgeons, there are only winners. Although everyone approves of the initiative, almost no-one actually feels obliged to support it. The project belongs to the project leader *alone*.

> I believe that everybody thinks: This does not affect me, I don't have to become involved with this, I'll just let it go. (Member of the executive committee)

The *personalization* practice and the *appointment of the chief physicians* are full of contradictory symbolism. They communicate a message which conveys exactly the opposite of the initiative's proclaimed goals. For example, although more cooperation was officially sought, the personalization leads to the chief physicians not being and not becoming involved in the project. In a similar vein, the position of chief physician hitherto stood for 'being the boss': autonomy, power, specialization. Chief physicians are able to take drastic measures, for example with respect to their interns and are known for being difficult to integrate and to tame. The symbolism of the position of chief physician is collectively known and understood by the medical staff. The appointment of the new chief physicians hence suggests that 'everything will remain the same', that is, everyone is more interested in their autonomy and 'own box' than in procedural cooperation. The appointment illustrates an example of context production on the meso-level (Soeffner, 1991). Yet, because the executive committee fails to discuss the meaning and implications of the appointment, the micro-level actions and interpretations of the new structure by the medical staff follow collectively shared symbolism and meanings. Accordingly, the new structure is just a structure on paper – real changes are unlikely to take place.

Second episode: Defining a detailed concept (February–June 2005)

In the beginning of the second episode, the new treatment center structure is still very abstract. The key challenge for the project leader is therefore to define details and make the center concrete, without damaging his relationships with the leading physicians. He will have to make decisions about processes and resources, but in such a way that no downgrading of individual protagonists or sub-specialties can be inferred.

Context. The context situation that the project leader is dealing with in the second episode can be described as follows: the practice of *personalization* has allowed the project leader to avoid conflicts and discussions, but the downside is that he is the only one who identifies with the project. Consequently, the project base (physicians, nursing staff) cannot help him with the implementation. The *avoidance* of a definition of core competencies and the *maintenance of the balance of power* and the official *equality of all medical sub-disciplines* make it difficult

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to pay attention to the formulation of important details, such as responsibilities, patient flows, team size, and the content of the managerial functions. Only after a particularly ambitious chief physician uses the unspecified rules to his own advantage and operates on patients who should ideally be treated by other chief physicians, is pressure brought to bear on the governing body (and especially the project leader) to capture the hierarchical details in a set of regulations.

> Because not all people interpret the treatment center as you do yourself and they have other ideas. Then it is important to say: This is what the regulations stipulate. (Chief physician)

Leadership practice: mitigating. Even though the regulations (which are supposed to define all of the protagonists' rights, obligations, and boundaries) are seen as 'back-up insurance' with which to sanction members' actions in a worst case (such as the star surgeon's 'solo run'), the actual discussion of the written proposal results in a 'mitigation job'. Expressions such as 'is subordinated to' and 'is responsible for and decides' are reformulated, because of strong opposition by the physicians. The work is slowed down considerably when essential questions regarding team size, patient distribution, and consultation hours become the subject of debate. Different approaches are tried out (cautious use of variations of organizational charts, etc.), but the group is reluctant to define clear goal-oriented measurement criteria for resource allocation.

Context production. As a consequence of mitigating, the regulations remain vague and the responsibility to act in everyone's interest is left with each chief physician. The professional norms are thought to take care of the problem. In the end, the problem of resource allocation and disposal rights is solved *conventionally*. The group of physicians explains that the initiative is only feasible if the treatment center obtains many more resources and asks to appoint five new senior physicians. In this way, the pressure to prioritize and the feared 'personal assessment' and comparison between the chief physicians can be avoided. However, the five new positions are a considerable investment, and diametrically opposed to the project's original economic argument.

