Identity and Relationship Frames in Medical Leadership Communication

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ABSTRACT

Purpose: A frame is an interpretive scheme of meanings that guide participants' interpretations in social interaction and their actions in social situations (Goffman, 1974). By identifying early-career physicians' identity and relationship frames, this study seeks to produce information about socially constructed ways to interpret leadership communication in a medical context. *Methods:* The data consist of essays written by young physicians (n = 225) during their specialization training and workplace learning period. The analysis was conducted applying constructive grounded theory. *Findings:* Three identity and relationship frames were identified: (a) the expertise frame, (b) the collegial frame and (c) the system frame. These frames arranged the meanings of being a physician in a leader-follower relationship differently. *Originality:* The findings suggest that identity questions discussed recently in medical leadership studies can be partly answered with being aware of and understanding socially constructed and somewhat contradictory frames.

Keywords: frame, identity, leader-follower interaction, leader-follower relationship, leadership communication, medical leadership

Identity and Relationship Frames in Medical Leadership Communication

The questions of who should lead highly qualified white-collar professionals and how to do so have led to intense discussions in institutionalized organizations. Problem solving requires collaboration but may also engender confrontations between professionals and the administration: if earlier decision making enjoyed a solid foundation in professional autonomy, today's problems are far too complex to be solved within narrow silos of action (Ruben *et al.*, 2018). Even though medical leadership evidently has benefits in the decision-making process, enhances the effectiveness of resource management and promotes social performance and quality of care in hospitals (Sarto and Veronesi, 2016), the division between "management" and "medicine" has provoked serious discussion (Kuhlmann and Van Knorring, 2014).

The division between leader and physician roles has largely been viewed as an identity question. When an individual identifies with a certain role, that role becomes an essential part of that individual's self-definition (Ashforth *et al.*, 2008). When the physician identity differs greatly from typical leadership identity (Andersson, 2015), a challenge emerges. Physicians obtain great satisfaction from their clinical work (Spehar *et al.*, 2014), and most medical leaders hold on to their primary physician identity (Montgomery, 2001) because they are socialized into the medical profession before their leadership identity begins to develop (Hall, 2005). Additionally, medical leaders may be confused about their identity, believing that they lack either managerial or clinical credibility, at least to some extent (Loh *et al.*, 2016). On the other hand, it is possible to create new leadership identities that deconstruct the contradiction between physician and leader identities (Berghout *et al.*, 2020).

In this study, identity is examined from the leadership communication viewpoint. It is defined as the meanings people reflexively attach to themselves (Brown, 2020). Those meanings

may be arranged in many ways and are also negotiated within a context: the question "Who am I?" may thus lead to different answers between and within situations. The core of physician identity has been located in the patient-physician relationship, which can be threatened by organizational and societal challenges (e.g. Berghout *et al.*, 2020; Real *et al.*, 2009; Schwenk, 2020). However, physician identity and leadership identity are also constructed in collegial and leader-follower relationships. The present study focuses on the latter, defined as a hierarchical workplace relationship exhibiting formal power imbalance and grounded on socially constructed expectations (Authors, 2020). Depending on expectations, the question "Who am I in relation to you?" may elicit different answers between and within situations. Since relationships are constituted in social interaction (Manning, 2014), it is reasonable to examine leader-follower relationships as communication processes.

Studies on the leader-follower relationship have thus far focused either on medical leaders' communication competencies or on relationship outcomes. In competence studies driven by the objective of to find the key attributes of a good medical leader, a tendency to expend effort on two-way communication and emphasize reciprocity (van der Wal *et al.*, 2015), conversational skills, sharing, approachability, availability and supportiveness (Pell *et al.*, 2015; Authors, 2015) have been identified as important medical leadership abilities. An awareness of both one's own communication behavior and that of others has been cited as a key aspect of leadership communication (Henninger and Barth, 2009). Although limited to describing quite general behavioral categories, the findings emphasize the importance of relational aspects in medical leadership.

