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"I Want to Break Free"— German Locum Physicians Between Managerialism and Professionalism

Abstract: In the last decades, managerial instruments have gained importance to medical decisions and the logic of managerialism is juxtaposed with the logic of medical professionalism. Recent changes in the hospital employment structure raise the question of contradictory logics not only at the organizational but also at the individual level. Therefore, we investigate the rise of locum doctors which is a relatively new phenomenon in Germany. Our qualitative interview study with 21 locum tenens, permanently employed physicians, and chief physicians shows that locum physicians re-contextualize professional standards in hospitals. According to their self-perception, patient care stays at the center of their medical practice regardless of economic, bureaucratic, and hierarchical requirements as well as hospital-specific routines. We argue that the interrelationship between professionalism and managerialism exists not only within organizations but also on an individual level of locum doctors.

Keywords: Professionalization, managerial logics, professional organization, locum physicians, hospital

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Health care systems throughout the world are experiencing similar pressures, such as the need to decrease costs as the burden of treating disease and the aging of populations increases (Kikuzawa, Olafsdottir & Pescosolido, 2008). Almost all developed countries are seeking better and more efficient ways to deliver medical services (Glied & Smith, 2011). For this reason, health care systems are undergoing processes that reconfigure professional practice (Correia, 2017; Mechanic & McAlpine, 2010; Numerato, Salvatore, & Giovanni, 2012; Scott, Ruef, Mendel, & Caronna, 2000).

In Germany, recent health care reforms have led to major changes that affect hospitals' profits or losses because of the introduction of a remuneration system for medical procedures based on diagnosis-related groups (DRGs), irrespective of whether these are private, non-profit or public hospitals. The reorganization of organizational processes and structures (e.g. new incentive schemes, outsourcing activities) that accompanies these processes affects professional standards as well. These developments lead to changes in the hospital physicians' work context resulting in a deterioration of working conditions and a deprofessionalization regarding the strong focus on management issues (Dent, 2005; Hogwood, 2016; Mattei, Mitra, Vrangbaek, Neby, & Byrkjeflot, 2013; Rosta & Aasland, 2011). At the same time, we observe a shortage of doctors in German hospitals and an increasing acquisition

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of new forms of employment, the so-called self-employed doctors or independent contractors, i.e. self-employed doctors without employees (hereinafter referred to as locum physicians). In contrast to other countries (e.g., UK), these locum physicians are not simple medical replacements, but are highly sought-after professionals and have a high status since they are highly skilled and finished specialized training. The individual level and the employment status of physicians working in hospitals have been neglected in the discussion of (changing) professional behavior so far. However, the employment status, and in particular the attachment or detachment of physicians to a specific hospital may influence the extent to which they are affected by organizational restructuring, their scope for strategies to react to these changes, and the handling of complementary and competing logics of managerialism and professionalism. Using the example of German hospitals, we examine how reorganization in hospitals affects physicians' professional practice by considering the physician's employment status (dependent employee vs. self-employed) and analyze how locum physicians individually cope with conflicting and competing logics of managerialism and professionalism.

Drawing on a qualitative study of locum physicians, permanently employed physicians, and chief physicians in hospitals, we find that breaking free of organizational constraints and becoming self-employed as a locum physician can be an attempt at reprofessionalization. We contribute to the literature on professionals dealing with competing institutional logics in organizations by highlighting the individual behavior of physicians who become self-employed and are subsequently (re-)engaged as locum physicians in hospitals. As a result, the relationship between managerialism and professionalism has different dynamics at the organizational and individual level. In health care organizations, managerialism has so far led to a decline in professionalism. This is due to health care reforms which are perceived to strengthen managerial control and economic rationales—as opposed to professional autonomy—in decision making. At an individual level, managerialism leads to more professionalism since solo self-employed locum physicians concentrate on the basic values of their profession, their professional expertise, and client-centered autonomy to offer high-quality standards in order to remain in the market. In addition to studies with a focus on competing and changing institutional logics (Martin, Armstrong, Aveling, & Dixon-Woods, 2015; Thornton, Ocasio, & Lounsbury, 2012), our analysis provides insights into the role that the employment status in professional organizations plays in hampering or fostering the articulation of professional values in general.

In the next sections, we first briefly introduce hospitals as professional organizations and physicians as members of a profession. We rely on the theory of professions to describe the aligned changes of employment relationships in German hospitals. We then introduce our qualitative study and present the analysis of our data. In the discussion section, we develop conclusions and put forward implications for further research.

