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INTERLEVEL INFLUENCES ON THE RECONSTRUCTION OF PROFESSIONAL ROLE IDENTITY

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Research on roles and identities generally represents a micro perspective that does not account for the reconstruction of *professional* role identity, owing to insufficient attention to institutional forces. We trace institutional influences on professional role identity reconstruction and extend theory by building bridges across institutional, organizational, and individual levels of analysis. Findings indicate that agentic reconstruction of professional role identity is enabled and constrained by an institutional environment that provides interpretive, legitimating, and material resources that professionals adopt and adapt. Institutional forces also impact organizational arrangements that further influence microlevel agency. We elaborate interactions among these three levels of analysis.

> I will give you an example of what can happen in [the traditional model]. A fellow comes in for a minor problem, a 15-minute appointment. As he is leaving he says, "By the way, I am having some pain in my chest." So the physician tells him to schedule another appointment. Next day the patient dies of a heart attack. This is not good patient care. . . . The way I practice has changed. . . . Now I spend more time with the patients [and] provide comprehensive care. I don't deal with one problem at a time. . . . I am very satisfied with the whole thing because of better care for patients.
>
> -Physician interviewed at time 2 in this study
>
> I provide better-quality care [now]. . . . I am certainly more dependent on other providers. . . . I've now gotten to the point where I turn to my nurses and say, "What is left now that I need to do myself because you can't?" . . . I don't feel threatened in my clinical autonomy. . . . I feel I'm actually doing a better job, filling the gaps. I don't think I knew those gaps existed before: you just do what you have to do to get through that visit.
>
> -Physician interviewed at time 3 in this study

Professionals perform significant roles in organizations and society. It is thus crucial that researchers understand the dynamics underlying professional role identity change. Professional identity is an individual's self-definition as a member of a profession and is associated with the enactment of a professional role (Ibarra, 1999; Pratt & Dutton, 2000). Enacting a particular role gives rise to "role identity." According to Ashforth, a role identity "provides a definition of self-in-role" and includes "the goals, values, beliefs, norms, interaction styles and time horizons that are typically associated with a role" (2001: 6). The way that professionals view their role identity is central in how they interpret and act in work situations (Pratt, Rockmann, & Kaufmann, 2006; Weick, 1995). In the case of physicians, for example, a change in role identity enactment can have life or death implications, as the first quotation above indicates. Accounts of physicians' resistance to change in their traditional role identity continue to surface in the literature (Doolin, 2002; Fiol & O'Connor, 2006; Reay & Hinings, 2005). Yet such change is possible, as the above quotations illustrate. At a time when changes in professional fields such as accounting, law, and medicine are being documented (Greenwood &

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Suddaby, 2006; Powell, Brock, & Hinings, 1999)—changes that have ramifications for how professionals perform their roles and view their identity—understanding the dynamics underlying professional role identity reconstruction is timely. In this article, we investigate interlevel influences on professional role identity reconstruction.

One literature stream has produced valuable insights into the individual dynamics that impact role identity construction (Ashforth & Saks, 1995; Ibarra, 1999; West, Nicholson, & Arnold, 1987). Research in this stream attends mainly to microlevel phenomena. Its ability to account for influences on *professional* role identity (re)construction is more limited. In highly professionalized fields, institutional forces such as professional associations and governments can constrain or enable the construction of role identity. For example, dominant or alternative institutional templates that define what constitutes professionalism, and government regulations that specify what a professional can or should do impact how professional role identities are constructed. Attending to the impact of institutional forces on role identity reconstruction has both practical and theoretical implications. On a practical level, such attention would allow professionals who envision changing role enactments to understand the extent and the boundaries of their agency and the extraorganizational influences on their roles. Theoretically, when institutional forces are not explicitly accounted for, the picture of professional role identity construction that emerges is one that is contained within organizational boundaries, when, in fact, this construction is highly influenced by extraorganizational forces. As this study will demonstrate, institutional elements can influence role identity reconstruction along more than one trajectory.

Another literature stream documents the impact of institutional environment on changing professional organizations and boundaries (Greenwood, Suddaby, & Hinings, 2002; Scott, Ruef, Mendel, & Caronna, 2000; Townley, 2002). These studies tell one little about how such changes affect professionals operating in micro contexts and whether and how these changes affect individuals' professional role identities. Yet, in recent years, there have been repeated calls for researchers working with institutional approaches to cross levels of analysis (Barley & Tolbert, 1997; DiMaggio, 1988; Fiol & O'Connor, 2006) and to examine "the interdependence between institutions and individual identity and roles" (Dacin, Goodstein, & Scott, 2002: 52).

In general, cross-fertilization between the two cited literature streams has been limited. The purpose of this study was to build bridges across macro and micro levels by integrating institutional, organizational, and individual dynamics that influence the (re)construction of professional role identity. Unlike most work on role identity construction and change, which has emphasized the individual level of analysis and perhaps included organizational context as a constraint (e.g., Ashforth & Saks, 1995; Ibarra, 1999; Nicholson, 1984), the present research integrates an additional level: the institutional level.

Further, unlike previous studies that have focused on the construction of the work and professional identities of individuals at early career stages (Becker, Geer, Hughes, & Strauss, 1961; Davis, 1968; Ibarra, 1999; Pratt et al., 2006), we traced the influences on the *re*construction of role identities of professionals at later career stages. We use the term "reconstruction" to denote a significant change in a role that a professional has enacted over time and has considered to be self-defining. The careers literature indicates that individuals with more work and personal maturity may have different motivations for seeking career changes than individuals at earlier career stages (Hall, 1986). However, this literature does not attend to the interactions between individual motivation and institutional forces. As will be shown, models that are legitimate in the institutional environment of professionals may constrain the career choices of professionals motivated to seek role identity changes.

In this study, we sought to refine and extend theory by building a model of the interlevel influences on the reconstruction of professional role identity. We used a case study as a basis for extending theory (Creswell, 1998; Eisenhardt, 1989; Vaughan, 1992). We focused on change in the professional role identity of physicians and tracked these changes longitudinally in a health care unit in Canada. Our findings indicate that the institutional environment of these professionals was a source of interpretive, legitimating, and material resources that both enabled and constrained the reconstruction of professional role identity. Furthermore, the institutional dynamics' influence was conveyed along a double trajectory: a direct one, as the agents in the case adopted and adapted resources, and an indirect one, whereby institutional dynamics affected organization-level arrangements that further influenced microlevel agency. As the professionals engaged in microlevel actions aimed at assembling resources supporting professional role reconstruction, their agency interacted with the macrolevel influences.

PROFESSIONAL ROLE IDENTITY RECONSTRUCTION

Professional Role and Identity

Professional identity is an individual's self-definition as a member of a profession (Ibarra, 1999; Pratt & Dutton, 2000). It is associated with the enactment of a professional role (Pratt et al., 2006). Barley pointed out that role and identity are two sides of the same coin: while roles look outward toward the interaction structure in a setting, identities look inward toward the self-definition associated with role enactment (1989: 50). Enacting a particular role gives rise to role identity, "the goals, values, beliefs, norms, interaction styles and time horizons that are typically associated with a role . . . a role-identity provides a definition of self-in-role" (Ashforth, 2001: 6). Stryker and Serpe stated that "identities are reflexively applied cognitions in the form of answers to the question 'Who am I?'" (1982: 206) and that these answers refer to "internalized positional designations that represent the person's participation in structured role relationships. Thus, there is an intimate relationship between role and identity, emphasized in the term 'role identity'" (1982: 206).

Nicholson (1984) stated that there are situations in which individuals may proactively seek changes in a role so that the role better matches their identity and others in which a role change may engender personal development as individuals absorb the change by altering identity-related attributes. However, research indicates that role and identity evolve interactively (Ashforth, 2001; Ashforth & Saks, 1995; Barley, 1989; Hall, 1986; Ibarra, 1999) and that "there is no simple causal directionality" between social structures, roles, and identity (West et al., 1987: 301).

Although some research on work roles and identities has appeared in the literature, the *professional* aspect of roles and identities has received little attention. Further, studies that focus on professional models generally demonstrate a macro sociological perspective and tend to ignore the individual dynamics associated with professional role identity reconstruction.

Macro- and Microlevel Research

Macrolevel research of particular relevance for our study is work in institutional theory in which professional roles are viewed from a structural perspective—as fixed within institutionalized systems. Microlevel research tends to focus on the individual-level dynamics that impact roles and identities. This literature occasionally integrates the impact of organization-level elements on roles and identities. These two literature streams correspond to the structural and symbolic interactionist perspectives (Ashforth, 2001; Stets & Burke, 2003; Stryker & Statham, 1985). From the structural perspective, roles are given positions in a social structure, whereas from the symbolic interactionist perspective, roles are emergent and negotiated among individuals.