Outcome-focused studies have mainly examined the perceived quality of the leader-follower relationship, based on leader-member exchange (LMX) theory, which is grounded in

the idea of mutual activity in a relationship that leads to either high- or low-quality social exchange in the relationship (Graen and Uhl-Bien, 1995). The quality of the exchange also has important outcomes in health care. Chullen *et al.* (2010) found that LMX quality moderated the relation between followers' perceptions of fairness and organization-focused citizen behavior and task performance, with lower LMX associated with deviant behavior directed at the individual. A positive correlation has been found between reporting-specific trust and organizational identification (Jungbauer *et al.*, 2018) and between servant leadership dimensions and LMX (Hanse *et al.*, 2016). High-quality LMX has also been associated with role clarity, meaningfulness and predictability, which are linked with lower levels of emotional exhaustion (Gregersen *et al.*, 2016).

Earlier studies emphasize the importance of a good-quality leader-follower relationship, but they only explain the perceived quality of communication and provide a limited understanding of interpretations within that communication. When "beauty is always in the eye of the beholder," we hold that there are certain social constructions explaining the perceptions of leaders' communication competence and the leader-follower relationship. Thus, we concentrate on examining interpretative frames that guides interpretations and actions in leader-follower interaction.

The Focus of the Study

This study examines medical leadership communication involving leader-follower interaction and focusing on interpretations. The study is aligned with the communication approach of leadership studies (Ruben and Gigliotti, 2016) and the social constructionist branch of leadership communication studies (Fairhurst and Connaughton, 2014). Our focus is on leadership rather than on management, although both management and leadership functions (e.g.

Algahtani, 2014) were on display in the data (perhaps partly because the Finnish the word *johtaja* means both "manager" and "leader.")

A tension between physician and leadership identities has often been presumed. We regard the question of different meanings attached to oneself as a physician as also reflecting a mutual leader-follower relationship. Accordingly, we approach leader-follower interaction through identity and relationship frames (Dewulf *et al.*, 2009). A frame guides the participants' interpretations in social interaction and ways of acting in social situations, and different frames may occur simultaneously (Goffman, 1974). When different frames exist—that is, meanings are arranged differently—different interpretations of leader-follower interaction, participants and participants' actions arise. By identifying the frames, we seek insights into the socially constructed ways of interpreting leadership communication from the perspective of one's own identity and the mutual relationship.

It has been predicted that leadership competence will be a high priority for physicians in medical education and in future health care settings (Lindgren and Gordon, 2016). Barrow *et al.* (2011) have shown that early-career physicians view leadership differently than senior physicians, but only a couple of studies regarding medical leadership have focused on those "who could be seen to be 'developing' as leaders" (Gordon *et al.*, 2015, p. 1250). The present study focuses on the kind of constructions that early-career professionals have regarding medical leader-followership and on how these constructions guide their interpretations in communicating in the leader-follower interaction relationship. We strive to understand how young physicians in specialization training make sense of medical leadership communication through identity and relationship frames.

Theoretical Approach

Leadership as Meaning Management

The present study involves certain key assumptions. First, we see all knowledge as historically and culturally bound (Burr, 2003). For instance, a spirited discussion of medical leadership has emerged in the context of recent health care reforms and societal changes that have made clear the need for changes in health care management and the importance of medical leadership (Authors, 2018; Kirkpatrick *et al.*, 2016). Second, language is central to creating identities, relationships, organizations and cultures; this underpins the notion that social phenomena are explained by interactions and social practices (Burr, 2003). For example, the idea of contradictory physician and leadership identities is reinforced in social practices that are observable in health care organizations (Authors, 2018). Third, instead of the transmissional view, communication—in the form of social interaction—is meaning-oriented, and meaning is "the primary generation of human action" (Drazin *et al.*, 1999, p. 293).