Conceptual framework

Analytical approaches towards professions, and related perspectives on changes in professional work, primarily concentrate at the organizational level or on groups of professionals. As the subsequent literature review will draw out, the analytical merit of these perspectives on changes in professional work needs to be complemented with an analysis of the integration of individual physicians into professional organizations, and, more specifically, with an analysis of the implications of the employment status on professional practice.

Hospitals as professional organizations

Conceptualizations of professional organizations point to the relevance of different organizational units and occupations within these organizations. Traditionally, the medical profession is the most powerful category of staff within the health care system (Seifert, 1992). This power mainly results from the key position of physicians in hospitals as professional bureaucracies (Mintzberg, 1979). Although professional organizations "vary in the robustness and the legitimacy of their claims to expertise and in their status" (Suddaby, Greenwood, & Wilderom, 2008, p. 990), the most important resource of these organizations is their knowledge expertise in relation to the strategic apex, the technostructure and the support staff. The strategic apex is the managing directors of hospitals. The technostructure comprises in particular analysts who standardize, control and optimize the processes in the organization (e.g. clerical support staff). In hospitals as a professional bureaucracy, the technostructure plays a subordinate role because the professionals organize their own treatment standards within the professional community. The so-called support staff—nurses and allied health staff in hospitals—are completely oriented towards the requirements of the operating core. In the operating core of professional bureaucracies, professionals like physicians must carry out the central work and are in a key position (see Figure 1). Professional organizations' configuration tends to encourage the relatively autonomous and independent action of their workforce and rejects formal management controls to protect the professional autonomy (Abernethy & Stoelwinder, 1990). Consequently, the logic of medical professionalism is promoted. In contrast to Mintzberg's (1979) other archetypes of organizations (e.g. simple structure, machine bureaucracy, adhocracy), the control mechanisms in professional organizations are based on the operating core, which in turn influences all other administrative components because of its professional autonomy and dominance.

Mintzberg's organizational configuration is historically situated in the power relations and organizational structures of the 1970s. Therefore, it is challenged significantly by health care reforms in Germany in the last two decades which have profoundly affected hospitals as professional organizations. Especially the implementation of case-based compensation systems has led to increasing cost transparency for medical treatment procedures in Germany. DRGs also promote competition in the hospital sector because internal processes become standardized and thus more manageable. In view of this development, strategic aspects become more important for hospitals—a change that is reflected by the prevalence of profound reorganization measures with respect to processes and structures. In this model, the logic of business-like health care (Reay & Hinings, 2009; Szymczak & Bosk, 2012), which aims at increasing efficiency, dominates. Moreover, cost pressure resulting from greater competition leads to restructuring processes in hospitals (Ernst & Szczesny, 2005; Tiemann & Schreyögg, 2012). In sum, these developments strengthen the technostructure of hospitals (Llewellyn, 2001; O'Reilly & Reed, 2011) because the members of the technostructure now "serve to effect standardization in the organization" as Mintzberg (1979, p. 30) points out. In this context, new functional areas like case management, medical controlling, and quality management become relevant. Consequently, in Germany the dominance of the operating core has been weakened, the support staff has been reduced, and the strategic apex and technostructure occupy a larger space (see Figure 1).

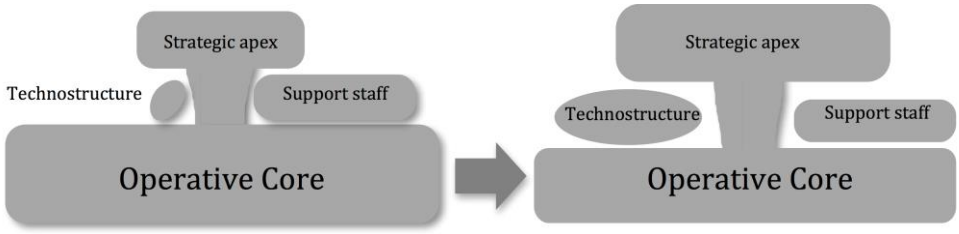

Figure 1. *Professional bureaucracy in transformation (Mintzberg 1979, p. 355, modified by the authors).*

The question that arises at this point is to what extent these changes in the organizational configuration affect the professional understanding of physicians.