Writing from an institutional standpoint, Scott (2001) indicated that some values and norms are applicable to specific types of positions, giving rise to roles. Certain conceptions of appropriate roles, routines, and scripts are associated with actors and identities in such a way that these conceptions are "prescriptions (or proscriptions) of behavior" (Scott, 1994: 63). In most professional fields, strongly institutionalized beliefs and values define professionalism (Abbott, 1988; Powell et al., 1999). Both the institutional and sociological perspectives have focused on the impact of professions on the definition of roles and on the regulation of member action as a macro process (Abbott, 1988; Freidson, 1993; Greenwood et al., 2002; Macdonald, 1995). Professions are said to exercise control by such means as training, testing, and setting principles for action (Abbott, 1988; Scott & Backman, 1990). Thus, the view is that strong identification inducement processes shape the identity of members of developed professions.

Although institutional theory has contributed to academic understanding of the institutional mechanisms and templates that define professional roles and boundaries, it has not been helpful in explaining how professional roles and identities change or are reconstructed in micro contexts. Understanding this reconstruction requires attention to the meanings, actions, and interactions of agents in organizational settings (DiMaggio, 1988; Townley, 2002; Zilber, 2002).

Microlevel theory, on the other hand, focuses on individuals and the organizational contexts in which individuals construct professional role identities. (For a review of the identity construction literature that focuses on the micro analysis, see Pratt et al. [2006].) Van Maanen and Schein (1979) noted that dissatisfaction with a role can lead professionals to redefine it by changing the mission associated with the role. Nicholson (1984) proposed that outcomes of work role transitions include four modes of adjustment—replication, absorption, determination, and exploration—that vary on the basis of role and personal development. For example, role exploration represents cases of simultaneous personal change and role change and is likely to occur when a role's incumbent has a

high level of discretion in shaping the role. In Nicholson's model, the institutional factors that influence the level of discretion (given, for example, an incumbent's position in an institutionally established hierarchy) are not a focus of analysis.

A few empirical studies that focus on how professionals are socialized into or adapt to new roles and construct their professional identities have been conducted. Ibarra (1999) found that consulting and investment banking professionals' adaptation to new roles involved experimentation with provisional selves that served as trials for professional identities. Pratt and his colleagues found that work-identity integrity violations due to "experienced mismatch between what physicians did and who they were" (2006: 235) triggered the identity construction of medical residents. These studies have produced valuable insights into the microdynamics of work/professional role identity construction and the organizational contexts in which such construction occurs. However, these studies do not focus on the role identity *re*construction that may occur later in careers. Neither do they explicitly address the influence of a wider institutional environment on the content and the dynamics of role identity (re)construction.

The macro and micro streams of research have developed in parallel rather than interactively. Each stream leaves out important dynamics of professional role identity reconstruction. We took seriously the advice of those who have called for research that integrates macro approaches that focus on institutions and structures and micro approaches that focus on agents' interpretations, actions, and interactions (Barley & Tolbert, 1997; Beamish, Hitt, Jackson, & Mathieu, 2005; Dacin et al., 2002; Stryker & Statham, 1985). Our aim was to examine the content of and the interlevel influences on professional role identity reconstruction.

METHODOLOGY

Research Setting

The case: A Canadian health clinic. The research site was a health clinic that served a population of several thousand people in a defined geographical area in a Canadian province. The clinic was owned and operated by a group of eight family physicians and employed a varied support staff. The physicians also performed surgeries in the local hospital. Prior to the implementation of the changes, the physicians performed their work as a consortium of independent practitioners and were paid individually on a fee-for-service basis by the provincial government. In Canada, each provincial government funds all medically necessary health care services to the citizens of the province. Regional Health Authorities (RHAs), set up by provincial governments, oversee health services and providers—except physicians—in specific geographic regions. Professional associations representing physicians negotiate their fee structure with the provincial governments.

The changes we studied were initiated by the clinic physicians themselves in the late 1990s. At this time, the RHA and the government of the province in which the clinic was located were considering the need for health care innovations focused on wellness and integration of services. Following a series of meetings initiated by the physicians and involving representatives from their own group, the RHA, and the provincial government, the participants developed a model that included several changes. These were a fundamental change in physician compensation: a transition from a fee-for-service system to a capitation system with a fixed salary based on serving defined populations; the institution of an integrated information system; the colocation of various health care professionals; the adoption of a multidisciplinary, integrated approach to service delivery; and the hiring of a nurse practitioner to do health promotion, among other things. These changes were developed into a three-year experimental "project" whose activities were facilitated by an "integration team." The role of this team was to ease implementation of specific integrative programs, and its members included representatives from different stakeholder groups. Project participants identified health concerns in the region, and the integration team helped set up multidisciplinary thematic teams to address the integration of services related to these health concerns. The first such team had the theme "well baby" and brought together the project coordinator, physicians, and public health nurses. Thematic integration teams were also developed around asthma, hypertension, and diabetes. Each thematic team created strategies to integrate services, remove duplication, and offer education. As decisions about payment systems, colocation, and integrative activities were being considered, the issue of professional roles became a significant theme in the project participants' discussions.

Rationale. We became interested in this case because it featured significant change and reconstruction and gave us the opportunity to track the dynamics of changes at multiple levels. The case could be considered unique (Yin, 2003) in that the changes attempted at the clinic were highly innovative for this province. The project involved fast-paced, high-magnitude change. Project participants

indicated that they were unaware of any other project that had attempted as many changes as they visualized in as short a time. As researchers, we had the opportunity to track the changes occurring at the individual, organizational, and institutional levels over four years beginning with the inception of the project and ending after its completion.

In this article, we focus on physician role identity for two reasons. First, the physicians were involved in multiple aspects of integration (such as the asthma, well baby, and diabetes teams) and were subject to all the changes that affected the system (payment, information system, physical colocation). As the project coordinator stated, "Everything that you are trying to change involves the physician, whereas from the allied providers' perspective . . . you're only modifying your role slightly." Second, physicians are a highly professionalized and institutionalized group, and studies have documented both their opposition to changes viewed as reducing their autonomy and the importance of their support to the success of innovations in health care delivery (Denis, Lamothe, Langley, & Valette, 1999; Doolin, 2002; Reay & Hinings, 2005). Because the physicians in our study appeared to be open to the changes, this case provided the opportunity to extend theory (Eisenhardt, 1989; Hartley, 1994; Vaughan, 1992) on enablers of role identity reconstruction for professionals.

We adopted a case study approach with a focus on qualitative data (Creswell, 1998; Hartley, 1994). As we were interested in interlevel dynamics requiring data collection from different sources, the case study approach proved to be particularly helpful (Creswell, 1998). We used the naturalistic inquiry method designed to reveal phenomena in their natural settings (Lincoln & Guba, 1985). This approach was the appropriate vehicle for the thick description "so essential for understanding of context and situation" (Lincoln & Guba, 2002: 206), which is important in a study aimed at comprehending the interacting dynamics that influence change in professional role identity.

Data Sources

The overall research project of which this study was a part had a longitudinal case research design focused on tracking a variety of changes over the life of the provincial health clinic's pilot project and beyond. Data collection included observing meetings, compiling written material, and conducting three sets of interviews with stakeholders at the inception of, during, and at the end of the health clinic's pilot project (times 1, 2, and 3, respectively). Interviewees included the physicians, key decision makers in the RHA, and a variety of project participants, as is shown in Table 1. Over the three time periods, we conducted 74 interviews. We used "purposeful sampling," approaching all key participants in the project and interviewing each at least once. Most key participants were interviewed twice or more. We did not have three interviews with every participant because over the life of the project, various individuals changed positions or were hired late. All the physicians involved in the project were interviewed at both times 2 and 3. (By time 3, one of the physicians had left for reasons unrelated to the project.) Of the eight physicians, four were in later career, three were in mid career, and one was in early career (but had already practiced in other clinics).

Interviews lasted from one to one and half hours. Most interviews were conducted by two members of the research team, which included the current authors. Our interview strategy combined use of the interview guide approach (in which topics to be covered are specified in outline form) and the standard open-ended interview approach (in which the wording and sequence of questions are predetermined). As Patton (2002: 347) indicated, the strategy of combining the two interview approaches calls for specifying certain key questions while leaving other items to be explored. Interviews were tape-recorded, although two participants preferred not to be taped, and we took detailed notes during the interviews. All interviews were transcribed.