Leadership practice: delaying decisions. Since, under the given circumstances, making decisions is very difficult and highly politicized, decisions regarding *actual* work processes and team affiliations are postponed until the very last moment. Only then is there enough pressure to take action to force the governing body to make a decision. One advantage is obvious: owing to the tight timeframe, the people affected by the decision are not involved in the process; instead, the decision can be taken top-down. A resident describes the situation as follows:

> Everything always comes too late. They talk a lot, do nothing, and then suddenly it's decided and that's it. It takes an enormous time pressure before something happens. (Resident)

Context production. The decision-making practice of agreeing with everything that does not concern one directly (*inside the box thinking*) creates the context that the initiative is perpetually negotiated between the hierarchies (from executive committee to the project

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manager/project team and back). This is due to it being impossible to fulfill even the smallest part of the initial promise without additional resources. Since the executive committee is not interested in having the project fail, the project leader's practices proves successful, even if the emotional costs – in the form of a long period of extreme uncertainty – are great. For more than a year, the team members receive information bit by bit, partially from rumors, while nothing changes in their everyday work routines. Then, suddenly, everything has to be implemented within a few weeks. This way, discussions of or a reflection on the implications of the new structure are impeded. The insecurity binds the (cognitive, emotional, temporal) resources of the people who will be affected.

Leadership practice: respecting disciplinary boundaries (avoiding direct confrontation). Even though the initiative moves forward, the project leader decides to hand over the leadership responsibility for the initiative to the designated future administrative head of the treatment center at a surprisingly early stage. In doing so, he shows respect for the implicit borderline and professional norms: The physicians accepted him on the 'strategy scene' (Goffman, 1959), where he was involved as member of the executive committee. However, the issue now comprises the physicians' 'internal affairs', in which external persons should not interfere. Due to his own medical background, the project leader is familiar with the professional norm of *not issuing a direct instruction to a colleague* who is a chief physician. This is likely to have motivated the project leader's decision. The risk is simply too great that he may transgress this norm sooner or later. To avoid direct confrontation, he decides to step back and hence 'accepts' the existing boundaries. At the same time, it frees him from some of the responsibility in case the implementation of the center does not succeed.

Conclusion episode two. Overall, the planning status remains a highly abstract organizational chart until three weeks before 'going live'. The final selection of the team members only takes place under the utmost time pressure. On a critical note, it becomes obvious that no task-sharing change organization has been built. The negotiation process, which the project leader has geared towards maximum controllability, makes it impossible to closely and continuously incorporate the persons actually involved into the planning process. Although many people are involved, no-one is able to develop an independent role in the project organization. *More than ever*, the initiative is therefore dependent on the project leader. However, he hands over the leadership to the young chief physician, who, in addition to performing surgery, is also in charge of the emergency unit. Given the complexities of these responsibilities, most people expect that the new chief does not have the necessary resources to implement the initiative successfully. In addition, most people expect no real changes to occur since the concept of chief physician has been re-introduced into the new structure. Everyone knows that this implies working 'under' a chief physician and not 'working with' a managing physician as it was originally proposed.

Third episode: A plunge into cold water (July–August 2005)

The main leadership challenge in the third episode is to transform the treatment center and have it running even though many questions persist.

Context. The context situation in the third episode can be described as follows: Despite the approaching deadline, the center management stays relatively calm. Everybody knows that

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the start of the new center will be a 'plunge into cold water'. On the morning on the day of the go live of the treatment center, the physicians are divided into four teams (see Figure 1) and assigned to a ward, a consultation room, or the operating room. At 8:00 a.m., the hospital staff starts working under the new structure.

Leadership practice: relying on the self-organization of the professionals (along hierarchies and patient-paths). The physicians' work practices are highly *standardized* and largely *pre-structured* by the patient. The *ethical rule* to always act for the patient's well-being is deeply anchored in the physicians' practice. This provides a frame of reference regardless of the work structures or organizational chart in place. As a consequence, the physicians' everyday practices remain the same on the day that the new structure finally comes into force. The main concern is less about how the initiative is implemented than about whether all the patients will receive correct treatment. The physicians therefore cope relatively well with the reorganization. The self-organization is supported by typical patient pathways. The physicians seem to switch to an *emergency mode,* in which they all work with enormous dedication. They 'adopt' their patients (*personalization*) and, step-by-step, steer them past the system problems. An intern evaluates the situation as follows:

> I find this problematic. The bad, the really catastrophic performance [of the project management] during the reorganization is not visible, because everyone tries to cover up the deficiencies for the patient's sake and well-being. And I have a feeling that they [the project management team] count on that. (Intern)

However, the administration and the IT systems, whose adaptation to the new team structure had been forgotten during the run-up, are affected severely by the conversion and the lack of detailed planning.