Physicians as professionals

Physicians are the prototypical profession (Freidson, 1970). Professionalization, professionalism, and professions are considered in professional sociology from different theoretical perspectives. A prominent or even universally accepted theoretical position, which is able to illuminate the subject area occupation or profession in the modern society in all its facets, is not to be recognized at present, however. A general distinction can be made between the largely "theory-free" traits approach, the structure-functionalist, the symbolic-interactionist, the structure-theoretical, the power-theoretical, and the system-theoretical professional approach, which each emphasize different aspects of the development of professions and/or professional action. In our case, especially the traits approach of professions is helpful to understand the acting and status of physicians as well as shifts of professionalization and deprofessionalization (e.g., Brennan et al., 2002; Carr-Saunders, 1955; Cruess, Johnston, & Cruess, 2002; Goode, 1957; McClelland, 1985; Sox, 2007). According to this approach, professionals fulfill several characteristics among which professional autonomy, cooperative self-control and the commitment to a professional ethos play a decisive role. Professional autonomy results from the state conferring the right upon the medical profession to regulate those issues independently which form part of their professional expertise. Depending on the national context, professional legislation and self-control can extend to aspects such as the medical curriculum, the admission into the profession, the content and structure of specialist training and much more. The commitment to a professional ethos is documented from ancient times in Professional Codes of Ethics such as the Hippocratic Oath which exhibits the moral norms of professional communities.

Beyond the discussion of traits inherent to professions there have been influential attempts to capture the logic of professionalism in a theoretical model. Freidson (2001), for example, uses the notion of an ideal type to develop a comprehensive account to professionalism. Freidson distinguishes between three different forms of division of labor, which are conditioned by the logic of action to be found in each specific occupation. The three forms of division of labor are, on the one hand, the bureaucratic-managerial, the competition-based-consumerist, and the specialized-professional forms. This differentiation is based on different degrees and conditions of the control of the working conditions, the problem or task relation and the specific ways of working. According to the “third logic” of professionalism, the social sphere is ruled by highly qualified specialists who organize and control their business by themselves. Professionals are thought to act primarily to the benefit of others and, in this, provide the society with high-quality goods and services at reasonable prices.

Such supremacy of professionals is juxtaposed with the market logic in which consumers have the final power and the logic of rational-legal bureaucracy where production and distribution are controlled by the management of large organizations. According to Freidson (2001), monopoly, as well as the professional judgement and discretion, are intrinsic to professionalism. This stands in sharp contrast to managerialism with its emphasis on competition and efficiency through standardization. Freidson (2001) further argues that professions do not defend themselves well against managerialism implying and adjudging the power of management. However, Llewellyn (2001) analyzed how clinicians could acquire managerial expertise, or learn the discourse, and deploy it as a resource in a new medical management role (see also Thomas & Hewitt, 2011). Moreover, as depicted in Freidson's idea of a "third logic", the special kind of knowledge ascribed to professionals allows them to exercise discretionary judgment with respect to highly individual cases in clinical care. This, however, can collide with the requirement of cost-effectiveness and standardization which dominates the strategic apex respectively their managerial perspective on hospitals.

The major changes in hospitals outlined above can, therefore, be interpreted as a form of deprofessionalization within the medical profession, as doctors lose power due to the loss of autonomy through improved management control (Noordegraaf, 2006, 2016; Reed, 1996). In fact, hospital physicians are transformed into ordinary employees who have to commit themselves to organizational goals (Wilkesmann, 2016). In sum, physicians' professional behavior today is shaped by contradictory principles in professional organizations (Berki, 1985; Evetts, 2009). Thus, hybrid forms of professionalism risk to be blended with other logics to the extent that they lose their core elements (Martin et al., 2015, p. 394). Over 70 years ago, Parsons (1939) argued in a normative way that 'professional men' behave toward patients as altruistic servants, whereas "businessmen" mainly follow their self-interests. However, both behaviors are a result of institutional patterns and structures (Riska, 2010). Reay and Hinings (2009) discuss a rivalry of logics and a co-existence of governance structures that increase efficiency and medical professionalism, with a strong orientation to the physician–patient relationship guiding the services. In this context, the weakening of autonomous spaces appears to threaten professional work and harm professional values, especially if autonomous and committed professionals lose their ability to treat their patients as individual cases. More recent approaches, however, stress that the "rivalry picture" of professional and managerial logics should be abandoned for the benefit of an advanced model of professionalism which overcomes the idea of hybridity (Noordegraaf, 2015). Instead of being seen as a threat to professionalism, management and organization are then depicted as normal aspects of professional work. Exemplary empirical studies have also demonstrated how physicians mediate and co-create new organizational environments against the background of their traditional structured forms of power (Waring & Bishop, 2013). Other studies examined the identity work of medical professionals in managerial roles (McGivern, Currie, Ferlie, Fitzgerald, & Waring, 2015). The logics of professionalism and managerialism form, thus, the background for multifaceted social processes which culminate in hospitals as professional organizations. Recent studies point to the importance of the wider institutional context for the maintenance of professional values (Martin et al., 2015, p. 394). Consequently, hospitals as professional bureaucracies provide an appropriate example for a social sphere where the three logics of professionalism, market, and bureaucracy meet and often cannot be easily unified. However, it remains widely unclear how the situation affects hospital physicians' professional behavior at the individual level with respect to their daily clinical work.