Time 1 interviews were conducted after funding for the project had been announced and before implementation had started. Interview questions at time 1 focused on obtaining views on the wider context surrounding the project (including developments in the health care system), on the prevail-

TABLE 1
Interview Participants

Participants	Time 1	Time 2	Time 3
RHA senior administrators	6		4
Project coordinator	1	1	1
Clinic manager	1	1	1
Clinic physicians	4	8	7
Clinic nurse practitioner	1	1	1
Clinic registered nurse		1	1
Clinic staff	2	1	1
Public health and home and community care personnel (supervisors, nurses, and program specialists)	9	7	8
Hospital acute care supervisor	1	1	1
Hospital continuing care supervisor	1	1	1
Total	26	22	26

ing service delivery methods and structures, on the level of satisfaction with the prevailing operations, on the envisioned organizational changes, on the drivers of the change, and on the significant stakeholders in the project. The specific notion of professional role identity was not a central focus in the interview questions at time 1, although some data on roles prior to the changes were gathered. However, during the course of our attendance at integration meetings, it became clear that roles had become a significant issue as practitioners from different professions tried to integrate their services, and we thus decided to focus on this subject. In the time 2 interviews, we made the notion of professional role identity a central theme. The time 2 interviews, conducted about two and a half years after the time 1 set, tapped into participants' views of changes that had occurred in the wider environment and in the organization. They also explored professional roles (including practices, interactions, relationships) before and after the changes, the motivation for and experience of change, and the enablers of and obstacles to role changes. The time 3 interviews were conducted one and a half years after the time 2 interviews, or about four years after the inception of the pilot project. At that time, the pilot project had ended. At time 3, questions again examined participants' views of the changes that had occurred in professional roles and relationships as well as their views of the organizational and institutional changes. Time 3 questions also tapped into the lessons learned and the possibility of their diffusion elsewhere in the region. Extensive probing was used throughout all the interviews.

In this article, we focus primarily on three main data sources that provide detailed information on dynamics at different levels. Table 2 details these data sources and the associated role identity elements. The first data source of particular importance here is the time 2 set of interviews, because they provided the richest information on role changes. The time 1 interviews provided useful information on roles before the changes and on the macro- and microcontextual elements of the changes. The time 3 interviews confirmed the findings obtained at time 2 regarding professional role identities and further established that the changes were not temporary. Thus, we drew upon the times 1 and 3 interviews for further insight and corroboration. The second focal source of data for the current study was our observations of 17 integration meetings, each attended by at least one researcher. These meetings allowed us to gather information on how roles were being addressed and negotiated throughout the life of the project. Field notes were taken during each meeting and typed shortly thereafter. Meeting minutes prepared by the project coordinator corroborated our meeting notes. The third important source of data was the written material we gathered. Archival material consisted of private studies and government reports on the health care system in the province and in Canada, summaries of RHA policy changes affecting health services in the region, and medical professional association publications addressing issues of payment systems, medical care models, and health care reforms. Additional written material included the project mission, objectives, operational model, and milestones, as well as progress reports from the various programs (e.g., well baby, asthma) and charts from these programs outlining the division of responsibilities among practitioners. Thus, we derived our data on different elements that influenced the reconstruction of physician role identity from a variety of sources.

TABLE 2
Sources of Data

Influences on the Reconstruction of Professional Role Identity	Sources of Data
Institutional dynamics	Interviews Summary of government reports Studies of the provincial and Canadian health care sector Statements of policy changes by the RHA Medical professional association publications on payment systems, medical care models, and health care reforms
Organizational dynamics	Interviews Field notes Minutes of meetings Written project material
Microdynamics	Interviews Field notes Minutes of meetings Written project material

Data Analysis

We adopted a qualitative case study approach to uncover a wide variety of dynamics at different levels and to achieve a detailed understanding of the way that they interacted. We approached the data analysis with three broad foci of attention. The first was the content of professional role identity change, as evidenced in descriptions of role identity before and after the change. Physicians were

asked to describe their professional role at the time of the interviews, to elaborate on how it was different from past role enactments, and to give examples. For instance, such statements as "Now I practice my role as a member of a team of providers. . . . Before, I saw myself as an autonomous provider" indicate a change in the content and enactment of professional role. Physicians' descriptions of the content of role changes converged on four themes, which are presented in Table 3. Although we used the physicians' views as the basis for mapping the content of role changes, we found that other practitioners described, in similar ways, the changes they had observed in physicians' role enactment.

The second focus comprised the macro- and microdynamics that influenced the reconstruction of professional role identity. In the analysis of these dynamics, we initially coded the data by applying a set of descriptive themes that closely resembled the terms used by the participants. We then derived a set of pattern codes that suggested thematic links in the data (Miles & Huberman, 1994). For example, we applied such descriptive captions as "government influences," "professional influences," and "RHA influences" to segments of data text that referred to each of these influences. We agreed that these influences could be subsumed under the pattern code "institutional elements," which was

TABLE 3
Physician Role Identity: Past and Present

Role Identity Content Change	Representative Quotations from Physicians
From: Autonomous provider; sole responsibility for patient care	My practice with the project . . . it's made me more aware of what the other health care professionals do and their role in the care of the patient. So it's given me a better appreciation for them as sort of parts of the team. So I don't look on myself so much as an individual, but as part of a team in patient care.
To: Member of a team; primary, but shared responsibility for patient care	We're clearly using more people, we feel much more comfortable sharing responsibilities than we did before. And that issue of control is far less important than it was. So I think that's really developed. . . . We've come a long way.
	The way we used to do things is . . . asthma was controlled by the doctor, and the diabetes, there was no integral care with the dietician and the nurse educator. So that I think there is a lot more togetherness (now) . . . (Patients) get more scope to their disease by having these people involved. And I'm still involved with them, but they get additional expert input from the team.
From: Focus on treatment	The way I practice has changed. . . . Now I spend more time with the patients and practice preventive care.
To: Focus on treatment and prevention	I'm also on Well Baby Team and the Asthma Team. . . . Now that's a physician providing input and direction. . . . and pooling that with expertise of others and trying to develop programs . . . Physician yes, but a physician in a prospective, preventative way.
	I think just the whole idea of moving towards wellness, or trying to promote health is significant. . . . I think the project allows you to try and move in that direction, to be proactive rather than reactive.
From: Limited concern with guidelines	We have changed in the sense that we are looking more at standards as a practice, not only as doctors—but as a community, public health nurses, those kinds of things—what we provide, making sure . . . to follow standards or guidelines.
To: Focus on best practice guidelines	Now . . . I'm far more focused on guidelines and quality of care issues. . . . It's because of my involvement in the project.
	There's more team involvement and more pathways for diseases that we never had before.
From: Partial view of patients (focus on present illness)	The style of practice has changed for the better, I think. Certainly I feel much more satisfied professionally when I get more comprehensive, spend more time, and clearly make sure that the patient and I deal with the issues appropriately.
To: Holistic view of patients	You have to look at the patient as a whole. . . . So if you don't have the whole picture, then it's more difficult to make the proper recommendations and decisions.
	I think that this integral part will help me to be more aware of things that I might not have thought about in looking at the illness in a broader picture.

viewed mainly as a macro influence. We noted a tendency for an element at one level, say at the macro level, to interact with elements at the micro level. For example, we had considered "colocation" of different practitioners in one physical space to be an organization-level (or macrolevel) theme. However, several quotations that addressed colocation also indicated that presence in the same space had facilitated interaction between different professional groups, allowing the building of trust. Thus, such quotations were also coded with "interactions," which we considered a microlevel dynamic.

The third focus was identifying links between the macro and micro influences. This involved three analytical tasks. The first task was identifying explicit references to such links in the data (as the above example on colocation indicates). The second was comparing the information available in different data sources derived from different levels. For example, an examination of themes in government-commissioned reports addressing the need for health care reforms (a potential institutional influence) indicated that participants were also referring to several of these themes (such as "prevention") as part of their aspiration (an individual-level dynamic). The third task consisted of looking at the same data through different analytical lenses—institutional, organizational, and individual. This examination was significantly facilitated by the composition of the research team, which had members versed in research in a variety of areas, including, but not limited to, professions and institutions, organizational change, and role and identity. Thus, we brought different perspectives and levels to bear on the data collection and analysis. Our regular meetings to discuss the data and the emerging model allowed us to hone in on the dynamics at the macro and micro levels, and on their interaction.

In the analysis of the interview material, we sought to discern whether patterns could be established for multiple physicians. Once we established a pattern, we sought to determine whether interview material from nonphysician participants supported it. We looked for additional dynamics related to physician roles that were not mentioned in physician interviews but could be found in other practitioners' interviews and other sources of data, such as meeting notes. Thus, in interviews with other practitioners, we found evidence of subtle strategies these practitioners used to influence changes in physician views. Although not mentioned explicitly by the physicians as an element that influenced changes in their perspective, we included these influence strategies in our discussion as there was evidence of such strategies in other data sources.

Following a strategy of reiteration, we went back and forth between the data and a broad literature base—as we integrated different levels of analysis—seeking important themes. When a theme emerged either from the data or the literature, we searched the other to find evidence of the theme or to explain its absence. In case studies, extant theory can be employed to compare and contrast findings with the data from one's own study and to extend or elaborate theory (Creswell, 1998; Eisenhardt, 1989; Hartley, 1994).