Leadership is thus treated in this study as a relational process of comanaging meanings (Ruben and Gigliotti, 2016) and defined, following Fairhurst (2007, p. 5), as an "influence and meaning management process which advances the objectives and takes place among actors." Instead of focusing only on the leader, attention is directed to the meaning-making and meaning management of both leaders and followers (Fairhurst and Connaughton, 2014) which emphasizes (inter)action and follows Mintzberg's (1982) view of the importance of leadership behavior in leadership studies. In her definition, Fairhurst (2007) tends toward Robinson's (2001) view, which defined leadership as something exercised in talk or actions when articulated ideas are recognized as advancing important and meaningful tasks. For example, in a medical consultation situation, if all the (inter)actions are recognized as helping find a solution to the medical problem

at hand, all those (inter)actions are leadership; it is the *process* of leadership that is highlighted, rather than solely the leader's communication behavior (Robinson, 2001). Leadership is not just about an individual in a given role; it can also be shared or distributed and thus cocreated in interaction (Fairhurst, 2007). However, in health care, leaders still have medical responsibilities. Through this and other moral and judicial responsibilities, appointed leaders represent the organization, and a certain leadership role is expected of them (Barge, 2004). In the present study, we analyze these expectations.

Our focus is on young physicians' constructions. In their study on medical trainees, Gordon *et al.* (2015) found that they often conceptualized leadership traditionally, as behavior, personality, role and hierarchy. These findings suggest that the individualist discourse of leadership was dominant among medical trainees, and leadership was seen as leaders' actions (see Gordon *et al.* [2015] for a fuller account of leadership discourses in the health care literature). In their study, trainees also appear to have a reasonably traditional conceptualization of following; although they acknowledged that following involves some active participation, they largely conceptualized it in terms of passivity and hierarchy. However, as a group of medical students progressed in their education, the relational discourse of leadership was strengthened in comparison to individualistic discourse. The findings of Gordon *et al.* (2015) indicate that leadership is viewed differently in various career phases. We suggest that it is not merely the conceptualization of leadership that changes; physician identity also changes, resulting in an evolution of the conceptualization of the leader-follower relationship.

Frames as Schemes of Interpretation

Frames are "meanings applied to [a] situation" (Fairhurst and Connaughton, 2014, p. 407) and a culturally constructed way of understanding and arranging things in a social

interaction (Goffman, 1974); actors define situations through frames, and social reality emerges from the definition of a situation. Based on Bateson's (1972) notion of cues of interpretation in social situations, Goffman (1974, p. 21) defines a frame as a "schemata of interpretations" that guide understanding in social situations by infusing meaning into a seemingly meaningless sequence of actions. For instance, in leader-follower interaction, situations and all that is said and done in them are interpreted through existing frames. When actors seek to understand according to the principles by which they should act, frames help organize the expectations in a social situation (Goffman, 1974).

One or several frames can occur in the same situation, and frames can also change within situations (Goffman, 1974). Whenever social interaction takes place, communicators bring with them their frames and try to apply previously constructed meanings. Because a frame provides a scheme for interpreting and acting, different frames legitimize different kinds of actions (Virkki *et al.*, 2015). While socially constructed, frames direct us to think in a certain way and even restrict us from thinking differently (Hancock and Garner, 2011). In medicine, Peräkylä (1989) has reported that different kinds of principles guide actions in different areas of specialization. If a great divide exists between frames, misunderstandings—that is, incompatible interpretations—are also likely to occur.