Physicians' employment in German hospitals

Regarding the organizational integration of professionals, a change in the employment structure raises the question of contradictory logics not only at the organizational level but also at the individual level. Indeed, the attachment of physicians (as dependent employees), or their detachment (as independent contractors) from hospitals varies historically. In German hospitals, physicians usually work as employees and receive a fixed salary. However, before the introduction of the public health care system in Germany at the end of the nineteenth century, physicians predominantly worked as independent contractors and were not included in a hospital's organizational setting. Hospitals developed compensation structures to ensure the employed chief physicians an almost equal or higher income in comparison with their resident colleagues (Wilkesmann, 2016) because they were allowed to augment their relatively low income by treating and charging wealthy patients. However, the implementation of DRGs, along with new labor legislation adopted in 2004 owing to a decision by the European Court of Justice on new daily and weekly hour maximums, resulted in increased demands for medical personnel accompanied by the goal of decreasing fixed salary costs. As a result, physicians employed in German hospitals earn comparatively low wages in relation to their workload (Mitlacher & Welker, 2012). Furthermore, managerial steering instruments aim to involve chief physicians more closely in fulfilling organizational objectives, thus giving economic considerations increasing importance in daily medical practice. New contracts include budget targets as well as personal or departmental target agreements involving bonus–penalty schemes, and the pay-out of variable bonuses depends on the degree of goal achievement

In Germany, the increasing demand of medical personnel leads to (1) the recruitment of physicians from different countries all over the world, and (2) a growing number of locum physicians (Keller & Wilkesmann, 2014). The phenomenon of contingent and nonstandard employment in the hospital context is relatively new but can be observed in several countries, e.g. the US and the UK (Alonzo & Simon, 2008; De Ruyter, Kirkpatrick, Hoque, Lonsdale, & Malan, 2008; Hoque & Kirkpatrick, 2008; Hoque, Kirkpatrick, De Ruyter, & Lonsdale, 2008; Houseman, Kalleberg , & Erickcek, 2003; Kirkpatrick & Hoque, 2006; Simon & Alonzo, 2004). Houseman et al. (2003) analyzed agency work of nurses and showed that, in contrast to hospitals, agencies were able to recruit nurses and other hospital professionals by paying them more than hospitals did. Since 2007, German hospitals have been allowed to deduct costs for physicians who are not permanently employed and typically serve as temporary substitutes for permanently employed physicians. However, in contrast to other contingent workers, locum physicians are less affected by the disadvantages of atypical employment, since they are better compensated and not bound by directives as dependent employees are (Wilkesmann, 2016). Notably, the decision to become a locum physician is only an option if a physician has finished specialized training and obtains a Certificate of Completion in Specialist Training (Facharztanerkennung). There are about 4,000 to 5,000 locum physicians in Germany which is around 1% of all physicians in hospitals. Most of them are engaged in the field of anesthesiology because here is the highest need of hospitals since they keep the operating rooms running. Moreover, this unit has rather standardized processes promoting an easy engagement of temporary workers such as locum physicians. Self-employed physicians, who are (only) temporarily engaged in hospitals, are by law not bound to organizational constraints. Therefore, they can—in comparison to their permanently employed colleagues—in principle be considered as less dependent on organizational forms of control, and therefore may be better able to defend professional values in their everyday practice. The emergence and expansion of this new group of contingent workers in hospitals presents a challenge with regard to understanding and theorizing broader transformations in professional work and

the interplay of contradicting logics of professionalism and managerialism at the organizational and individual levels in light of changing employment structures.