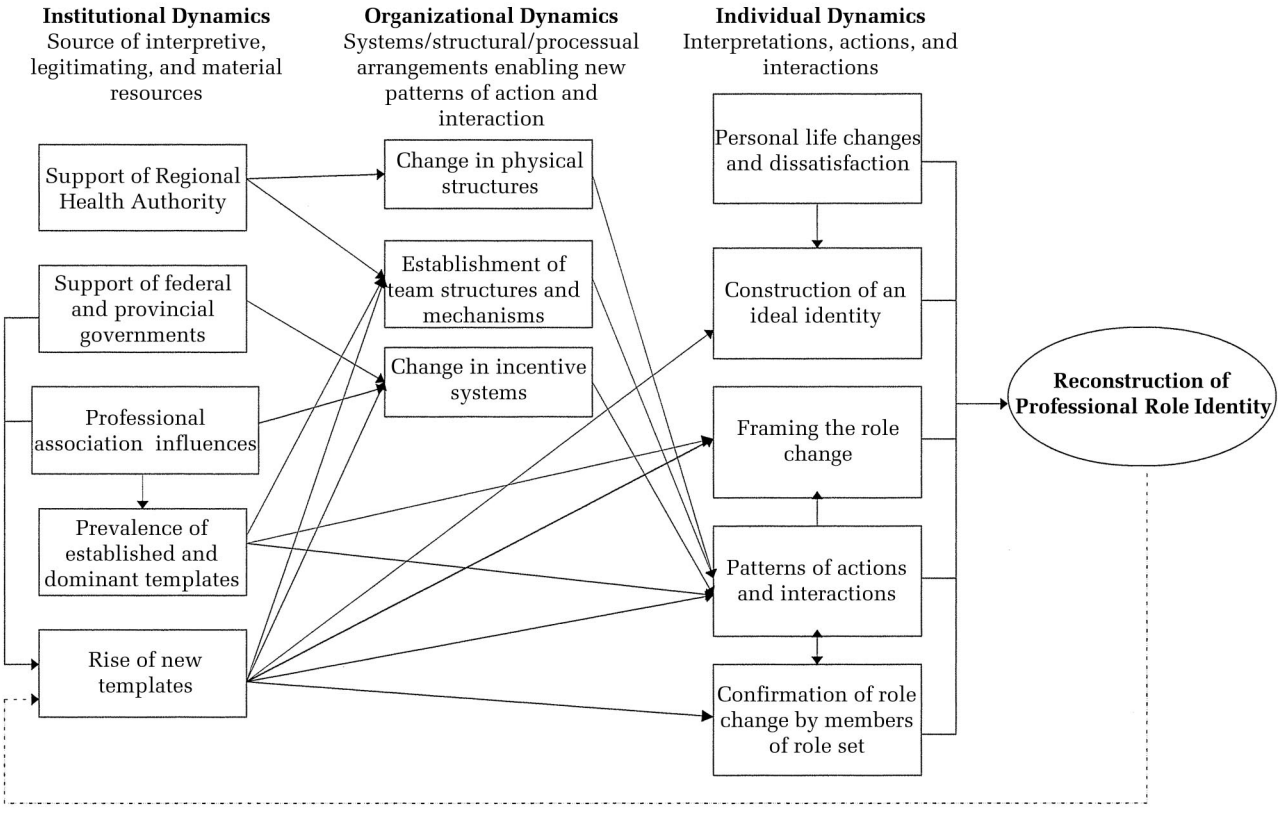
Throughout the data analysis, we met regularly to exchange notes and to discuss and refine the emerging model. We also sought feedback on our emerging model from peers (LeCompte & Goetz, 1982). Some were studying the same setting (as part of a larger research project), and others were researching a variety of health care changes in the area. In addition, we sought feedback on our analysis from project participants and received comments from three, who indicated that the model we derived was a faithful representation of the dynamics. Their more specific comments, and those from our peers, allowed us to refine our understanding and presentation.

Our methods entailed multiple iterative processes and were consistent with recommendations to establish the credibility of findings (LeCompte & Goetz, 1982; Lincoln & Guba, 1985): we triangulated by collecting data from multiple sources; we provided extensive quotes from the data; we used multiple investigators who engaged in continual intrateam communication to collect and analyze data; we relied on peer examination to corroborate our findings; and we used "the most crucial technique for establishing credibility" (Lincoln & Guba, 1985: 314), which involved project member confirmation of the categories, interpretations, and conclusions of our report. The next section presents our findings.

THE RECONSTRUCTION OF PHYSICIANS' PROFESSIONAL ROLE IDENTITY

We used an in-depth analysis to elaborate a model of the interlevel influences on professional role identity reconstruction. Figure 1 presents the outcome of this process. We elaborate on the model as we proceed with the analysis. Here, initially, we present the content of the change in professional role identity found in this research, and we then address the macro and micro elements that influenced this reconstruction of physicians' professional role identity.

FIGURE 1
Interlevel Influences on the Reconstruction of Professional Role Identity



Content of Physician Role Identity: Past and Present

When asked about the changes in their professional roles, physicians addressed a variety of content issues. They indicated experiencing major changes in the ways they performed their role and defined themselves as physicians (as Table 3 illustrates). Physicians stated that they viewed their professional role as having changed from one focused on autonomous service provision, with sole responsibility for patient care, to one focused on team provision, with shared responsibility for care:

> The change for me has been previously working on the assumption that most of medical practice doesn't lend itself to team, to now me thinking of myself as wanting to be part of a health care team in everything. . . . Being part of a team is when you recognize that [health issues] are multifaceted, and are better dealt with by the combined resources of multiple people. You feel the need to work in combination to realize the kind of health care you envision and you value. . . . My role as a physician has changed for good. I tend to think less autonomously.

Physicians also pointed to a shift in practice from providing brief clinical treatment to spending more time with patients and focusing on prevention:

> I see a difference. Before it was just see the problem. They're in, they're out the door. Now, for example, when a fifty-year old guy comes in for a driver's medical, I've become more consistent about going through their risk factors for heart, stroke, cancer, even though that's not the focus of the driver's medical. . . . You feel more responsible for their overall health, rather than just the problem they come in with.

Physicians indicated a change in focus that involved placing more emphasis on "best practice" guidelines, as the presence of other practitioners stimulated them to "stay current on what's going on." They also described a change in perspective and practice, from giving partial attention to a patient's present illness to taking a holistic view of the patient, as the opening quotation in this article points out. The provision of "comprehensive" care was associated with a higher level of satisfaction

for the physicians. They referred to the importance of "look[ing] at the patient as a whole" and "at the illness in a broader picture" (as the quotations in Table 3 indicate).

Thus, there were major changes in how physicians interacted with patients, how they related to other practitioners, and how they viewed themselves as physicians. Physicians' interactions with patients transitioned from a transactional mode to a relational mode, and their interactions with other practitioners changed from those of autonomous specialists to those of multidisciplinary team members. The physicians expressed higher levels of satisfaction with practicing preventive and holistic roles. These role identity changes were significant because they entailed new behaviors and logics (ends-means chains and justifications) that motivated and legitimated behaviors, and new interactions and relations among actors (Scott et al., 2000). In the next three sections, we turn to the influences on the reconstruction of professional role identity.

Institutional Dynamics

Governing and funding bodies. The institutional influences mentioned by the physicians included the impact of the RHA. The RHA governed the work of health care professionals other than physicians and had the potential to be an obstacle or facilitator of reconstruction of the physician role by hindering or sanctioning the collaboration of nonphysician professionals in the delivery of patient care. Physicians viewed the RHA role as a positive one in terms of allowing multidisciplinary teams and the colocation of a variety of health services in the physician clinic. They attributed this positive role to "the good relationship and the feeling of good trust between the [RHA] and the local clinic," indicating that RHA senior management gave "permission to go ahead and make some local decisions." Participants also pointed to other stakeholders that lent their support to the project, including the provincial government, which funded a number of "infrastructure changes that were needed." They noted the convergence of views among a variety of stakeholder groups that were all in favor of the changes. The project coordinator said:

> We've had drivers from the different stakeholders. . . . We've had the RHA saying we really want this and [the] nurses saying this is good for nurses. . . . We've had the same for doctors. So we haven't had a group that has said . . . this is not good for us [or] for the system. Everybody has said, our discipline can take this and move forward and elevate our level of practice.

Another institution-level influence was the physicians' professional association. Physicians differed in their perceptions of the view of the medical association. Some said it was generally opposed to the changes, because it was an advocate for "strong physician autonomy and fee-for-service." Others stated that the association was not openly opposed to the changes in physician pay and roles and was using the project as an opportunity to learn more about alternative payment and operational models for physicians. The view here was that as an advocate for physicians, the professional association was interested in the conditions sustaining their retention. Overall, however, the physicians agreed that the association had not taken a strong stance on the changes relating to physician pay and role. In fact, changing the physician payment system to capitation required an agreement among the provincial government, the physicians, and the physicians' association itself.

