Doctors as institutional entrepreneurs – leading quality improvement in clinical contexts

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Introduction

Implementing quality improvement (QI) in clinical contexts is notoriously challenging, with many initiatives delivering little or no improvement in practice.[1,2] While the reasons for this are likely to be complex, Easton highlights the role of established organisational culture in frustrating clinicians' efforts to improve healthcare processes.[3] Thus, unlike in manufacturing contexts, where process improvement typically involves operating more efficiently *within* 'the rules of the game',[4] QI in healthcare is typically a *countercultural* activity, which challenges existing rules, norms and beliefs. We were interested, therefore, in how doctors function in order to deliver QI in clinical contexts.

Materials and methods

Given our interest in leadership of QI as a social phenomenon, an interpretivistic methodological approach drawing on the principles of grounded theory[5] was chosen. Key informant interviews[6] were conducted with a purposive sample of doctors, including former RCP chief registrars, Darzi fellows and doctors with strategic QI roles locally and nationally.

Results

It was apparent from interview data that there are cultural norms operating in healthcare settings that make successful leadership of QI initiatives challenging. There was a strong sense of individual professional autonomy amongst doctors, and it was also clear that powerful individuals could exert significant influence over their colleagues.

Doctors who had led QI used a number of strategies to tackle established cultural norms, with networking activity often proving the most successful approach. At times this involved them developing their own networks as a means of building social and political capital, while at other times it meant acting as a network broker on behalf of others and/or between powerful individuals and groups.

Discussion

Doctors who sought to implement QI in healthcare settings typically found that they were engaged in a largely counter-cultural activity. They therefore operated as *institutional entrepreneurs*– actors who display institutional agency by instigating change. Institutional agency denotes 'episodic forms of power'[7] in which agents 'mobilise resources, engage in institutional contest over meanings and practices, develop, support or attack forms of discourse or practice – all involving discrete, strategic acts of mobilisation'.[8] Networking was a commonly-used strategic act. Yet, QI methodologies, not least Langley et al's Model for Improvement,[9] often describe a model that treats the organisational context as apolitical or culturally inert. Theorising QI as a countercultural activity gives greater insight into the challenges with which QI leaders are faced than do traditional, technical-rational models of QI, and is more likely to indicate useful approaches to leading QI in these settings.

Conclusion

Currently, doctors who successfully implement QI often do so within a cultural context that is not ready to embrace QI, and powerful individuals and groups can act to derail their efforts. Consequently, these doctors exhibit considerable agency and function as institutional entrepreneurs in seeking to change the rules of the game. ■

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