Data and methods

We engaged in a qualitative study to assess the impact of contradictory logics in hospitals not only at the organizational but at the individual level with a special focus on the view of locum physicians. More specifically, we investigate how locum physicians cope with conflicting and competing logics in German hospitals. In 2014, we conducted 21 semi-structured interviews: 13 interviews with locum physicians, five with permanently employed physicians, and three with organizational representatives who assign locum physicians. We aimed at triangulating to enhance credibility of the findings presented by examining multiple perspectives of the people concerned and by the quality of data (Miles, Huberman, & Saldana, 2014). In our sample we achieved informational redundancy and theoretical saturation (Saunders, Sim, Kingstone et al., 2018). In this sense, further interviews did not reveal additional information relevant to the research questions so that we decided not to acquire more interviewees. Moreover, we were constantly engaged in critically reflecting our findings and research process-oriented to the principles of falsification. As Crouch and McKenzie (2006) claim in case of a small sample size, we can confirm that all authors were immersed in the research field due to prior research which helped to create a diversified sample which covers relevant aspects with regard to the research questions. We gained access to the interviewees by directly and simultaneously contacting personally known gatekeepers, through calls in relevant newsgroups, and by using the snowballing technique. Snowball sampling is an established method for identifying and contacting hard to reach populations such as physicians. By choosing different ways of recruiting interviewees, we avoid the downsides of snowball sampling such as bias and dependency on the subjective choices of the first respondents (Faugier & Sargeant, 1997). The respondents were predominantly male and between 31 and 70 years old, and represented the following fields (in order of frequency): anesthesia, emergency medicine, critical care, internal medicine, psychiatry and psychotherapy, gynecology, surgery, and radiology. The interviewees have a working experience of 18 years on average.

The locum physicians in our sample indicated they had worked in five to 40 different hospitals. Ten male and three female locum physicians were interviewed which roughly equals to the overall gender distribution of locum physicians in Germany.

The interviews were conducted face-to-face and on the telephone by a core group of four interviewers. The interview guideline contained open questions on the interviewees' professional biographies, on the locum physicians' professional behavior and cooperation with core staff and superiors in hospitals as well as the physician–patient relationship and critical incidents.

All interviews were audio–recorded, transcribed, and anonymized. The length of the interviews was on average 49 minutes. The data were analyzed with the method of qualitative content analysis (Mayring, 2000), including a deductive application and an inductive development of codes. We started with a theoretical formulation of definitions, e.g. consequences of engaging locum physicians, and applied these codes to the interview transcripts. Likewise, we formulated inductive categories out of the material, e.g. reasons to become self-employed, to be able to code relevant narratives. We, then, explicated coding rules for the categories and identified examples. The transcripts were primarily encoded individually and the codes were subsequently compared and discussed in several team sessions. Correspondingly, the coding system was constantly checked and modified, inductively expanded, and revised. After the revision of categories and coding agenda, we applied the final code scheme

to all transcripts and interpreted the results. Rater influence was controlled by having at least three researchers participate in the data interpretation process and by team discussions of the match of encoded codes to jointly develop the code system.

Table 1. *Participant characteristics*

Participant characteristics	
Age	29-73 y; median: 50 y
Gender	14 male; 7 female
Working experience	2-35 y; median: 18 y
Function	13 locum physicians; 5 permanently employed physicians; 3 organizational representatives
Clinical specialty (physicians only)	Anesthesiology / A&E (8); Surgery (3); Neurology / Psychiatry (3); Internal Medicine (2); Urology (2); Gynecology / Obstetrics (2); Radiology (1)

Results

Managerialism resulting in deprofessionalization on organizational level

The interviews revealed that health care reforms and the resulting changes in hospitals affect the medical decisions of employed physicians in the operating core of the professional organization in manifold ways. Most importantly, the managerial staff of the technostructure and non-professional aspects such as budget constraints or profit criteria gained in influence and restricted the professional behavior of physicians. Changes at the organizational level and the dominance of the managerialism in hospitals have led locum physicians to perceive a deprofessionalization of their daily work when being permanently employed, which especially affected their professional autonomy, the quality of patient care, and public welfare. A permanently employed physician expressed this widely shared observation as follows:

> In most German hospitals the administration is increasingly taking the reign. One has too little say, too little leeway. This is a form of disempowerment of physicians, which I cannot accept. (Permanently employed physician 20: 8).