An analysis of documents issued by the physicians' association indicates both its openness to changes in methods of paying physicians and its reservations about such changes. The association's position is outlined at the beginning of its publication, the *Alternative Payment Plan (APP) Handbook*:

> While many physicians may be content with the existing situation (fee-for-service), there are compelling reasons to at least explore other options. Research tells us that how a physician is paid has an influence on both practice patterns and service delivery. By offering physicians the chance to choose an alternative funding model, . . . other innovative health delivery models may develop that could: promote wellness; promote comprehensive primary care; promote continuity of care. . . . Exploring APPs is the first step in making it easier for innovative medical delivery models to evolve and develop. (Alberta Medical Association, 2001: 1–2)

The *Alternative Payment Plan Handbook* expressed the view that directing funding into an APP should be conditional on protection of a "physician's professional autonomy and clinical independence" and maintenance of the physician's right to return to a fee for service (Alberta Medical Association, 2001: 3–4). Thus, although not an eager and unconditional proponent of APPs, the physicians' professional association responded to demands by physicians and other stakeholders to experiment with new models of payment and delivery.

The support (or lack of opposition) from various institutional stakeholders facilitated the change in the physician unit we studied and in the role enacted by the physicians. Greenwood and Hinings noted that the occurrence of a "reformative pattern

of value commitment" enables change in institutionalized models; such commitment prevails when different stakeholder groups favor an articulated alternative over a "template-in-use" (1996: 1035). Although Greenwood and Hinings do not deal specifically with the issue of professional role identity, their formulation is helpful in shedding light on how reconstruction of role identity was facilitated in this case. Effecting a role change in an environment similar to that of the physicians we studied here requires the convergence of the views of multiple stakeholders on the legitimacy of the role change.

Physician role reconstruction is embedded in a web of relationships involving a multitude of institutional level governing and funding bodies. Further, the levels of interdependence among different providers and the institutions that govern their practices are numerous and complex. Thus, for example, although the physicians were not directly accountable to the RHA, they had to rely on its approval of the changes in the practices of other occupational groups (nurses, dieticians, etc.) reporting directly to it. In addition, government and professional associations often erect and enforce institutional constraints that significantly affect the behaviors of health care professionals (Luke & Walston, 2003: 207). A change in the role of a group of professionals that has a centrally embedded role in a system—such as family physicians in the health care system—is likely to significantly affect the roles of members of other occupational groups that are unable, on their own, to accept or reject the change. In the case we studied, the various governing and funding bodies supported the project and provided the legitimacy and/or material resources needed to help change physician roles. The impact of nonphysician governing bodies and the professional association on colocation of services, establishment of teams, and changes in physician pay (organization-level phenomena) is shown in Figure 1.

Institutional templates. The physicians pointed to the initial difficulty involved in the divestment of traditional roles defined by dominant templates:

> If you have an existing model around what a physician does, and you try and match that up to this different model of an asthma [integrative] team, they are in conflict. . . . Professionally you certainly have a lot of paradigms too. . . . One of the implicit things is that the physician should always be in charge and the physician always works autonomously. . . . While we're in that, is there really room for other roles that the physician has? . . . That's something that you probably have to address at a very fundamental definition level. And a medical school level and so on. Not that it cannot be done in this sort of environment, once people have been working for a while. But it does take a lot of time. . . . We've had a lot of success, but I think we've underestimated the power of people's impressions and paradigms.

Physicians also indicated that under the traditional model, delegation was difficult as it evoked a sense of loss of control over patient care and the patient-doctor relationship:

> When the nurse practitioner started seeing people, like her Well Woman Clinic. And she'd see my patients and do yearly exams on them. And initially I felt a sense of well, if they don't come see me, how am I going to know what's going on? And then I went through a phase of some irritation, I'm ashamed to admit. I've been working with MY patients, and using that autonomous mindset. And the nurse practitioner would come along and say, "Oh I need to ask you a quick question. It's about your patient that I'm seeing here." . . . Now the feeling could be that the patient-doctor relationship is actually being diluted because part of it's being dealt with by someone else. But my feeling is that it's better, because the better the service the patient is able to get, the better I look. Even if it isn't something that I've done.

These quotations are indicative of the physicians' engagement with both the traditional templates and the emerging alternative templates in the institutional environment. They talked about alternative models that were gaining acceptance in the health care field and stated that the principles underlying their role changes had their roots in such models. A physician stated: "The concept of primary care renewal developed in the literature in the early nineties and our project came from that history." The physicians indicated having attended international conferences on integrated approaches to health care that provided them with alternative views of roles and practices. They also pointed to a number of government-commissioned reports that addressed the need for practice changes similar to the ones they were experiencing.

Numerous archival sources, including studies conducted by academic researchers and industry analysts and reports commissioned by federal and provincial governments, document traditional and alternative ways of providing health care (e.g., Commission on the Future of Health Care in Canada, 2002; Denis et al., 1999; Marchildon, 2005; Premier's Advisory Council on Health, 2001). In these reports, the role of the family physician often receives attention, as a visit to such a physician has been a patient's point of entry into the health system. In Canada, the provincial and federal governments strongly influence the role of physicians

(Coburn, 1993). Unlike countries in which the government's influence is more limited, in Canada the government wields much power in shaping medical practice, because it pays physicians. Thus, government-commissioned reports and their recommendations have a major impact on institutional themes and templates that affect how physician roles are interpreted and possibly shaped.

The archival sources addressed the differences between the old and the new templates. According to these sources, the traditional methods of payment (fee-for-service), of entry into the health care system (through a physician), and of organizing work (fragmentation, professional specialization, and protectionism) were obstacles to delivery of primary and comprehensive care (Commission on the Future of Health Care in Canada, 2002; Marchildon, 2005; Premier's Advisory Council on Health, 2001). These reports converge in recommending several changes. These changes include "implementing alternative approaches for paying physicians and providing better alignment between physicians and regional health authorities"; "encouraging groups of health care providers to establish "care groups" and offer a range of services"; "providing [citizens] with better information about how to stay healthy"; "implementing new models of care like comprehensive primary health care and disease management approaches"; and "consider[ing] greater use of clinical practice guidelines" (Premier's Advisory Council on Health, 2001: 6–8, 38). (Tables containing additional quotations on old and new templates, taken from archival sources, are available by request from the first author.)

The professional association engaged with these emerging themes, but with caution. Although its publications advocated a collaborative and multidisciplinary team approach to primary care delivery and noted an "increased interest by policymakers and providers in alternate delivery systems" (Alberta Medical Association, 1996: 7), they also cast the family physician as the point of entry into the system and as the central authority on patient records. The physicians' association also advocated family physicians' maintenance of "a strong patient-doctor relationship," even in the event of alternate delivery of health care (Alberta Medical Association, 1996: 7). Similarly, with respect to payment mechanisms, the association's view was that the traditional fee-for-service method of remuneration should continue at the same time that alternate payment mechanisms were explored (Alberta Medical Association, 2002).

Thus, different templates prevailed in the institutional environment. This is not surprising, since the values and goals of different bodies with legitimate authority to speak on the health care system varied. Even the physicians' association engaged simultaneously with themes from the traditional and the emerging templates, reflecting the perspectives of different segments of the profession, as this physician quote illustrates: "There is a core of physicians that are forward-thinking and recognize that something has to change. . . . There is also a core of physicians that say, . . . We will not tolerate change." The different themes, deriving from the traditional and the emerging templates, were available as alternative interpretive and legitimating resources that the physicians could and did draw on in enacting traditional or reconstructed roles. However, these templates also limited the range of role content that the physicians could consider in the reconstruction of their role identity. Although they could exercise some agency in their choice of adherence to a traditional role template or the adoption of an emerging role template, they were constrained by those templates viewed as legitimate at an institutional level. In other words, institutional dynamics both enabled and constrained role identity reconstruction. As these findings indicate, research on role identity (re)construction would benefit from attention to the impact of institutional forces on the (re)construction, yet this is generally a neglected area in such research.

A question that remains is, How do professionals deal with the tensions emanating from the push of traditional role templates adopted through extensive socialization and experience, and the pull of alternative role templates circulating in the institutional environment? As will be explained in later sections, other influences favored the reconstruction and adoption of new roles; the physicians did not, however, reconstruct their role or adopt a new one without maintaining links with the past. Figure 1 shows the impact of templates (old and new) on a number of organizational and micro elements. We elaborate on these relationships in subsequent sections.

Organizational Dynamics

Governing and funding bodies sanctioned or facilitated integrative mechanisms and structural changes at the organizational level. Such changes—including the modification of physician pay, colocation of services, and establishment of teams empowered with negotiation and decision-making ability—were mobilized by the physicians, who chose those arrangements that supported changes in practices consistent with their envisioned role. Thus, organization-level changes came to be as a

result of the interaction between microlevel action and macrolevel institutional forces.

Incentive system. Before the project, physicians were paid on a fee-for-service basis, the impact of which is described in the following physician quotation:

> Under the old system you have to see between six and eight patients an hour for most doctors in order to meet your overhead and make a living. So that doesn't allow for very much teaching time for each patient, or any prevention of any type. . . . I think most doctors would admit that they may be able to quickly assess a problem, prescribe a few medications, and that's about it. . . . How can I say it properly without sounding like all doctors are trying to pad their pockets? But it's an economic reality. . . . The fee-for-service system isn't a system that rewards complexity of work, or difficult problem solving. It simply rewards, in most cases, high volume. And it's fee-for-service, not fee for difficult work. . . . There's a lot of dissatisfaction with the fee-for-service system, both with the doctors and patients.

