Chapter 5
How Institutional Contexts Shape Professional Responsibility

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In this book, scholars explore various approaches to understanding and implementing professional responsibility. In particular, several chapters explore the impact on professional responsibility of various professional development activities such as recruiting, training, inducting, and incentivizing professionals. My goal in this chapter is to delve more deeply into conceptualizations of professional responsibility from an institutional perspective that takes into account the relationships of professionals to salient stakeholders in their environment. This perspective also helps to clarify the types of pressures that stakeholders place on professionals, with a particular focus on those in the medical and educational fields.

Definitions of Professional Responsibility

To begin, it is important to recognize differences in how 'professional responsibility' is defined and interpreted. Multiple definitions have been proposed, including in this volume, demonstrating the complexity of the concept. For the purposes of this chapter, I offer two generic definitions, to illustrate the nature of institutional pressures confronting professionals. Using institutional theory terms, we can think of these as *normative* and *coercive*.

The normative approach: Professional responsibility is a moral obligation to behave correctly in accordance with normative expectations.

The coercive approach: Professional responsibility is a duty or obligation that is legally required as part of a role.

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Both types of responsibility carry negative sanctions for noncompliance. The normative approach draws from the normative expectations of a relevant community (which could range from a local community or broader society, as well as a professional community of peers). Violations of behavioral expectations can take the form of loss of face, respect, and esteem; loss of relationships; and loss of the ability to be part of the social life of the relevant community. Noncompliance with legal requirements as part of a role carries the force of law and has a coercive element, up to and including loss of licensure and the legal ability to practice the profession.

Avoiding negative sanctions for noncompliance with normative or coercive expectations may be a motivator for professionals to behave responsibly. However, an institutional theory perspective demonstrates that the benefits of conformity with expectations can be more far reaching than merely avoiding punitive sanctions. Yet, institutional theory also highlights the challenges in complying with expectations when they arise from multiple sources who may hold incompatible ideas about how professionals should behave. In what follows, I explore these complicated challenges in more depth.

Institutional Theory Principles

Over the past 30 years, scholars have increasingly drawn on institutional theory as a revealing lens for the study of social behavior, because of its potential to explain why individuals, organizations, and professions act as they do, even when the behavior may not appear to be the most technically rational or efficient course of action (Scott 2008; Tolbert and Zucker 1996).

A central premise in institutional theory is that the norms, beliefs, and rules in the relevant environment play a key role in shaping behaviors. The relevant environment, also referred to as the terrain or *field*, has been conceptualized as the community of actors (e.g., individuals, groups, and organizations) that partake of a *common meaning system* and whose participants interact more frequently and fatefully with one another than with actors outside the field (Scott et al. 2000, 13). A field's common meaning system is also referred to as its *institutional logic*, which provides the organizing principles and practice guidelines for field participants (Friedland and Alford 1991). This observation might suggest that uniformity exists within each field with respect to a field's common meaning system (Scott 2008). However, the institutional logic is both created [produced] and enacted [reproduced] by the actors themselves, who may bring different interests to a field and who thus may not agree on which norms and principles deserve priority.

To deal with the potential for competing interests within a field, actors in the environment draw on resources—typically resources reflecting their legitimacy and power—in order to navigate across the field and to engage effectively in their preferred behaviors. In particular, the concept of *legitimacy* underpins much of the dynamic of institutional theory. Definitions of legitimacy abound in the literature. Suchman's (1995, 574) definition is well suited to our purposes: legitimacy is a generalized perception or assumption that the actions of an entity [in this case, a

Fig. 5.1 The process and outcomes of legitimacy

profession and its members] are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and rules—that is, a field's institutional logic. As noted, the meaning system is socially constructed, rather than existing as objective truths or beliefs that are the same always and everywhere. Thus, the logic is developed and enforced by the community of actors in the field, with some actors having greater normative or coercive enforcement power than others.