The interviewees criticized the increasing market orientation in the hospital, noting the greater importance of decisions that rely on profit or commercial criteria. They emphasized that their medical autonomy had been eroded because economic incentives took precedence over medical requirements:

> If you go to a doctor there is a difference between the fact of what a patient really needs and the fact of what the hospital management wants. Even the chief physician then exerts pressure because he has agreed to several targets in his or her contract. And of course, you see frustrated physicians everywhere, apart from all the working pressure and the permanent shortage of staff which prevails everywhere. (Locum physician 03: 29)

This quote also shows how chief physicians adhere to the new commercialized requirements and how they pass pressure down to their subordinates. In this respect, physicians in hospitals perceive that the organization and organizational representatives constrain their professional work, leading to work situations in which following professional standards is made more difficult:

> We live today in a massive commercialized form of medicine.... What really frustrates is that really the only ones who have something to say in hospitals are the hospital managers. As a doctor, you should be allowed to act in line with professional values, but that's over.... In addition, an incredible time pressure is put on the physicians. (Locum physician 05: 27).

Against this background, physicians consider quitting their jobs as permanently employed physicians in hospitals and working as a locum physician as a way to break free from working conditions in hospitals that strengthen managerialism and restrict professional behavior in a way which challenges the physicians' professional autonomy, commitment to patients' well-being, and economic independence.

Locum physicians also choose this form of employment because, among other advantages, it offers better income opportunities. They invoice all hours worked, whereas physicians employed in a hospital often do unpaid overtime. In this sense, economic criteria do play a role in their decisions to become self-employed. Whereas the possible financial motivation of locum physicians resonated in the subtext matters of professional autonomy clearly dominated the interviews with both employed physicians and locum physicians. Consequently, working as a locum physician can be seen a means of medical reprofessionalization with regard to professional autonomy, status, and adherence to professional values.

Working with locum physicians, however, does also affect working conditions of permanently employed. One criticism referred to responsibilities for peripheral tasks, such as documentation, which may increase with the recruitment of locum physicians. Especially chief physicians also worried about the effort to teach locum physicians about standards and routines specific to a given hospital or department. On the other hand, as locum physicians are typically hired when permanent positions cannot be filled, they positively affect working conditions of permanent staff as they reduce overtime and work intensity in times of shortages of personnel. Apart from these questions of work intensity related to vacancies and their compensation with locum physicians, as we will discuss below, the deployment of external medical staff does also impact on the possibilities to defend professional standards.

Managerialism resulting in reprofessionalization on individual level

Shifting from being permanently employed in a hospital to being self-employed enabled locum physicians to uphold the main characteristics of professional work. Locum physician interviewees emphasized a higher degree of autonomy and better working conditions compared to employed physicians. They underlined that they can escape both exhausting working conditions as well as economic and hierarchical controls, as they are not formally integrated into hospital structures and chief physicians are not authorized to issue directives with regard to medical decisions.

> I am totally committed to the patients. One could also say: I can order what I want, because I am not subject to any economic constraints of the hospital or anything else, but I'm practicing medicine really well and I do it for the patients. (Locum physician 01: 159)

In addition, the short-term nature of working as a locum physician for a specific hospital and hospitals' fear of accusations that they are avoiding social insurance contributions through pseudo self-employment (as, for example, by integrating self-employed physicians into organizational hierarchies and processes) provide locum physicians with freedom from orders and the ability to change workplaces if their autonomy is undermined or they observe malpractice.

> [Being a locum physician] makes it easier to say 'I am not contributing to what is going on here, because I do not want to'. And then I go. This is why I am a locum physician. (Locum physician 01: 175)

Following their own self-perception, the employment status allows locum physicians maintaining their professional ethos by giving priority to professional criteria in carrying out their medical activities instead of capitulating to superiors' economically driven directives. This autonomy is particularly important for them regarding treatment decisions. Moreover, locum physicians have leeway to keep their knowledge up-to-date because they do not have to apply for an exemption in order to attend conferences or other forms of further training. In organizational settings, permanently employed physicians often depend on the goodwill of chief physicians when it comes to their professional development. The autonomy locum physicians enjoy in this respect means that they rather base their patient–oriented decisions on the latest scientific findings than on organizational routines or chief physicians' directives and, thus, strengthen the knowledge base of their professional work.