The physicians had negotiated a capitation-based payment system as part of the changes. The movement to the capitation system, which involved a fixed salary based on serving a defined population, had a major impact on how physicians enacted their role. They now had incentives to change their practice and to spend more time with the complex cases, focus on prevention, and refer patients to other practitioners who offered education services. Referring to the impact of the change in the payment system from fee-for-service to capitation, a physician stated:

> You literally change from one day to the next how you're being paid. The whole thought process and the mind-set of going from "I only get paid when I see the patient," to "I'm getting paid to try and keep these people healthy." . . . We're trying more to access other services for those patients, whether it's a diabetic clinic, whether it's seeing the nurse practitioner for smoking-related issues. . . . Under the old system you had to see the patient to get paid.

Previous research has shown that changes in compensation can encourage physicians to change their practices and to collaborate in multidisciplinary teams (Denis et al., 1999). This research, however, did not focus specifically on enablers of role identity reconstruction. Our findings indicate that a change in incentive system (an organization-level element) enabled a change in physician role reconstruction by engendering different patterns of behaviors and interactions with patients and other professionals. It is also important to note the impact of the institutional environment on the physician role reconstruction. The change in the payment system would not have been possible without the rise of alternative templates based on criticisms of fee-for-service and the need to explore alternative payment systems, and the willingness of governing and funding bodies to support such systems.

Physical structures (colocation). The physicians had explored a number of integrative mechanisms and structures, such as implementing new information systems that would allow "cocharting" of patient information by different practitioners. Implementation of a new system was still at an experimental stage at the time of the study and had not yet yielded substantial results in terms of reconstruction of the physician role. However, another integrative mechanism was colocation of services. With the support of the RHA, asthma, diabetes, and well baby services that had been provided by different occupational groups in dispersed physical locations were moved into the physician clinic. Colocation facilitated communication and interaction between physicians and other practitioners, allowed the building of trust between professional groups, and supported the change in practices, as a physician pointed out:

> When we moved the diabetic lipid education over into our clinic, the number of referrals took off. . . . I originally envisioned that we didn't need to be under one roof, that we would actually virtually communicate if we had the appropriate computerization. But I've changed my mind and I believe that passing each other in the hall and saying, "Oh by the way," has made a big difference to the amount of communication and the feeling about working collegially.

Studies on the arrangement of physical space in organizations shed light on the dynamics in the case. Hatch and Cuncliffe stated that the "physical marking of group boundaries is associated with strong group identity in organizations" (2006: 243). In the present case, colocation removed physical boundaries that separated the groups and allowed interaction, engendered trust, and enhanced physician willingness to refer patients to other practitioners, who became participants in patient care, sharing in the roles reserved for physicians prior to colocation.

Team structures and mechanisms. Other organization-level elements that facilitated the physician role change were team structures and mechanisms. We recognize that a more detailed model could be constructed with inclusion of a fourth level—the group level. However, to simplify our model and presentation, we included teams acting at the organizational level under *organizational dynamics.*

We also realize that several organizational (and group) dynamics are intertwined with individual dynamics. Classifying some influences as either *organizational* or *individual* involves a certain level of arbitrariness, as is often the case in classifications.

With the approval of the RHA, an integration team and several thematic teams were set up to facilitate integration of services. This occurred in an institutional environment in which health care reform reports were advocating integration, coordination, and delivery of services by multidisciplinary teams. The integration team brought together representatives from the RHA, the physicians, and other professional groups, and oversaw and directed the entire project. The project coordinator indicated that the integration team vetted such issues as the thematic integrative programs (well baby, asthma, and hypertension) that would be put in place and helped "identify the stakeholders who should be on the [thematic] teams."

Physicians played a key role in the decisions of the integration team and led one or more of the thematic teams that were set up. The thematic teams worked out the finer details of the integration and set policies related to team functioning and protocols regarding the role of each team member (physician, respiratory technician, nurse practitioner, etc.) Issues that the thematic teams could not resolve were referred to the integration team. Its structure and processes enabled physician role change as representatives with the power to approve or reject decisions were members of the team; their decisions were thus seen as granting legitimacy to proceed with different practitioners' role changes. The thematic teams also enabled physician role change by bringing together members involved in the change to agree on how roles would be reconstructed.

Team meetings served as a mechanism whereby representatives of the different professional groups could negotiate how roles would be redefined in the integrative environment:

> Physician: Well Baby Clinic is a nice example of that. It used to be that I talked to the moms about breast feeding and I did the exam and all of that stuff. And the same with the public health nurse. . . . I think it was tough for both parties, both the public health nurses and the doctors because we asked them to stop doing the exams. And they asked us to stop talking about breast feeding and doing those kinds of things.
>
> Interviewer: How did you reach an agreement as to who does what?
>
> Physician: We pretty up front said, "Let's list the things I do and the things that you do, and those that are duplicated, let's negotiate who does it." So it was clearly a sit-down negotiation.

Studies indicate that "the phenomenon of the team is replete with struggles over professional claims" that prevail during negotiations (Bucher & Stelling, 1969: 6) and that professional groups often attain power by taking it away from other groups (Abbott, 1988). A number of factors help explain why role boundary negotiations did not appear to be particularly contentious in this case. First, the physicians reconstructed their role in such a way as to allow for an enhanced scope of practice and a higher level of accountability for other occupational groups. No power was taken away from those groups. Rather, by widening the range of services provided to patients, the different occupational groups attained satisfactory scopes of practice, which made the change in the physician role a noncontentious issue. Moreover, because the physicians headed the thematic teams and played a major role in the integration team, no decision was made without their approval. Their position at the top of the institutionally sanctioned power hierarchy (Scott & Backman, 1990) relative to the occupational groups represented during the negotiations was not contested.

Figure 1 shows that adherence to the power relations prescribed by established templates enabled team structures and mechanisms. It also shows that the RHA and new templates that focused on integration and multidisciplinary team delivery of services enabled the team structures and mechanisms. In brief, institution-level elements enabled changes in organization-level elements (incentive systems, physical colocation, and team structures and mechanisms) and, in turn, the organization-level elements facilitated the new behaviors and interactions (microlevel elements) that aligned with the new professional model.

Individual Dynamics

Microdynamics involving interpretation, action, and interaction influenced the reconstruction of professional role identity. Some dynamics were intertwined with each other or with forces at the institutional or organizational level. Note that we considered different strategies for organizing the microdynamics that follow, including (1) presenting them according to the sequence in which they occurred and (2) categorizing them as involving either meanings or actions. However, as several of these dynamics took place simultaneously and

most of the dynamics had both meaning and action components, it became apparent that such categorizations would impose artificial distinctions that the data did not bear out. Note as well that the dynamics classified as *individual* can have a *group* component and can refer to individual action and interpretation in the context of a work/professional group, whose members may have had similar experiences and/or acted collectively.

Personal life changes and search for more satisfactory roles. The older physicians mentioned an individual-level dynamic that appeared to be a significant enabler of the reconstruction of professional role identity. They referred to personal life changes, such as aging, that had accompanied shifts in their views of the meaning and value of work. They also mentioned identification with older patients. As the following quotations from two of the older physicians indicate, personal life changes were intertwined with changes in professional role identities:

> At the time I was clearly earning money to support my family, but now I don't care about the money any more. This is about professional satisfaction. . . . This is not a job, it's a way of life I guess, a cause, a vocation. . . . That financial aspect of doing the work is not good enough.

> I've got more difficult patients that I'm dealing with now. I'm trying to sort out more difficult problems with them. That could be a function of myself getting older. Sometimes your patients get older with you and your patients start to get more complex. . . . Since the Project started, I noticed I've been working longer with more difficult patients.

Among the younger physicians in the group, there was anticipation that embarking on the change would result in better-quality care for patients and higher satisfaction for the practitioners. The youngest physician, who had joined the clinic a few months after the start of the project, anticipated achieving "rewards that come from being able to practice your job in a more holistic way." This physician also indicated working harder than ever before because of enjoyment of the work and stated that his role as a team member had "grown tremendously." Physicians from different career stage groups commented on the coming together of all physicians in the clinic to bring about the changes. An older physician pointed out, "We have a very cooperative group," and a midcareer physician said, "We kind of all work together already. And that sort of familiarity with one another helped" (in the sense that there was agreement among the physicians, as a work group, to undertake the changes).

In their study, Pratt and his colleagues (2006) found that resident physicians, who were in the initial stages of their professional careers, had little discretion in reformulating their work roles. The authors predicted that more discretion gained through experience or expertise would enable role changes. Our study indicates that changes in professional roles are facilitated not only by a higher level of work experience, but also by life experiences and personal maturity. Researchers have indicated that life influences external to the workplace—such as aging or a midlife crisis—may affect individuals' motivations for seeking role changes (Ashforth & Saks, 1995; Nicholson, 1984). Hall (1986) indicated that a change in a person due, for example, to an increased awareness of values and interests influences role changes in the individual's later career, when he or she confronts "such identity issues as, 'What do I want to do with the rest of my life?'" (Hall, 1986: 131). Hall further noted, "Thus, in midcareer, career transitions and life event changes become increasingly interconnected" (1986: 135). Nevertheless, the search for more satisfactory roles was not limited to the older physicians. For the younger physicians, the enactment of a reconstructed role provided the opportunity to offer better service and to achieve more professional satisfaction.