Research on frames and framing is multidisciplinary, manifold and scattered, which has advantages and disadvantages (Borah, 2011; Dewulf *et al.*, 2009). Vague conceptualizations have led to distinctly different approaches to frames (Scheufele, 2000), but a great deal of freedom can be found in working with the concept (Denzin and Keller, 1981). Two main approaches to framing research have been identified in the literature; Borah (2011) and Scheufele and Tewksbury (2007) have labeled them psychological and sociological. In

communication studies, Dewulf *et al.* (2009) have categorized them as the cognitive and interactional paradigms of frame research. While the cognitive paradigm defines frames as cognitive representations, the interactional paradigm approaches frames as co-constructed meanings that are created in interactions (Dewulf *et al.*, 2009). Even though the present study is based on essay data, frames are seen as socially constructed, reconstructed and deconstructed sets of meanings.

Frames may shape the meanings of communication content, processes and the participants. In their theoretical study, Dewulf *et al.* (2009, p. 157) examined what gets framed in framing and identified three different focuses: (a) issue frames, (b) identity and relationship frames and (c) process frames. The present study concentrates on identity and relationship frames, which arrange the meanings that young physicians construct about themselves and their relationships with leaders as counterparts (see Dewulf *et al.*, 2009). When identity is defined as the meanings one reflexively attaches to oneself (Brown, 2020), then the identity frames consist of different ways of arranging those meanings that produce different ways of seeing oneself. Relationship frames consist of meanings attached to mutual interactions and the counterparts.

In medical leadership studies, there are no studies on identity and relationship frames as such. However, in examining first-line nurse managers, Viitanen *et al.* (2007) applied the frame approach to identify typical dispositions related to managerial work and leadership; they identified four ways of framing the leader's position: (a) nurturing mother, (b) administrative nurse, (3) rational producer and (d) expert and developer, which can appear in parallel. Viitanen *et al.*'s (2007) findings also implicate how meanings assigned to oneself include meanings assigned to the mutual relationship.

The aim of this study is to idnetify the identity and relationship frames of young physicians by analyzing how they present themselves in their role and how they describe their relationships with leaders in leadership communication situations. We do not examine leader identity; rather, the focus is on the interpretative frames through which young physicians interpret leader-follower communication.

Method

Data

To achieve the study aim, essays written by young physicians during their specialization training were analyzed. In Finland, specialization training includes medical content and workplace learning, along with interprofessional social and health care management and leadership education. We chose this group based on the assumption that participating in leadership education to achieve skills and a formal qualification in medical leadership heightens sensitivity in observing leadership communication in the workplace.

The essays were collected during a module on leadership interaction and organizational communication that drew participants from all the specialties. This assignment was required for the completion of the module. However, that requirement did not extend to its inclusion in this study. The instructions were very broad, with no word limit set. The participants were asked to write about their observations of leadership communication and communication practices in their workplaces and about what specifically applies to leadership communication in health care organizations. The instructions were based on the understanding that, when writing about their

own experiences and observations, young physicians would frame those situations and make interpretations through these frames.

In all, 225 completed essays from 3 to 7 pages were provided; 120 participants were doing their workplace learning in specialized care in hospital organizations and 105 in primary health care centers. The data covered workplaces in large and small organizations. The specialization fields of the participants ranged from general medicine to psychiatry. We did not collect information about participants' specialization fields, but many mentioned it in their essays. Based on this information, we believe that at least half of all 49 possible specialties were represented.

Ethical principles were carefully followed throughout the process (Finnish National Board on Research Integrity, 2020). The integrity of the research subjects was respected; extensive information was provided about the study, participation was voluntary and when returning their assignments in virtual workspace, participants were asked to give written consent for their essays to be used for research purposes. If that consent was not given, the relevant essay was excluded from data. No pressure was placed on the young physicians to participate. To protect informant privacy, all personal information like names and workplaces was removed before analysis began. Finland's national research policy states that an ethical review is not usually needed when a study's research subjects are adults and the study does not expose them to exceptionally strong stimuli or possible harm. Thus, no approval was sought for the study.