Context production. It quickly becomes apparent that the structure with six chief physicians, but only four teams is not understood (see Figure 1). The question of 'who is the boss now?' is raised constantly. Within the first month, two new teams suddenly surface in internal documents, namely 'team PHK' (pelvis, hip, knee), as well as the 'foot team'. The division into four teams, which was undertaken due to the critical team size, dissolves itself in the first few weeks in favor of an 'organization around individual personalities [i.e. the six chief physicians]'. The management does nothing about this, but tolerates the reversal to six teams without comment. Consequently, the administration and the IT department, which are still organized according to the old structure, completely lose the sense for 'who has to do which task for which physician' and collapse.

Conclusion episode three. The lack of defined micro-processes triggers an 'emergency mode', which favors a reversal to the old organization around the chief physicians. Consequently, the absence of a detailed planning of processes and roles has a massive impact on the initiative's eventual outcome. Overall, the initiative has changed little in the surgeons' daily work. The support functions are, however, improved. The total breakdown in the course of the conversion to the new team structure triggers a far-reaching shake-up. The IT systems and patient processes are standardized. The administration suddenly moves from the periphery to the center of the change, which brings considerable benefits. Planned change was therefore possible, but only with respect to the information-processing support systems. It was not possible to affect the core of the professional organization. The executive

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committee's original aim to 'influence the cultural structuring of the hospital' has not been achieved. The system of professionals with an organizational structure that is oriented towards specialization is still in place.

Discussion

Our central concern in this article has been to provide a theoretical perspective that illustrates how context is integral to a leadership-as-practice understanding. To achieve this, we have built on the sociology of knowledge and practice literature and provided an empirical illustration of these theoretical arguments with data from a change project at a Swiss hospital. In the remainder of this paper, we discuss our empirical and theoretical insights and outline their implications for understanding and doing leadership in healthcare organizations (and elsewhere).

Understanding leadership

Leadership practices are context producing. The practice turn offers an understanding of context that stresses its temporal and situational influence (Maitlis and Lawrence, 2007; Samra-Fredericks, 2003) as well as its active production. Each action is simultaneously 'context-shaped' and 'context-shaping' (Drew and Heritage, 1992: 18). In our case study, for example, the choice of 'consensus practices' (e.g. giving chief surgeons more resources) contributes to the construction of the traditional organization *around personalities*, in which all following actions have to refer to this initial one. This context (re)production is an ongoing process of social interaction that creates common points of reference and a repertoire of practices, which ultimately results in a collectively shared social web (Knoblauch, 1995). In our healthcare organization, the social web's mission seems to preserve autonomy and harmony in the loosely coupled systems of chief physician teams. It is important not to conceive of these contexts or web of practices as objective, rigid frames of interactions (Knoblauch, 1995). They are not 'rules' that influence the actor unilaterally, but the actor 'commits' to the rules of a particular context by acting in an accountable way towards them (Rawls, 2002). The possibility to actively *play* with contexts is demonstrated, for example, in the 'solo run' of the most ambitious surgeon at the beginning of episode two: by doing surgeries that actually belong to the 'home turf' of his colleagues, he is able to reinterpret the context according to his own interests. Context is thus 'both a scene and also . . . the object of my actions' (Schütz and Luckmann, 1984: 311). The human agency consists of the decision which context the actor wants to take into account through bringing / referencing this context into the interaction. However, our understanding of human agency does not imply a linear, controllable leadership situation. Instead, own interventions are diluted by the reciprocity of actions, deviant interpretations, misunderstandings, and power relations. Context production in leadership could be characterized as 'an ongoing improvisation enacted by organizational actors trying to make sense of and act coherently in the world' (Orlikowski, 1996: 65). Leaders are neither free nor determined in their actions by the context they find themselves in (Grint, 2005). Leadership practices and context constitute, reinforce, and limit each other. Neither leadership nor context is essentially given; both are 'products' of social interactions. Our data hence provide an empirical illustration of the *constitutive approach* and show how leadership actively (re)produces context (Grint, 2000, 2005). Some of the challenges that we identified in the case study are well-known to organizational scholars. Among those

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challenges are the allocation of scarce resources (Burgelman, 1983), and the processes of collective decision-making (March and Olson, 1976). We have shown that in our case, these challenges were *self-made*: They were the consequences of well-established practices that (re)produced a specific context, culture, and organization (Barley and Tolbert, 1997). The actors *themselves* create the structures that constitute a 'non-receptive' or a 'receptive' context (Pettigrew et al., 1992: 268) for certain kinds of actions and decisions. It is thus the repertoire of practices that constitutes the *central* context for leadership practices.