Thus, studies have addressed how personal life changes or career stages and role identity reconstruction are interrelated. However, the impact of the institutional environment surrounding these elements is often absent from such studies. Research on role reconstruction in professional fields would require attention to institutional forces and, more specifically, to the templates considered legitimate, and thus available, for individuals seeking role reconstruction. Templates provide interpretive resources to professionals seeking role reconstruction and, as such, both enable and constrain reconstruction. Had the professionals in our study been operating in a more stable and homogeneous institutional context, their ability to seek innovative roles could have been more limited.

In essence, what happened in the setting we studied was a conjunction between personal changes and the prevalence of several other institutional, organizational, and individual dynamics that interacted in positive ways, enabling the reconstruction of professional role identity. No less significant than the physicians' life changes and dissatisfaction was their construction of an ideal identity that was partly influenced by such changes

(as demonstrated in Figure 1). We pursue this issue next.

Construction of an ideal identity. Physicians pointed to dissatisfaction with the enactment of traditional roles focused on piecemeal treatment and high-volume practice, and a motivation to explore other models. However, although they had embraced the concepts of integration, holistic care, and prevention in principle, the initial vision they had for the project and for their role was not clear, as one physician outlined:

> That's one of the things about this project that's been perhaps the most difficult. . . . [Physicians have concerns around] "What does this team do? What do I do? What if [patients] are given information that's different to the information I've given them?" I think that to have a more detailed theoretical model that could answer those questions and express things more explicitly may be the most valuable thing we could do now. And then based on that, you need to have a few people that do it and they could provide the working model for others.

Research shows that the ability to observe role models allows professionals in role transitions to identify potential identities and to build a repertoire of tacit knowledge, routines, and attitudes that they can use in adapting to a new role (Ibarra, 1999). The physicians did not have role models they could observe and thus faced difficulties in reconstructing their role. In one of the meetings held early in the project and attended by physicians and other participants, we observed that the discussion turned to the definitions and boundaries of different practitioners' roles. A participant said, "No one has seen the bigger picture of the puzzle to be able to put it together." To this, another participant responded that "the analogy should be more like a pile of blocks" that the practitioners themselves could arrange. During interviews, the physicians indicated that not having a clear role template, although a challenge, was also an opportunity in the sense that they were not constrained by a specific model and thus had the freedom to tailor the changes to suit their community's needs. They made numerous references to "innovations" that they were incorporating into their roles.

Ashforth wrote that disappointments and external and internal changes may trigger doubts about the viability of role occupancy, leading an individual to seek and weigh alternatives and possibly to identify with favored prospects (2001: 14) in such a way that an ideal identity is elaborated. The discrepancy between an ideal and a current identity can motivate change (Markus & Nurius, 1986; Pratt, 2000). In the present case, the ideal identity the physicians visualized, although not fully elaborated, centered on integration, wellness, and comprehensive care, which were themes gaining prominence in the health care field. Thus, themes beyond individuals and their organizational situations affect the content of ideal identities. Despite the wide range of themes that are potentially available for inclusion in role reconstruction, the themes professionals take into account are likely to be constrained by what is considered legitimate in their institutional environment. Figure 1 shows the links between alternative templates at the macro level and the ideal identity at the micro level.

Framing the role change. The physicians indicated that the difficulties they faced consisted not only of finding new ways to perform their role, but also of giving up aspects of their old role that they deemed to be important. As one physician stated:

> I had problems giving up management of the illness [and] allowing, say, a nurse to manage the insulin adjustment [for patients], but now have allowed the diabetic nurse to do those things. . . . The nurses have more of a role in the management. They have more accountability too. But I think the ultimate responsibility for the patient is still with the physicians.

Some of the changes introduced produced a perception that the physician-patient relationship was being compromised by delegation to other practitioners. Having control over patient treatment was a significant aspect of their professional role that physicians found difficult to divest:

> My ability to maintain control, I felt that would be eroded. . . . If you really do care about the outcome for your patients, you want them to take your advice regarding treatment. . . . This asthma clinic situation has actually increased my sense of influence, because of having other people reinforce the messages. . . . Now my influence has increased by the power of two. . . . And so the experience has been one of me feeling much more capable.

A number of dynamics are worth noting here. First, physician role reconstruction was associated with reframing. Frames are templates for understanding and interpreting issues (Weick, 1995). Second, reframing incorporated both change and continuity in the definition of professional roles. Third, as they reframed their roles, physicians drew on new and old themes prevalent in their institutional environment. Although some work on framing and role identities has appeared in the literature (e.g., Ashforth & Kreiner, 1999), research on role change has not paid sufficient attention to the language role incumbents use to frame changes.

Physician control over patient care was a central theme in defining the physician role. This was evident not only in the physician quotations about their professional socialization and experience, but also in the medical professional association discourses that, despite promoting change, upheld the importance of maintaining physician autonomy and central authority over patient care. It was thus not surprising that physicians indicated finding it difficult to give up or to share some aspects of patient care with other providers. However, the data showed that the physicians, who expressed initial concern about the loss of control over patient relationships, reframed control as the ability to influence health outcomes, as the quotation above indicates. They viewed their influence as increasing, since the message they gave patients was reinforced by other members of the team. In fact, nowhere did the physicians mention giving up control over patient relationships. Research indicates that continuity in some aspects of identity facilitates change in other aspects of identity and that framing allows the establishment of continuity (Chreim, 2002; Pondy & Huff, 1985). Furthermore, the physicians stated that by giving up routine components of their role and by having other practitioners reinforce the education aspects of patient care, they reaped two rewards. First, they freed up time for dealing with "complex problems" where their expertise was needed, and second, they allowed the patients to receive better education, since other practitioners were highly adept at this task. Physicians maintained an attractive role identity rooted in their ability to deal with complexity and their desire to provide the best care for patients.

In another vein, extant research on framing has given insufficient attention to institutional context. Analysis of the frames used by physicians demonstrates the impact of institutional templates on role reconstruction. The changes in the professional role of physicians were enabled by alternative discourses focused on delegation and integration that were gaining legitimacy in their institutional environment. However, the traditional discourses emphasizing physician control over patient care constrained these changes. By incorporating both continuity and change in the frames they used to understand and present their reconstructed role, the physicians discursively managed the tensions between the old and the new templates. Figure 1 shows that both established and alternative templates influenced the framing of role changes.

Figure 1 also shows that patterns of action and interaction impacted framing, which was affected not only by the interpretive resources available in the environment but also by the experiences, actions, and interactions of those doing the framing (Weick, 1995). Thus, for example, by delegating responsibilities and reaping the rewards of delegation, physicians were able to reframe this activity—previously seen as detracting from quality patient care—as enhancing patient care.

Actions and interactions. Several actions and interactions involving the physicians enabled professional role change. These included physician initiation of and control over the content and process of role change, the building of trust, physician exposure to other perspectives, and confirmation of the role change by members of the physician role set.

The physicians pointed out as role change enablers their own initiation of the change and their presenting a united front (overall agreement with the change) in negotiations with the funding and governing bodies and the other occupational groups. Other participants were of the same view but added another enabler: the fact that the physicians maintained control over the process of change. As a project participant pointed out, the physicians had "more autonomy in the pace of the change" than other practitioners.

Because a physician was assigned to head each of the thematic teams and because decisions involving a change in physician practice required physician acceptance, the power of the physicians remained unchallenged for the most part. The other groups' members recognized that for integration to occur, physicians had to be satisfied with the process and outcome. Other practitioners made efforts to accommodate the needs expressed by physicians. For example, in one meeting held to discuss integration of well baby activities involving the physicians and the public health nurses, the issue of location—at the physician clinic or the public health building—arose. It appeared that colocation would involve inconvenience for both groups, yet the public health nurses agreed to move their well baby activities to the physician clinic to allow for the least inconvenience to the physicians. The general tendency was for practitioners to defer to physicians on issues that seemed of importance to the latter.

Participants also mentioned that meetings and frequent interactions between the physicians and other occupational group members led to better understanding and trust among the groups and facilitated physician delegation of tasks. As a health specialist pointed out:

> [Doctors view these asthma] programs as black holes that suck up patients—everything goes in, nothing

> comes back. . . . So we had to work with them to prove to them like, "Look, we're not here to take control or to take management away." . . . They started seeing patients coming back [and] saying, "That was really good. I never knew this. . . ." And I think over time, it was just kind of a trust building thing. So they knew the program wasn't about taking control.