Analysis

Frame analysis (Goffman 1974) is not a uniform method; rather, it is a conceptual tool that helps organize data. It offers the possibility of conducting analyses in different ways by facilitating the interpretation and understanding of data (Denzin and Keller, 1981). As frames

consist of meanings (Goffman, 1974; see also Laitinen and Valo, 2018), the specific objective of our analysis was to identify how meanings are arranged as frames of identity and relationship. This was pursued by analyzing young physicians' descriptions of themselves in relation to their leaders; these manifestations were examined to construct their hidden and partly unconscious frames.

The analysis followed the principles of constructivist grounded theory (Charmaz, 2000). However, we did not continue data collection beside the analysis, as often occurs in grounded theory studies; on the contrary, when beginning we already had a complete dataset (Charmaz 2011). We began by immersion in the data to grasp tones of voice and create an understanding of young physicians' social reality in their workplaces and leadership communication in those contexts. The first round implied that contradictory conceptualizations of leadership communication exist, which supported our original theory-based idea of the appearance of several frames. After a thorough read-through of the essays, initial (or open) coding was started, employing the constant comparison principle (Charmaz, 2006; Glaser and Strauss, 1967). A segment was chosen as the unit of coding (Charmaz, 2006). The data was examined segment by segment, with comparisons made between them. Every segment included a thought or claim describing young physician's position in the workplace and in relation to one's leader. Interestingly, young physicians represented themselves not only in the first person ("me" and "I") but also in the third person: "a physician is" and "physicians are," which implies that they had socially constructed and adopted expectations. Parallel with creating open codes, axial coding was undertaken (Strauss and Corbin, 1990). Particular attention was paid to the ways of self-representation by accounting for "who am I (as a physician/as an employee)?" and the "rights, responsibilities, and duties" (as a follower and a leader; Virkki et al., 2015, p. 8) of both

young physicians and their leaders. This arranged open codes into three categories around being a physician in leader-follower relationship; the preliminary labels were “physicians are experts,” “physicians need physicians to lead” and “leadership is hierarchical.”

The analysis continued toward greater abstraction, not to form a single core category, but rather to refine the structure of frames through focused coding to select the most important initial codes (Charmaz, 2006). We proceeded by asking, (a) “What kinds of meanings describe a young physician’s professional identity and organizational position?”; (b) “What kinds of meanings characterize leaders?”; (c) “What seems to legitimize—i.e. what are the rights and duties of—leadership?”; and (d) “What kind of communication behavior is to be expected from a leader or follower?” This enabled the construction and definition of the three identity and relationship frames that were ultimately labeled the expertise frame, the collegial frame and the system frame. Each frame provided a key to answering two questions: “Who am I?” and “Who am I in relation to the other?” The frames also included meanings of situational and contextual issues that justify different positions and meanings of power in the leader-follower relationship.

The analytical process was abductive in nature (Charmaz, 2011) and leaned on the theoretical concept of frame as Goffman (1974) introduced it. The last phase of analysis involved returning to the original essays to ensure that the reconstructed frames were recognizable in the data. Since multiple frames may occur in one conversation and frames may change (Goffman, 1974), we also looked for changes in perspective within and between essays. However, we did not count the occurrence of each frame type in the essays, because the aim of the study was to identify possible frames that may appear and change during leader-follower interaction.

Finally, we confirmed these findings by introducing them to the next groups of young physicians in specialization training and a group of medical leaders; both recognized the labeled

frames and found the expertise and system frames especially familiar. They were also able to recall many workplace situations in which these frames appeared to guide leader-follower interaction. Next, the three frames are presented as results. All examples were translated from Finnish by the first author. In the examples, the identifier "E" refers to the running number of the essays, with an identification number added.

Results

In the essays, young physicians described their physician identity and leader-follower relationship through three frames: expertise, collegial and system. Each frame arranged the meanings of a young physician's professional identity in relation to the leader in distinctive ways, creating a frame of an identity and mutual relationship. Each identity and relationship frame then guides the interpretations in different ways.