Leadership practices and context are recursive. As argued above, contexts are made up of practices which are both context-shaped and context-shaping. The relationship between leadership practices and context is therefore *recursive*. For example, due to the context that all surgeons were regarded as equals, the project leader had to suggest that all be appointed chief physicians in order to preserve the balance of power. This leadership practice re-created the context of personalization, which, in turn, favored certain leadership practices over others. This provides a good illustration of how leadership practices are *dynamic*, *situated*, and, in the long run, *dialectic* (Denis et al., 2010). The practices are *dynamic* in that leadership actions at one time can change the potential for effective leadership at a later point in time. For example, once it was decided that the managing physicians involved in the new center were to become chief physicians, direct leadership of this group of people by the project leader were no longer possible because of professional norms and a culture in which colleagues do not intervene in each other's businesses. The practices are *situated,* because leadership is found in specific micro-activities that are embedded in a specific situation (context). For example, depending on whom the project leader was interacting with (executive committee or physicians), he adopted different practices and arguments. The leadership practices are *dialectic,* because effective practices can have a downside. The temporal disconnection and delaying of important decisions was effective in the beginning of episode one: the initiative was approved and the project leader was able to get started. However, later in the process, the unanswered questions slowed the entire process down and ultimately lead to a reversion of the initiative's original aim. Our data also illustrate that practices represent *collectively* held knowledge (Knoblauch, 1995). Practices like the implementation of the initiative through 'a plunge into cold water' represent and refer to a stock of knowledge 'on how things work around here'. Knowing that they could rely on the collectively held work ethics of 'putting the patient first' and on the standardized work routines of the physicians, the start of the new treatment center did not cause too much worry among the management team.

As our data show, the four features are interrelated – they define each other. Together, they are responsible for the recursivity between leadership and its consequences and, together, they characterize the doing of leadership over the course of action and time. Our findings thus corroborate the usefulness of the four aspects which have been proposed in the realm of developing a leadership-as-practice perspective (Denis et al., 2010). We add to this perspective by further specifying the recursive relationship and by outlining additional context specifications below.

Leadership practices are historically grown and collectively stabilized. In our theoretical framework, we have argued that leadership practices develop as a standardized response to typical organizational challenges. They can be seen as socially acceptable heuristics on how to make decisions or how to solve problems. As such, they are closely linked to an

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organization's purpose and mission. For example, a university hospital aims to produce new knowledge through specialization (Lega and DePietro, 2005). When there were still enough resources available, the most efficient way to achieve this was through the structure of mostly independent clinical units (Gloubermann and Mintzberg, 2001). As a consequence of the multitude of specialties and different interests, the repertoires of practices which developed historically over time, emphasized *conflict prevention* and *harmony*. In response to a changed situation and scarce resources, the university hospital tried to change the existing context towards more innovative structures. However, they did not give up on their historically developed practices. Due to missing routines of collective reflection, their learning capacity (Cohen and Levinthal, 1990) and the potential for 'real' change was limited.

The reason for this observation might be that members of the organization relied on repertoires of practices that actually *gave rise* to the change initiative. For example, to overcome structural separation and personalization, the executive committee decided on organizational structures that would make cooperation and coordination among the chief physicians necessary. Yet the executive committee was neither able to collectively agree on a new allocation of resources nor was the appointment of the center managers into the position of chief physician really 'breaking' with the established practices. In both cases, the prevention of conflict was more dominant than the attempt to learn. The paradox of 'the more we try to change, the more we stay the same' (Hinings, 2006: 248) was evident also in our case study. The historically grown and collectively accepted set of practices hence poses a dilemma for leaders of change. It is the dilemma of establishing acceptance for change through accommodation or rejection of collectively understood practices. In the short run, the project leader was actually quite successful by drawing on established practices: depending on the context to which he referred, he was able to employ practices that matched and reinforced the context. He was therefore a successful player on both the clinical and the managerial milieu. However, what he did *not* achieve was a collective reflection on and discussion about concrete problems with regard to cooperation and interaction. He did manage to achieve first-order change as a by-product of the chaotic consequences for the administrative support systems and its subsequent professionalization. In order to achieve *second-order* change and increase the likelihood for organizational innovations, he would, however, have had to 'influence the conditions that determine the interpretations of situations and the regulations of ideas' (Norman, 1977: 161). But such an attempt was not undertaken.