As depicted in Fig. 5.1, the process of professional legitimacy begins when professional activities *conform* to expectations for, and requirements of, appropriate behavior (i.e., the norms and rules) that are held and enforced by important stakeholders in the relevant environment, including professional bodies and educational institutions. Such conformity generates perceptions of *legitimacy* in the eyes of key stakeholders, which in turn leads to tangible and intangible forms of *social support* for the profession, including access to resources, enhanced prestige, and invulnerability to questioning. Ultimately, these forms of social support serve as the basis for the profession's ability to perform, succeed, and survive.

For example, school superintendents and principals expect teachers to follow curricular guidelines and assure that students excel on standardized tests; when teachers conform to these expectations, they may be rewarded with teaching bonuses and opportunities for additional training; when teachers don't conform to these expectations, they may be subject to closer monitoring and denied requests for more favorable teaching assignments. In the medical field, hospital and physician leaders expect doctors to maintain low levels of readmission for complications following surgery; when surgeons conform to these expectations, they may be rewarded by referrals from colleagues for complicated cases and nominations for professional recognition; when surgeons don't conform to these expectations, they may lose hospital admitting privileges and be at risk of malpractice charges from dissatisfied patients.

Analyzing Stakeholders and Their Relationship to Professionals

Stakeholders constitute the essential actors in the profession's environment, whose perceptions of legitimacy are important because they have a *stake*—a potential or actual moral or legal interest—in how the profession operates. A stakeholder is

defined as any entity that *can affect* or *is affected by* achievement of the profession's objectives and/or who *may attempt to influence* the direction of the profession's activities so that they are consistent with the stakeholder's interests (Freeman 1984, 46).

The nature of a profession's relationship with its many stakeholders can vary substantially, which in turn affects the ability of a stakeholder to influence activities of others in the environment and the ability of the professional to behave responsibly. Several relational dimensions are noteworthy: the *closeness of the relationship* between the profession and the stakeholder, the *stability of that relationship* over time, and the r*elative power* between the stakeholders and the profession. Other dimensions characterizing stakeholders are the *legitimacy* and *urgency* of their demands on the professional.

In this section, I discuss two approaches to analyzing stakeholder relationships that have been employed in the literature. The first approach uses the lens of a stakeholder map (following Leahey and Montgomery 2011), which begins by focusing on the core work of the professional in order to identify key stakeholders, and assesses the closeness of the relationship (from a micro-level one-to-one relationship to a macro-level group-to-group relationship) between the professional and stakeholders in the relevant environment.

The second approach (introduced by Mitchell et al. 1997) builds on the first, but rather than examining the closeness of relationship, shifts the perspective to stakeholder saliency, by assessing the dimensions of a stakeholder's power, legitimacy, and urgency. Together, these two approaches can equip professionals with a deeper understanding of their organizational field and the sources of expectations, influences, and pressures they are likely to confront.

Mapping the Closeness of Stakeholder–Professional Relationships

Stakeholder maps can be developed based on different sets of variables, although a common method, and that used here, is to map the stakeholders according to the closeness of their relationship to a central entity—in this case, the education and medical professional. These relationships are shown in Fig. 5.2 and discussed next.

(a) *Personal Relationships.* The innermost circle represents the most central, micro-level relationship of a professional with an individual stakeholder: the teacher–student relationship and the physician–patient relationship. It is noteworthy that, while these micro-level relationships routinely take place within an organizational setting—the school and the hospital or medical clinic—they nevertheless occur in a way that transcends the organization by virtue of the personal interactions that typically are not observable to other organizational members.