The Expertise Frame

The expertise frame was constructed around the meaning of medical expertise. Being a physician means having highly specialized knowledge; physicians are autonomous, independent decision makers and self-directed critical thinkers with their own vision. Through the expertise frame, medical leadership is about leading experts, which means that being a leader is justified by medical knowledge and competence. However, because followers are themselves experts, leaders should recognize and explicitly acknowledge the limitations of their own competence: through the expertise frame, the leader-follower relationship is an interpersonal relationship between autonomous equals. Hence, this frame is an interpretative scheme of autonomous companions in conversation and cooperation, as this example suggests:

> Physicians are trained to be independent practitioners, and everyone does, at least on some scale, independent expert work. In a workplace of experts, a leader may have to be more equal and more willing to negotiate than in other kinds of leader work. (E10)

The meaning of relational equality frames interpersonal encounters such that both subjects esteem each other and each other's expertise. This guides interpretations in leadership communication situations, in which mutual appreciation of expertise and autonomy are expected. The expertise frame focuses participants' observations on reasoning and argumentation that allows people to draw their own conclusions about a situation, as the following excerpts suggest:

> We need a supervisor; that is for sure. We need a leader to listen to us and to tell us, openly, about the current important issues that concern our unit. (E72)
>
> A leadership style in which followers are simply told things and not listened to or given rational explanations is not a suitable model for a leader who leads experts. (E12)

Through the expertise frame, followers maintain their expertise power but also lend their administrative decision-making power to the leader. Through this frame, the role of the leader is to define courses of conduct and policies, but giving strict advice or asking tough questions, for instance, would be interpreted as "messing with" the follower's daily work, performance and medical (or clinical) decision making. As experts, all involved have a territory of their own, and violating the borders of that expertise is not appropriate. What is observed in leadership communication through this frame is transparency of the leader's decision making and openness of communication, which means that a leader rationalizes policy decisions and both listens and hears the expert followers, who have their own vision and knowledge. Transparency opens the

possibility for influence and is thus valued; by contrast, one-way communication is an insult to the follower's expert identity.

The Collegial Frame

The collegial frame is constructed around the meaning of membership in a community. Being a young physician means being a junior member of but still unquestionably belonging to that community. Collegiality entails meanings of taking responsibility for the whole area of specialization, but it also means internalizing the professional practices, values and responsibilities of one's community. Thus, this frame also carries some moral overtones of leadership, which requires a willingness to shoulder responsibility for and take care of others. Through this frame, the leader's status is based on prestige, which is built on wisdom that is competence and experience aligned with seniority. It is this prestige that justifies leadership, but collegiality also means equality, which produces interpretations of how one is both cared for as a follower and appreciated as a colleague. The following example describes how the leader takes care of followers and supports their competence (emphasis added):

> She [the chief physician] generates trust and is interested in the well-being of *her* juniors and their ability to manage work and work-related problems, which are often connected to patients in this job. For a young physician, it is very important how the chief physician reacts to requests for a consultation. (E43)

The collegial frame arranges the meanings of a leader-follower relationship as shared values and a hierarchy built on competence and experience. Thus, leaders and followers are simultaneously equal as colleagues and hierarchical in the senior-junior relationship. In a leader-follower interaction, the collegial frame produces interpretations of the leader's taking responsibility in a particular situation but also yielding to a conversation, which indicates relational appreciation

and acceptance of the followers. Through the collegial frame, the leader-follower relationship approaches a supervising relationship in which the availability of feedback and social support becomes invaluable.