However, since locum physicians have to offer their manpower in the job market, they are exposed to market risks such as unpredictable demand and have to engage in marketing activities, including skill acquisition to keep their knowledge up-to-date:

> So, all physicians need to improve their knowledge, but I have had the experience that one doesn't keep up to date when you're in practice. And at the clinic, you have to do that because you're expected to, but as an independent contractor you do that voluntarily, because when you have to defend your treatment as an independent contractor and have to explain, you have to improve your knowledge. Then you absolutely always have to have the latest news in your head, because only then you get the respect of your colleagues. Yes, one can quickly be out of the picture if you don't look at the further developments ... and if you don't regularly keep up to date. So that's a very, very important thing, especially for us. (Locum physician 02: 71)

> This need to improve one's medical knowledge in order to compete in a market

of solo self-employed reflects the market situation of professionals who are evaluated by peers (in comparison to patients as layperson). Therefore, considering market logics, managerialism promotes medical professionalism since locum physicians have to provide up to date services to be in demand by the market. Thus, the locum physician's stronger focus on the latest scientific results about treatments, further training, and professional (not organizational) standards shows how market and professional logics dovetail at the individual level. In this respect, locum physicians perceive themselves as being able to combine the two logics as they act and decide autonomously. As a result, the tension between professionalism and managerialism which holds true at the organizational level is reconciled on the individual level by the locum physicians.

Reprofessionalization on organizational level through engaging locum physicians

Locum physicians not only show reprofessionalization at an individual level. Evidence also hints at instances of a reprofessionalization of medical behavior at an organizational level. As argued above, locum physicians claim to consolidate their medical decisions rather on the latest scientific findings and the basic principles of the profession instead of following organizational routines and directives of chief physicians. In this sense, they contribute their knowledge in cooperative work arrangements and thereby reorient reasoning and decision-making towards professional knowledge. In addition, permanently employed and locum physicians reported that locum physicians conduct informal training by sharing their manifold expertise with permanently employed physicians in hospitals. In this context, they distribute knowledge they have gained in numerous hospitals, where they learned about alternative medications or operation techniques, or point to malpractices that endanger patient care.

Sometimes, locum physicians even propose specific structural changes for the department they are working in. For example, engaging locum physicians in hospitals allows time and space for professional training of the permanently employed physicians to support the maintenance of their professional standards.

> I tell the chief doctors: When I'm here, you can allow your subordinates to go on vacation, to accomplish training leave, and so on. In this sense, I'm here to improve the working conditions. (Locum physician 10: 37)

> So, we had actually quite positive experiences because the benefit is that locum physicians are often specialists, and otherwise many colleagues are freshmen .... On one hand, locum physicians are of course novices in terms of organizational structures, but on the other hand you can learn a lot ... that's why I find it really positive. (Employed physician 01: 82)

> In the end, we are thankful because locum physicians take much of the load off. (Employed physician 03: 262)

In sum, as solo self-employed workers, locum physicians hold a new, more autonomous position within the organization, promoting a reprofessionalization in hospitals. This is due to their changed employment status resulting in the need to keep the locum physician's knowledge up to date and supporting autonomous decisions by being not bound by organizational directives.

Discussion and Conclusions

Summary of findings

Against the background of profound health care reforms, this paper uses the example of locum physicians in German hospitals to analyze how reorganization in hospitals affects physicians' professional practice by considering the physician's employment status (permanently employed vs. self-employed) and analyze how locum physicians cope with conflicting and competing logics of managerialism and professionalism. We start from the assumption that the major changes in the hospital sector promote the accountability and control of professionals, resulting in pressure to conduct and adopt more 'business-like' practices (Carvalho, 2014). More specifically, physicians in hospitals perceive this development as decreasing the quality of their working conditions, and in particular their ability to exercise professional autonomy. The resulting combination of professional and managerial logics of medical work at the organizational level leads to unintended effects. Some physicians changed their employment status, they quit their hospital jobs and become self-employed as locum physicians. In other words, they had become solo self-employed to evade the rivalry of competing logics (Reay & Hinings, 2009) in hospitals and reprofessionalize their medical care through focusing on medical professionalism. They are then (re-)engaged in hospitals and affect organizational practices since they are not subject to management or bound by organizational directives. This finding aligns with the result of Jones and Green (2006) found in their case study on general practitioners in the UK with regard to a higher job satisfaction of locum physicians because their occupational status allows them to do so-called nice work. Adding to the research on hybrid manager-professionals' identity work (McGivern et al., 2015), locum physicians rather support the view of representing and protecting professionalism in hospitals through simultaneously using and integrating professionalism and managerialism at an individual level.