Leadership practices are routinized (everyday knowledge versus managerial ideologies). One could wonder why the project leader did not take more risks by challenging the existing order and the established practices. Yet, practices and the production of contexts occur *routinized* (Feldman and Pentland, 2003). For example, the recurring leadership practice of personalization enacted a context of fragmented decision-making in which no one was willing to really commit to the change (March, 1991). The practice of personalization was not chosen deliberately, but was self-evident: it constituted deeply embedded knowledge. Even though the MBA course might have changed the project leader's orientation towards a managerial ideology, in direct interactions with his professional peers, he remained a 'cultural captive' (Tomasello, 1999). Social scientists who advocate a practice perspective (Schatzki et al., 2001), as well as researchers in the tradition of the sociology of knowledge (Berger and Luckmann, 1966; Garfinkel, 1967; Knoblauch, 1995, 2005; Luckmann, 1992; Schütz, 2003), have emphasized the precedence of the everyday experience

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over ideologies or theoretical knowledge (Berger and Luckmann, 1966). The intensity is stronger and the experience more relevant for our (practical) knowledge of the social world. It is the practical rather than theoretical knowledge that helps us to gain orientation and to reduce complexity. And it is this practical knowledge that leads to routinized, often implicit knowledge on 'how to do things'.

Leadership practices are symbolic and para-linguistic. Collectively understood practices provide leaders as well as the staff with important cues on how to interpret and make sense of what is happening. In many instances however, the implicitly held knowledge is in direct opposition to the official information. Because the practical knowledge is stronger than what is communicated officially, leaders need to be aware of the symbolic dimension of their doing; they produce observable practices which triggers collectively held knowledge (Knoblauch, 1995). We have outlined above that the chief physician position is known collectively to represent a hierarchical system with the chief physician as the central figure and autocrat. The appointment of the six center managers to the position of chief physician was therefore highly symbolic. The appointment suggested a different future than the one the center's official matrix structure communicated. Over the course of time, the four teams actually regrouped themselves around the six chief physicians and reverted to six teams. Although the content (text) suggested that changes would take place, the social form of the practice suggested that everything would remain the same. To use the words of a leadership classic, the managers failed to '(practically) walk the (official) talk' (Tichy and Sherman, 1994).

The example also illustrates that practices do not only represent 'Sprachwerke' (language, text), but include several para-linguistic *form aspects*, such as, rituals, stylistic devices, and time structures (Goffman, 1983) which serve as *resources* for leadership, i.e. they provide possibilities to widen a leader's scope of influence. What kind of para-linguistic practices are available is context-specific (situated, embedded). In hospitals, the repertoire appears quite comprehensive and includes, among other things, high levels of uncertainty, a strong hierarchical system, spatial separation of the different milieus, ethical necessities and constraints, high symbolism, time pressure, money. For example, the way in which decisions were made by the executive committee illustrates a temporal aspect: The delaying of decisions built up enormous external pressure; the waiting leads to a 'point of no return', so that, at the very last moment, the executive committee either followed conventional decision-making (allocation of more resources) or was able to make decisions that were hitherto impossible to make (selection of team members and tasks). Another example is the question of who gets involved in the process and who does not. The project leader was able to decide who can participate in the working groups (e.g. the exclusion of the chief physicians). He created these groups and 'closed' them depending on how supportive they were of his ideas. Securing the separation of milieus created a 'knowledge monopoly'. These situational elements are constitutive of a practice, as they decide who can interact with whom about what (Crozier and Friedberg, 1979). The relevance of the symbolic and form aspects has, however, been largely overlooked in organization and leadership studies. Our findings thus add to the linguistic understanding of context and practice put forward by discursive leadership scholars, and specify the understanding of context from a leadership-as-practice perspective.