This relationship is at the heart of what a medical or teaching professional does: "I provide medical care to you" or "I teach you." This relationship is

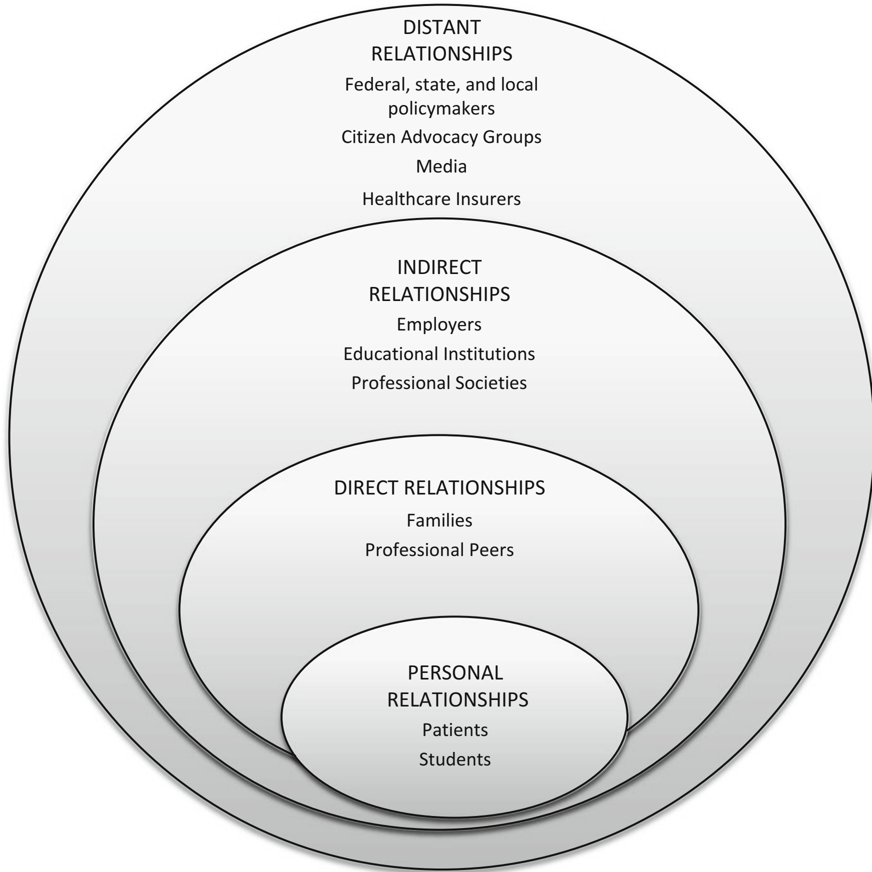

Fig. 5.2 System of stakeholder relationships in a professional environment

characterized by one-on-one, face-to-face interactions and is one where the greatest professional autonomy is exercised and where the greatest expectation for professional responsibility rests. This is because these relationships typically reflect substantially unequal power dynamics between the professional and the individual stakeholder who is dependent on the professional for services. At the same time, these interactions are commonly not observed by other stakeholders and thus demand the highest level of moral professional responsibility and trustworthiness[1] from the professional toward the individual student or patient.

[1] As elaborated by Hardin (1996), one's *trustworthiness* is demonstrated by engaging in behavior that reflects competence, benevolence, and integrity (i.e., honesty, fairness, and follow-through). The result is *trust*, defined as the willingness of an individual to be vulnerable to the actions of another, on a matter of importance to the individual, based on expectations that the other will not take advantage of the individual, even when the behavior cannot be monitored or controlled.

When professionals comply with expected norms of responsibility, perceptions of professional legitimacy will be strong, and the predicted outcome will be a higher degree of cooperation from stakeholders at this level (e.g., greater student effort in the classroom and greater patient adherence to recommended treatment regimes).

This personal relationship can be highly intense, although its duration can be variable. Some teacher–student relationships end when the school term ends; others may develop into a mentor–mentee relationship of long standing. Similarly, a physician–patient relationship may be intense during a period of treatment for acute illness, then diminish or end when the patient recovers. For others, particularly for patients with chronic conditions, the relationship may continue for the rest of the patient's life. When such relationships extend beyond the immediate period of interaction, the power dynamics may also adjust, with the student/patient moving from a vulnerable, dependent position to one of interdependency with the professional. In such circumstances, the stakeholder's expectations of professional behavior and responsibility may also adjust accordingly.