With the help of our research, the phenomenon of locum physicians can be more generally interpreted as an attempt of individuals to reprofessionalize health care by reestablishing professional practice—including the terms of updating professionals' scientific knowledge, autonomy in medical decisions, and economic privileges. Through self-employment they practice a specific form of hybrid professionalism (Noordegraaf, 2015), combining the logics of (self-)managerialism and (medical) professionalism. Consequently, the focus on this form of employment raises the question of the interrelationship between professionalism and managerialism not only on an organizational level but also on an individual level. The employment status is, thus, a key factor which contributes to a deeper understanding of the professional behavior of physicians working in the organizational context of hospitals.

Moreover, when re-entering hospitals as self-employed individuals, locum physicians disturb organizational structures. Standing out of hospital hierarchies, they explicitly promote professional values, such as the scientific foundation and cooperative self-control, allow the organization to make more time for further training of the permanent staff, point to malpractices, and bring in new professional knowledge. In this sense, locum physicians reprofessionalize medical decisions in German hospitals on both the individual and the organizational level.

Conceptual contributions

Through these findings, we contribute to theory by showing how individuals find strategies to manage the rivalry between the competing logics of managerialism and professionalism through leaving the standard form of occupation. Hybrid professionalism (Noordegraaf, 2015) in the sense of an interrelationship between professionalism and managerialism not only exists on an organizational level but also on an individual level. The example of locum physicians reveals that they also have to combine different logics to remain in the market. Interestingly, the relationships between

managerialism and professionalism at the organizational and individual levels were profoundly different: While the introduction of managerialism into hospitals as professional organizations was more controversial, combining managerialism and professionalism at the individual level of solo self-employed was perceived as a way to uphold professional standards and to reprofessionalize. As permanently employed physicians in hospitals, they had to follow the directives of chief physicians and make decisions based on economic criteria. Thus, the engagement of locum physicians in hospitals was perceived as a reprofessionalization on the organizational level since these experts align their medical decisions to professional standards and are able to decide autonomously and without being compelled to follow directions of chief physicians and organizational routines.

Adding to Mintzberg's professional bureaucracy, we can say that the boundaries of these organizations became permeable. In this context, it is not only the organization framing (and redefining) professionalism (Muzio & Kirkpatrick, 2011) but also the physicians who mirror these processes and not only passively adopt but also actively change them. Thus, changes in professional organizations like hospitals not necessarily lead to deprofessionalization since there are obvious chances to reprofessionalize the operative core.

Limitations and future research

Our findings are based on a qualitative study of the effects of changing working conditions in hospitals on the professional behavior of physicians. While we gained valuable insights into a previously under-researched topic, these insights are limited to a highly specific sample. Additionally, we have to take into account the special situation of a labor shortage, which implies lower risk to becoming self-employed as it is unlikely that they get unemployed and focusing on professionalism while being engaged in hospitals. Changes in demand for locum physicians might also negatively affect their capabilities of negotiating favorable and autonomous positions which allow them to defend professional values. Another study limitation results from sampling effects: Due to self-selection effects our sample might have included particularly those locum physicians who uphold high professional standards and not those individuals who are mainly driven by financial incentives to quit regular employment in a hospital.

Future studies should attempt to integrate the perspectives of other professionals in health care, such as nurses, and the patient perspective to gather a comprehensive understanding of locum physicians' professional role in the hospital. In light of an increasing need for multi-professional teamwork (e.g. Gadolin & Wikström 2016) and interprofessional cooperation (Körner et al. 2015) and a trend towards joint education of the health care professions, future research should particularly address how locum physicians can be adequately integrated in interprofessional teams to ensure high-quality patient care. This also raises questions regarding further qualification of the non-physician health care within the German health care system which suffers from a shortage of physicians.

It would also be interesting to observe whether the job of locum physicians will develop as an alternative career path to the classic hospital physician or established physician. Furthermore, a quantitative validation of the results would be worthwhile. Further perspectives would emanate from a replication of our study in other countries to estimate the impact of employment status on hybrid professionalism.

Last but not least, it would be worth looking at a comparison between different countries that both work under DRG conditions and engage Locum physicians.

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