The System Frame

Through the system frame, being a physician means being an employee and part of the health care organization, taking responsibility for one's tasks and being part of a larger entity. Through this frame, the leader's role is based on administrative responsibilities that are added to the physician's tasks and may also involve larger-scale decisions. In this frame, leadership is legitimized by administrative status and the source of power is in the authority granted, which defines the leader-follower relationship as hierarchical. The meanings of administrative and organizational rights and duties arise here, with roles based on an agreement A leader has appointed power over the followers, which makes problem solving easier but also limits discussion. Through the system frame, a leader is needed to control the rights and duties of employees but also the entities in a complex health organization, as the following examples indicate:

> Management group meetings as an arena for decision making sounds like the Stone Age, but hierarchy is needed to manage a large personnel [system]. (E60)
>
> In the hospital world, the leadership model is hierarchical. There are medical directors, chief physicians in different specialties, chief physicians from different units, deputy chief physicians and then the head of department. This kind of leadership model may be heavy, slow and bureaucratic, at least in a big hospital. It creates pressures for functional and positive interaction and communication and to keep personnel satisfied and motivated. In the business world today, there is a lot of team-based leadership, which is

> probably easier and more fluent. In my opinion, however, team-based leadership does not fit into the hospital model because of a hospital's structure and nature. (E42)

Through the system frame, the leader-follower relationship is hierarchical; because the system (that is, the organizational structures) defines this relationship from the perspective of organizational positions, the risk of alienation arises, which focuses interpretations in leader-follower interaction on closeness and distance. In addition, appreciation of one's efforts at work becomes central. Followers are responded to and rewarded with appropriate delivery of information and having the opportunity to express their opinions and have an impact on organizational planning. This produces a sense of being heard.

The Occurrence of the Frames

The three frames appeared side by side in the essays, with system and expertise frames often identifiable in the same essay. The collegial frame appeared less often, but it was also present. Some essays only featured one frame. A minor bias could be observed between primary health care and specialized care in hospitals. In the former, the system frame occurred more often than in the hospital context, where the expertise frame predominated.

Discussion

The present study contributes to the existing research on medical leadership by analyzing identity and relationship frames that are viable in leader-follower interactions to create a picture of how medical leadership communication is interpreted. It provides information on leader-follower interactions while also shedding light on the interdependence of follower identity and relationship: these frames make clear that it is impossible to separate "Who am I?" from "who we are together." In other words, who one is as a follower also defines leadership. Seeing leadership as a relational process of meaning-management (Fairhurst, 2007; Ruben and Gigliotti,

2016), our findings suggest that, through frames, the meanings of leader and follower are also present in leadership situations. While earlier relationship studies, including LMX studies, have focused on outcomes, the present study's results enhance our understanding of communication processes and suggest that leader and follower roles are interpreted through frames.

In this study, the open-ended essays instructions led to a large, rich and authentic dataset and made it possible to hear participants' own voices, which enhances the study's credibility (Lincoln and Guba, 1985). In the analysis, the theoretical idea of frames was followed. To confirm the dependability (Lincoln and Guba, 1985) of the identified frames, we next discuss them in the light of earlier studies and the similarities with ongoing medical leadership discourses.

The findings suggest that young physicians use three internally coherent frames: the expertise, collegial and system frames. The expertise and system frames appear to conflict to some extent. This setting resembles previous discussions of medical leadership (Kirkpatrick *et al.*, 2016) and more broadly the problematic relationship between highly qualified professionals and administration (e.g. Ruben *et al.*, 2018). Our findings suggest that different frames provide an explanation: the saying "we don't speak same language" likely means "we don't share same frame." When frames are socially constructed (Dewulf *et al.*, 2009), young physicians absorb them in both formal medical education and their workplaces. Thus, it is probable that the division between "expert" and "system" is strengthened and—even though a thorough discussion of this division is critical—easily becomes a fact-like idea. However, we claim that becoming aware of these frames provides one answer to the problem of the "dark side" of medical leadership (Loh *et al.*, 2016). As Berghout *et al.* (2020) have shown, reconstructing new, more collaborative professional identities is possible; this is also true of recognizing frames,

negotiating and changing frames within a situation and reframing (Fairhurst 2011) leader-follower relationships.