(b) *Direct Relationships.* The second ring contains stakeholders who may have a direct relationship with the medical or educational professional—e.g., families and professional peers—but who are not the actual recipients of the professional services. This remains a micro-level individual-to-individual relationship, and its duration typically parallels that between the individual service recipient and the professional. Stakeholders in this ring may act as surrogates for those in the center, interacting directly with the professional on behalf of the student or patient, in circumstances when a student or patient may not be able to articulate their expectations of professional responsibility, from either a moral or legal perspective. That is, students and patients may not always know what behavioral norms they should expect from the professional and may not know what is legally required. Family members of young students or disabled persons commonly play a large role as direct/surrogate stakeholders on behalf of a profession's especially vulnerable personal stakeholders.

Among the benefits to professionals for compliance with expectations from these stakeholders can be invulnerability to questioning; for example, a parent may be less likely to challenge the professional's behavior if it conforms with the parent's expectations about appropriate student-teaching or patient–doctor relationships. Professional peers also are less likely to question a colleague if the colleague's behavior appears consistent with expected norms of responsibility. At the same time, these direct stakeholders may provide some oversight of professional behavior, but may not always be able to enforce their expectations because they are not privy to all the interactions between the student/patient and the professional. Again, a profession's obligation to exhibit utmost adherence to professional responsibility when engaging with their most vulnerable stakeholders cannot be overstated.

(c) *Indirect Relationships.* This ring incorporates a broader set of stakeholders, most of which are groups and organizations, rather than individuals. It is at this

location that rules and guidelines become important, alongside moral norms that characterize the expectations in the first two positions. For example, this ring includes professional societies, whose members formulate guidelines for their professional peers, which typically are voluntarily imposed on members, with the (rarely imposed) sanction for noncompliance of expulsion from the society. Employers constitute another key stakeholder group, which can establish and enforce their own policies regarding responsible behavior for their professional employees. Similarly, educational institutions and universities can establish guidelines and rules of behavior for those studying to be professionals.

In each of these settings, sanctions for noncompliance can take the form of escalating disciplinary actions, with the ultimate sanction of dismissal from the organization or institution. The benefits for conformity are those associated with perceptions of legitimacy. That is, conformity with expectations of professional responsibility can yield access to additional resources and opportunities (such as promotions, bonuses, and raises), enhanced esteem (such as praise, awards, and recognition), and invulnerability to questioning (such as absence of monitoring).

The duration of indirect relationships typically lasts for the length of time that the professional is associated with the organization or institution. In the case of professional societies, the relationship may extend throughout the professional member's career; while for employing organizations, the relationship will no longer be relevant when the professional is no longer employed by the organization; and for universities, the relationship may end following completion of the degree. Alumni associations may continue the relationship, albeit with little ability to influence the behavior of the professional in a meaningful way.

(d) *Distant Relationships.* Stakeholders in this outer ring, farthest from the center of micro-level relationships, are agencies and other bodies that exert influence through macro-level connections to the collective profession. Most importantly, it is at this level that local, state, and federal policymakers affect professional behavior by means of laws and regulations with respect to licensing and rules of practice. Sanctions for noncompliance can be strict and include loss of licensure and the legal authority to practice one's profession. Because of the potential for coercive sanctions throughout one's career, the relationship of the professional to the licensing bodies is career-long.

Also at this level are actors reflecting market forces, especially in the healthcare field in the United States, such as health insurance companies, firms involved in pharmaceutical and medical technology development and sales, and competitors. In the education field, textbook publishers would represent this type of stakeholder. Often the interests of these actors are not well aligned with those of professions and the people they care for, yet their ability to influence professional behavior can be strong. For example, while health insurance firms legally cannot dictate how a physician treats a patient, the companies may exert indirect influence by placing reimbursement limits on the use of certain therapies and medications, perversely affecting professional decisions for reasons unrelated to a patient's health needs.