Leadership practices are taking place on different context levels. In our theoretical framework we have suggested an understanding of context that comprises three levels (macro, meso, micro). Depending on how people interact with each other, each level offers unique

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advantages to leaders to exercise their influence. In our empirical case, all three levels were in play; however, to different degrees and with different success. As outlined above, hospitals are organizations that are marked by plurality and complexity. They encompass different milieus and cultures with their own languages and ideologies (e.g. Glouberman and Mintzberg, 2001). Giving this setting, it proves problematic for leadership to rely on the macro context level for leadership. As our case study shows, the surgeons continuously misunderstood key terms like 'process-oriented organization' and were unable to grasp the needs of other stakeholders within the organization. Hence, trying to lead with macro-level Discourse *ideas* was un-productive. The process of sensemaking and sensegiving (Gioia and Chittipeddi, 1991) resulted in misunderstandings. In order to lead via ideologies, leaders need followers that are receptive to these ideas. Our empirical findings suggest that the project leader mostly tried to lead the change through creating facts, managing financial resources as well as proposing new organizational structures. These are typical instruments of what Schütz (1972) would describe as meso-context. The instruments create a 'secondary effect zone' (Schütz and Luckmann, 1984: 313) and serve as a substitute to help leaders address many employees at the same time without having to be personally present. On the other hand, this form of leadership is impersonal, anonymous and, according to Schütz (1972), only suitable for unambiguous information. Because of missing reciprocity in the interaction, it is impossible to clarify misunderstandings, distrust, or frustration. But this is exactly what happened in our case study. The project leader was facing the dilemma of not wanting to discuss the 'real' implications of the change and therefore kept conflicting milieus apart. Some of the misunderstandings and unclear responsibilities actually increased his room for maneuver temporally. However, the cost was that effective learning and 'real' change was not achieved. The micro level context, that is, practices of direct interaction, was only used within the milieu of chief physicians. Here, however, the project leader felt obliged to conform to expected behaviors and roles. As a consequence, he was successful at realizing change *formally*, but unsuccessful at bringing about real change *in practice*. Instead of orienting themselves towards macro-level Discourse ideas and ideologies, leaders might be more successful by focusing on their everyday micro-level interactions and practices. The possibility of using different context levels as resource constitutes a second specification of context from a leadership-as-practice perspective.

Doing leadership

Leading through context. An interesting empirical observation is that leadership via context is a feasible alternative when professional norms make direct leadership (managing, influencing) among colleagues impossible. Direct leadership by the project leader was possible as long as he played on the strategy scene (Goffman, 1959) as a member of the executive committee which had the decision power over budget issues and strategic questions (episode one). However, direct leadership became impossible when the project leader was a medical colleague (partner) on the medical scene and detail questions such as responsibilities and team membership had to be negotiated (episode two). Instead of leading professionals directly, healthcare leaders can try to ascertain ways to change the existing context and its constituting practices without losing credibility and trustworthiness (Denis et al., 1996). They gain (and keep) the credit by complying with expected and accepted norms, that is, by doing leadership that adheres to the existing context and the professionals' expectation (Denis et al. 2001). A typical attribute of doing leadership in healthcare organizations is therefore to deal

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with dilemmas and to find a balance between complying with and slowly changing existing practices.

Similar to the distinction between *d*iscourse and *D*iscourse (Alvesson and Kärreman, 2000) we believe that it is possible to talk about micro (lower case) *p*ractices and (capital P) *P*ractices. Examples of micro practices include the various leadership practices that we identified in our study. They stabilize and (re)constitute Practices such as power retention, problem solving or legitimization. Many of these Practices are defined by contradictory micro practices. The value of adopting a leadership-as-practice perspective is therefore to better understand the dynamics of overarching Practices and – in cases in which they prove to be dysfunctional – to find possibilities to change them by adjusting some of the micro practices that constitute them.

Leading change, changing leadership. Our findings suggest that if leaders are interested in changing the context, they need to start with the everyday routinized practices, which constitute the most relevant context for action. However, changing the practices might be easier said than done. We earlier noted that practices are usually self-evident and tacit because they draw on routinized knowledge. The endeavor to make changes would therefore require becoming aware of the established practices and making explicit that which is usually implicit, unspoken, and inarticulate (Carroll et al., 2008; Norman, 1977; Raelin, 2007, 2011; Schön, 1983).