Even though it appeared less often in the data, the collegial frame formed a coherent and separate entity of meanings. This frame included meanings of seniority, which implies that the leader-follower relationship can also be seen as a mentoring relationship. This is not surprising, given that participants were young physicians who were doing their workplace learning. It would be interesting to discern whether this kind of frame is recognized by senior physicians or medical leaders.

An established professional structure and hierarchy is particular to health care organizations. Viitanen *et al.* (2007) described first-line nurse managers' dispositions in relation to leadership, and some overlap between their results and the present study's findings exists: the expertise frame appears to have the same core meaning as the nurse leaders' framework of expert and developer, and the system frame resembles the administrative nurse leader. The perspectives of a nurturing mother and a rational producer are present in Viitanen *et al.*'s study, but we did not find either kind of frame or related meanings. The collegial frame focused more on professional identity building than on taking care like a nurturing mother among nurse leaders. Since interprofessionality is at the core of health care organizations, it would be interesting in future studies to study the frames of leading interprofessional work.

Even though this study was conducted in the context of medical leadership communication, these three frames may be found, at least to some extent, in other fields of knowledge-based work in complex institutions with highly specialized workers. However, when assessing the transferability of our results (Lincoln & Guba 1985), it is important to note that our participants shared the same professional education and career phase, forming a quite

homogenous group of physicians. A few participants had previous education in other academic or national cultures, but since the essays were not analyzed individually, nothing can be concluded about any such differences. It thus is possible that the emphasis of the frames would differ in other contexts, but considering the strong professional culture of medicine, it is presumable that at least same kind of elements would appear. However, further research is needed to evaluate the impact of contextual issues.

The importance of frames is in defining situations and infusing meanings into (inter)actions: the same kind of communication behavior is interpreted differently depending on the frame. In earlier studies, certain leaders' communication behaviors, such as reciprocity and approachability (e.g. Pell *et al.,* 2015; van der Wal *et al.*, 2015) have been valued by followers. In the present study, expressing appreciation led to different meanings through different frames: appreciation was aligned with expertise, with oneself as a person or with oneself as a trustworthy employee. In future research, it will be important to take these different interpretations into account. When leaders' communication competence is evaluated by followers in the workplace, analyzing the interpretative frames of the leader-follower relationship helps foster an understanding of why certain behaviors are perceived as good and why they have value for followers. These attributions depend on frames: if participants enter into a situation through different frames, the same communication behavior may be interpreted, for example, as patronizing, taking care or assertive leadership. Being aware of and identifying these frames of interpretation can be used in leadership practice.

Conclusions

This study shows that the frame approach provides a valuable understanding of the leader-follower relationship. While earlier studies have suggested that the conceptualizations of leadership and following evolve as physicians proceed in their careers (e. g. Gordon *et al.*, 2015), the present study shows that different identity and relationship frames may also exist simultaneously. Thus, our expectations of our leaders may be contradictory depending on specific social situations and the interpretative frames embedded in those situations.

Awareness of these socially constructed frames and their influence on leadership communication will help both leaders and followers make more accurate interpretations and create shared meanings in a leader-follower interaction. Being aware of frames also offers the opportunity to make changes: because frames can be reconstructed and situations can be reframed (Fairhurst, 2011), it is possible to construct new and more appropriate frames for the leader-follower relationship. This demands reflection and discussion. Metatalk, in which the participants explicate the frames, is one way to make frames more visible in leadership communication. It also supports constructing a shared frame in the leader-follower relationship.

To evaluate appropriate and skillful leadership communication requires identifying the frames through which the communication is evaluated. Identifying leadership discourses and identity-relationship frames could lay the foundation for medical leadership communication, which could strengthen appropriate and desirable leadership. In future research, naturally occurring data of social interactions would deepen our understanding of how frames are negotiated, changed and strengthened in leader-follower interactions and how situational and contextual dimensions are framed. A longitudinal setting would provide knowledge of the development and adoption of different frames.

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