> The complexity of a stakeholder map becomes especially apparent at this level when we acknowledge that stakeholders have relationships with one another, as well as with the professional entity itself. For example, the biomedical research community indirectly influences how healthcare professionals behave when research results are incorporated into clinical practice guidelines and protocols adopted by employing organizations, with which practicing professionals are expected to conform. Education policymakers may interact with textbook publishers to assure that preferred theories are given priority in textbooks, which are then required for adoption, thereby affecting professional behavior in the classroom.

Another example of distant stakeholder interaction that ultimately exerts influence on professional behavior at the individual level is the relationship between citizen advocacy groups, the media, and policymakers. Citizen groups, often via the media, may place pressure on policymakers, who in turn may respond with new regulations, laws, and guidelines about professional behavior. One example would be changing guidelines about how teachers present sex education in schools, as a result of local community pressure on politicians. Another example would be requirements for second opinions prior to surgery, imposed by health insurance companies. In both these cases, professional responsibility is redefined by distant stakeholders who are neither members of the profession itself nor direct recipients of professional services, but who nonetheless can have a profound influence on expectations of professional responsibility, both morally and legally.

The duration of distant relationships with the professional entity is less time based than issue based. When a particular issue ceases to be salient to advocacy groups, the media, and policymakers, the influence of these stakeholders on professional behavior recedes, until a new issue appears to capture the attention of such stakeholders.

A paradoxical consequence of the ability of distant stakeholders to influence professional responsibility and behavior is that, the farther away from the center of the stakeholder map and the one-on-one relationship that professionals have with the people they teach and care for, the less knowledge of individual relationships the distant stakeholders have. That is, a teacher can work with an individual student to help the student learn in a way that will be most effective. Ideally, a teacher can tailor the lessons to the student's individual learning style. All too often, however, standardized curricula and teaching guidelines generated by distant stakeholder groups (i.e., policymakers) restrict the discretion needed for individual learning.

A similar issue arises for the medical profession, should physicians' decision-making on behalf of an individual patient be constrained by clinical protocols, health insurance requirements, and drug formularies. Standardized curricula and teaching methods assume homogeneity in a student population, and standardized treatment protocols and formularies share this limitation. In both situations, professional discretion and autonomy—the hallmark of professional responsibility—is undermined.

Dimensions of Stakeholder Salience

The stakeholder map helps to identify important stakeholders in a profession's environment, based on the closeness of relationships—from micro- to macro-level relationships—that a profession has with various stakeholders. The stakeholder map also helps to specify the nature of the relationship in terms of its duration. Also noted is that stakeholders hold different degrees of power *vis-à-vis* the professional, and that the closeness of the relationship may be inverse to the amount of power the stakeholder has to influence professional behavior.

To enrich the analysis of stakeholders' ability to influence professional behavior, we can add a second perspective that highlights a different set of dimensions. Mitchell et al. (1997) have proposed a useful typology that enables an assessment of the nature of stakeholder *salience*, which rests in part on the elements of power, legitimacy, and urgency held by the stakeholder.

According to Mitchell et al. (1997:865–867), *power* is the extent to which a party to a relationship can impose its will in that relationship through coercive or normative means. *Legitimacy* is defined similarly to the definition used above; namely, the generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and rules. *Urgency* exists when a relationship with the professional is important or critical to the stakeholder and is of a time-sensitive nature.

For our purposes, four types of stakeholders described by Mitchell et al. can illustrate these features. The first two types possess only one of the three attributes:

(a) *Discretionary stakeholders* are actors whose *legitimacy* renders them important to the profession, but whose demands on the professional are less urgent and who have little coercive power over the professional. Their ability to influence professional behavior rests in fostering normative conformity with behavioral expectations. Included in this group would be educational institutions and professional societies.