Changing leadership practices could, for example, be supported by means of attentiveness, third party observations, or collective reflection. It would require the leaders to think about the consequences (functional and dysfunctional) of their practices for the immediate context and the overall organization in the short and long run. Leaders would have to reflect on alternative scenarios that might be more functional and what these 'new realities' would imply for the everyday practices. Instead of trying to teach professionals the so-called required skills and competencies, leaders should take the time to allow a new context to be produced and practices to be revised and 'regrown' (Carroll et al., 2008; Raelin, 2007). Since practices are held collectively, it would not suffice for leaders to undertake these reflections individually. In order to change an organization, its members need to collectively examine the practices-in-use and to understand their requirements and consequences. To lead change means to change the collectively held leadership practices.

Problem-oriented and bottom-up. Finally, in order to enable effective learning situations, we believe that it is most promising to develop new knowledge which is oriented towards a concrete problem. For example, to change medical practices, it is best to get close to the medical problem at hand and to provide alternative practices to solve the problem. This would imply considering in greater detail the actual micro-processes of care and cure and reflecting on possible ways to improve them. In this way, the direct integration of new knowledge into everyday medical practices would be supported. In addition, it would provide a more bottom-up approach that is closer connected to the expert knowledge. This might be particularly promising in situations in which leaders (like the project leader in our case) are depending on the experts' support and therefore limited in their power to lead top-down. The value of a leadership practice that emphasizes substance over status has already been shown beneficial in other context (Cohen and March, 1974). The great advantage of taking a problem-oriented micro-focus would be that it would enable different micro-milieus (different disciplines) to come together and for them to understand how their work practices

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are connected and how problems could be solved. Instead of applying abstract macro-level 'buzzwords', such as culture or innovation, change leaders should focus on the micro-level and concentrate on everyday concrete problems of concrete processes that everyone can relate to (Beer et al., 1990).

Limitations

We have stated that our case study represents a contextualized analysis of a change initiative in a Swiss pubic hospital. Given that we have paid so much attention to context, the question might arise as to what extent our results hold useful insights for organizations in other contexts. Clearly, the leadership practices that we have identified show an emphasis on conflict prevention and harmony. This might be particular relevant for Swiss hospitals, which are embedded in a national culture that values consensus and democratic principles. However, we have also argued that these practices developed out of past organizational arrangements that were marked by specialization. As this is typical for many expert organizations around the world, conflict prevention and the preservation of harmony might have been functional practices in other contexts in the past as well. However, what seems important to stress here is that the aim of this article was not to provide readers with a set of best-practices for successful healthcare leadership. Instead, we have tried to highlight, as it were, on a meta-level, how context and contextualizing are integral to the understanding of leadership from a practice perspective. Empirically, we have shown that the everyday practices provide an elementary cue in understanding organizations. Without knowledge and a collective reflection of these practices, change is likely to fail – not only in healthcare organizations. We would also argue that professional healthcare organizations are not the only organizational form in which strong professional communities have an influence on the overall organizational culture and logic. Other expert organizations such as cultural and artistic organizations, research institutions or governmental agencies are likely to have similar professional sub-cultures with own sets of practices. In addition, contextual attributes, such as pluralism and complexity, are to be found in almost all large organizations in today's business world (Denis et al., 2005, 2010).

Conclusion

This article has shown theoretically and empirically how leaders actively produce context to which they later have to refer. They achieve this through their everyday leadership practices, which are context-shaped but also context-shaping. Practices develop historically and prove functional for a specific organizational challenge. However, they can become dysfunctional when the nature of the challenge alternates. Since practices are routinized and understood collectively, they are difficult to change. In order to effectively lead change, it is often necessary to start with a review of the existing leadership practices and to enable collective learning. By focusing on what leaders 'really do', our analysis provides new insights for understanding and doing leadership from a practice perspective: First, context constitutes a leadership resource that can be created and used to the leaders' advantage. Second, practices and context include symbolic and para-linguistic aspects that deserve greater attention in future leadership studies. Third, different context levels provide different advantages for leadership. Overall, the paper has shown that context and contextualizing are

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integral to a leadership-as-practice perspective. Practices and context are two sides of the same coin.

Notes

1. The order of authors is alphabetical, reflecting equal contributions.
2. For a more detailed presentation of the data and the data analysis process, see Von Arx (2008).

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