(b) *Demanding stakeholders* are actors with a perception of issue-based *urgency*, such as advocacy groups and the media, who often use voice to urge conformity and reveal noncompliance with their expectations about professional behavior on a pressing issue of importance to them. Although they have no direct ability or power to enforce professional responsibility, their voice can be strong and can indirectly affect professional behavior by placing pressure on other powerful stakeholders, as below.

The next two types of stakeholders possess two of the three attributes, and hence are of greater salience to the professional (regardless of where they may be placed on a stakeholder map):

(c) *Dominant stakeholders* are actors with *power* and *legitimacy,* as these two features combine to give the stakeholder recognized and accepted authority to impose expectations about professional responsibility. Included in this category would be government bodies and employing organizations, which are in a

position to coerce compliance with their interests (e.g., through threat of licensure removal or loss of employment), despite being somewhat removed from the professional's central relationships. It is through these stakeholders that discretionary stakeholders (e.g., consumer advocacy groups) may attempt to influence professional behavior.

(d) *Dependent stakeholders* are actors with *legitimacy* and *urgency*, but who generally must depend on others with power in order to coerce compliance with behavioral expectations, as they do not hold legal authority. Students and patients constitute the main stakeholders in this group. As noted, the imbalance of power between the professional and these stakeholders, who are located in the inner ring of the stakeholder map, places a higher moral expectation on professionals to honor their responsibility, both morally and legally, to these more vulnerable stakeholders.

Unlike the concentric rings depicted as a stakeholder map in Fig. 5.2, Mitchell et al. (1997) depict stakeholder salience using three intersecting circles, as on a Venn diagram, each representing one of the dimensions of salience (legitimacy, power, and urgency). The overlapping segments would reflect the areas where stakeholders may hold two dimensions (e.g., dominant stakeholders with legitimacy and power, and dependent stakeholders with legitimacy and urgency); and the center segment would reflect the intersection of all three dimensions (characterized as definitive stakeholders). It is interesting to note here that none of the stakeholders identified in the stakeholder map could be characterized as a definitive stakeholder, possessing all three dimensions of stakeholder salience.[2]

While the positions on the stakeholder map shown in Fig. 5.2 are relatively stable in terms of the closeness of the relationship between the professional and the stakeholders, the nature of stakeholder salience is more dynamic. In particular, the dimension of urgency is likely to fluctuate as the needs and demands of patients and students, parents and reformers may shift over time. Nevertheless, an appreciation of the dimensions of stakeholder salience is a valuable addition to understanding the system of stakeholders within a profession's relevant environment.

Challenges and Practical Implications for the Professions

The foregoing analysis of stakeholder–professional relationships and stakeholder salience helps to reveal several thorny challenges for professionals. Many of these challenges stem from the reality that different stakeholders in a professional's

[2] A rare exception might be if a physician were treating the leader of government that has a national health service, who thus technically holds coercive power over the physician, as well as having legitimacy and urgency because of a need for health care.

environment hold potentially conflicting interests and expectations, as well as differing degrees of power to enforce behavior consistent with their interests. Scholars have referred to this reality as an example of *multiple institutional logics*, and a growing number of studies demonstrate various approaches that actors may engage in when confronted with conflicting pressures within their environment (e.g., Dunn and Jones 2010; Greenwood et al. 2010; Montgomery and Oliver 1996, 2009; Reay and Hinings 2005, 2009; Shipilov et al. 2010; Suddaby and Greenwood 2005). Many of these studies grew from ideas first introduced by Oliver (1991), who proposed that strategic responses to institutional pressures and expectations would vary along a continuum—from acquiescence and compromise, to avoidance and defiance, to manipulation. Each strategic response carries its own risks and benefits, depending on the nature of the pressure, as well as the stakeholders' salience and closeness to the professional. Because of the many contingencies that can affect a professional's strategic response to a particular pressure or expectation, an extended discussion of this literature is beyond the scope of this chapter. But suffice to say, professionals are not without their own resources and strategies to affect the behavior of other stakeholders, as well as to resist their attempts to influence the professionals' behavior.

Below are examples of some stakeholder-related issues that professionals in education and medicine are advised to pay particular attention to.

Responsibility for Vulnerable Stakeholders

First, the stakeholders with whom medical and teaching professionals most closely interact (patients and students) are generally also those who have the least power and hence are the most vulnerable to the actions of other stakeholders in the relevant environment. Thus, an important, but potentially overlooked, element of professional responsibility is how to protect the interests of these stakeholders from being trampled by more powerful actors in the environment, who may have different interests and priorities. For example, healthcare organizations and health insurance companies may impose restrictions on a physician's treatment decisions (e.g., by levying financial penalties for prescribing off-formulary drugs). Such constraints may pressure physicians into choosing a treatment option that is not in the best interest, medically, for the patient, while it may make sense financially. Teachers may face a similar dilemma, when curricular guidelines and textbook choices are imposed by policymakers, which, to many teachers, may not be the most effective way to encourage learning.

Thus, professionals routinely face the frustration and challenge of dealing with potentially competing interests of various stakeholders in their environment, who wield different degrees of influence. In these circumstances, deciding what is the most professionally responsible behavior is not always clear-cut.

Pressures for Confidentiality Versus Transparency

As noted in the above discussion about distant stakeholders, these are often powerful actors in the relevant environment who are in a position to impose guidelines and regulations about professional practice and responsibility. Yet, they are removed from the day-to-day activities in delivering professional services to individuals. As a result, policies may be developed based on assumptions of homogeneity in student and patient populations, rather than taking into account the need for professional discretion and autonomy at the personal level in deciding about what is best for an individual student or patient.

Exacerbating this problem is the potential for misperceptions about professional behavior. As seen in Fig. 5.1, perceptions that professional behavior conforms to normative and legal expectations lead to assessments of professional legitimacy, which in turn lead to access to tangible and intangible resources necessary to perform one's role. Therefore, it is essential that powerful stakeholders who control resources accurately perceive what professionals do. Yet, the work of professionals in education and medicine takes place in a micro-level environment (the classroom, the doctor's office) where actual behavior is not easily observed by macro-level decision-makers. Indeed, strong normative and legal expectations exist regarding confidentiality in the doctor–patient relationship, as well as confidentiality restrictions about student performance. Professionals thus face a quandary about responsibly adhering to confidentiality norms for their students and patients, while needing to assure that their (unobserved) behavior is accurately perceived as legitimate.

The Role of Professional Schools

An important element in the preparation of future teachers and doctors is educating trainees about the realities of the environment in which they will practice. This includes assuring that new doctors and teachers recognize the set of stakeholders whose expectations will affect the practice of medicine and teaching. A stakeholder map is a useful tool for this purpose, followed by an analysis of each stakeholder's relative power to influence professional behavior, highlighting areas where stakeholder interests may generate conflicting pressures on the professional.

Often such conflicting pressures create ethical dilemmas for professionals. Although medical ethics and teaching ethics are customary components of professional education, the typical issues covered in ethics training programs may not extend to the dilemmas of dealing with various stakeholder demands. Expanding curricular design to incorporate stakeholder-related issues would be a valuable addition to education about professional responsibility.

Bringing the community of stakeholders into the process of professional education is another avenue for enriching stakeholder appreciation for how professionals do their jobs and the challenges they face. All too often, stakeholders are so focused

on their own interests that they may fail to recognize when they are placing unrealistic demands on teaching and medical professionals. Professional education programs, especially those geared toward community outreach, are in a position to facilitate dialogue among the stakeholders in a nonadversarial way.

Summary

Every medical and teaching professional knows that he or she does not perform in a vacuum in the classroom or examining room. Rather, there are multiple voices in the environment expressing expectations about professional responsibility and how it should be enacted. As presented here, an institutional perspective can reveal characteristics of these voices—stakeholders—that should enrich professionals' understanding of their environment, toward the goal of better serving their primary stakeholders, their students and patients.

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