In an integration meeting where physicians and public health nurses exchanged information on each group's well baby exam schedule, a physician noted that the physician schedule was "based on habit," whereas the public health schedule was "based on best practice guidelines." The physicians then agreed to adopt the well baby exam schedule that the public health nurses used. Intensive interactions with occupational groups who approached patient health from different perspectives exposed the physicians to alternative practices, leading them to examine some of their own practices and decisions. Of importance is the fact that these practitioners did not passively observe physician role change but attempted to influence physicians in subtle ways, such as by bringing authoritative publications on clinical guidelines to their attention. A nurse pointed out:

> We brought it to the physicians and said, "These are what the clinical practice guidelines say around this stuff." . . . It brought a lot of conversation around, "Gee, do you do that in your practice?" . . . They started to actually examine some of their own practice. . . . So it started raising the level of awareness, and usage of some of those guidelines.

Furthermore, the physicians experienced confirmation of changes in their role from significant members of their role set, including other practitioners and patients. A physician stated:

> As a physician, I feel much more part of the team and I feel that feedback from other [practitioners]. . . . The nurses are starting to approach me with more confidence. At two o'clock in the morning a nurse phoned and presented extremely well where she felt that I should take over. And I said, "You've done so well, . . . what would you do now?" She said, "I would do this." So I think there's been a shift in responsibility. And I think she never would have said that a year ago, never would have approached me the way she had. And I never would have responded the way I had.

In later meetings, testimonials from the physicians indicated that patients had mentioned that they valued the changes in physician practice, that they were getting better health services, and that they were better informed about their conditions. Members of other occupational groups and administrators also mentioned changes in physicians' role enactment, noting that the physicians had progressively adopted new practices and norms gaining prominence in the health care field. A nurse said:

> We're more of a team now. Because it's multidisciplinary. . . . It's better because the public can now access health care other than through a doctor [such as through] a diabetes educator. Before you couldn't do anything without going through the docs. . . . I'm learning at university all about integration. . . . And I'm thinking this is where we need to be going.

Research on physician reaction to changes has produced findings—unlike those in our case—that indicate physicians resist changes in their professional roles (Kitchener, 1999; Reay & Hinings, 2005). These divergent findings can be explained in terms of agency. Kitchener, and Reay and Hinings, studied changes that organizational administrators and government officials initiated and imposed on physicians. In our case, the physicians' initiation of the change and their maintenance of power and control over its process and content facilitated the reconstruction of their role. Our findings suggest that the agency of the professionals involved—and particularly agents' presenting a united front—is a stronger enabler of role reconstruction than is the imposition of a change by institutional actors. Furthermore, Nicholson (1984), who focused on the individual level of analysis, indicated that an incumbent's discretion facilitates a change in role; the typical dimensions of such discretion include the capacity to choose goals and means. Research on discretion is limited; Nicholson wrote, however, that discretion appears to be related to occupational status. In fact, institutional theory helps shed light on one determinant of level of discretion. Physicians occupy a high position in an established, institutionally sanctioned hierarchy of occupations in the health care field (Scott & Backman, 1990). The physicians in our case were capable of exercising their power, and thus a high level of discretion, because the members of other occupational groups, who were seen as occupying lower positions in the established institutional hierarchy, deferred to them. (Figure 1 shows the influence of established templates on actions and interactions.)

With respect to physicians' examination and revision of their practices and role performances, here again bridging between formulations of deinstitutionalization and formulations of individual change is fruitful. Oliver (1992), who focused on deinstitutionalization, stated that new members bring interpretive frameworks that differ from ex-

isting ones, fostering diminished adherence to taken-for-granted practices. Schein (1996), who discussed individual-level change, stated that dissatisfaction with the status quo deriving from disconfirming information triggers "cognitive redefinition." Here, interacting with practitioners with different outlooks helped raise physician awareness of alternative views of health care and of different ways to perform their roles. Thus, an organizational context that enables the coming together of perspectives from various occupational or institutional fields may facilitate individual cognitive redefinition and role reconstruction.

As to confirmation of the physician role identity change, the literature indicates that such change is not likely to last if role set members do not affirm the enactment of the identity (Ashforth, 2001; Ibarra, 1999; Pratt et al., 2006). As members of a role set treat an individual as an exemplar of a role, they help validate the new identity (Ashforth & Humphrey, 1993). Interactions and role set member confirmation are closely related (as is demonstrated in Figure 1). Nevertheless, validation of professional role enactment is, again, an issue embedded in an institutional context. For the other occupational groups, validation of the reconstructed role followed in part from the fact that the physicians had adopted new norms and practices that were gaining legitimacy in the institutional health care environment. Figure 1 shows the influence of alternative templates on confirmation by members of the role set. It also shows the influence of these templates on actions and interactions that put into practice the emerging themes of integration and coordination of services provided by different practitioners.

In brief, researchers have indicated that studies of institutional models do not place sufficient emphasis on agents' actions, interpretations, and interactions and on how these dynamics help change existing models (Zilber, 2002). Similarly, the literature on professional role change has placed little emphasis on the institutional elements that influence such change. However, as we have shown, crossing levels of analysis provides a better understanding of the dynamics that influence professional role identity reconstruction. In our analysis, we focused mainly on the impact of the macrodynamics of institutional and organizational forces on micro dynamics. Although this study was not designed to elaborate on how the microdynamics might influence the macro elements, the data from time 3 do suggest that there is diffusion to the wider context.

Developments beyond Time 2

At time 3, a year after the pilot project had officially ended, the changes in the health unit were no longer referred to as "the project." The data gathered at time 3 indicated that further changes had occurred in the institutional environment and the organization and that the changes in professional role identity observed at time 2 were solidly established. At an institutional level, there was evidence of further deinstitutionalization, as the alternative templates were becoming more prominent, given their endorsement by various funding and governing bodies. The provincial government was making more financial resources available for integrative projects, and the medical professional association was becoming more supportive of alternative payment plans based on capitation for physicians. Several of these plans were being negotiated in the province. Further, the RHA was focusing more strongly on prevention- and wellness-based programs involving the cooperation of different practitioners. These programs were being elaborated throughout the region under a program titled "Building Healthy Lifestyles." The coordinator of the project we studied, who was given the position of coordinator of the regional healthy lifestyles program, indicated that what was learned in the project was being used as a platform for developing integrative programs throughout the region. Further, by time 3, one of the project physicians had assumed a senior position in a nationwide physician association that elaborates policy at the level of accrediting university programs and organizing for continuing professional development. This physician frequently spoke nationally about experiences in the project. The participation of previous project members in regional and national programs and associations allowed the diffusion of ideas about the potential process and the outcome of professional role changes (and thus, the dotted line in Figure 1 from the reconstruction of physician role identity to the alternative templates).

From an organizational (physician clinic) perspective, additional integrative programs were being elaborated involving members from a widening range of occupational groups. Moreover, when asked about their roles at time 3, the physicians we studied reiterated the change themes that appeared at time 2, as is shown in Table 3. The second quotation at the beginning of this article also illustrates this reiteration. The physicians and other practitioners saw the changes in their outlook on patient care and relationships with other occupational groups as enduring; as one physician said, "I don't see us going back to the way we were."

IMPLICATIONS AND CONCLUSION

The purpose of this study was to extend theory on the reconstruction of professional role identity by attending to the influence of institutional forces and by building bridges across the institutional, organizational, and individual levels of analysis. Studies of professional identity construction generally focus on microdynamics within organizational contexts and pay little attention to the role of the institutional environment surrounding those organizational contexts. Yet as Stryker and Serpe (1982) noted, whether roles are made or played depends on the larger forces and structures in which interactions are situated. Our findings indicate that institutional forces influenced professional role identity reconstruction through two paths: a direct path, along which the institutional environment of the clinic we studied provided interpretive, legitimating, and material resources that agents adopted and adapted in the reconstruction of their professional role identity; and an indirect path, along which institutional dynamics enabled organization-level structures and mechanisms that further influenced agency at the micro level.

Our case provides clear evidence of the duality of structure and agency (Giddens, 1984) in the reconstruction of professional role identity. The prevalence of traditional templates and the rise of alternative templates in an institutional environment create complexity, providing a wide variety of building blocks that the professionals in the field can assemble (Scott, 1994). A complex context is conducive to the exercise of agency. The Canadian health care field had a dominant physician role template focused on autonomy and treatment of disease, but also offered alternative discourses focused on integration and wellness. The physicians adopted and adapted these alternative themes as they reconstructed their roles, and so did the other practitioners who interacted with the physicians. Although offering the opportunity for the exercise of some discretion and choice, this environment also limited the range of role reconstruction possibilities considered legitimate. The combination of structure and agency in the reconstruction of professional roles varies in different contexts, as we will discuss later. We now turn to some of the major findings of this study, its contributions, and directions for future studies.

The study adds to micro conceptualizations of role identity construction. Microlevel research portrays role innovation as enabled by the discretion of role incumbents. Our findings indicate that the physicians' discretion emanated in part from institutional templates that defined the hierarchy of professional groups in health care and positioned physicians at the top of this hierarchy. Future research on role incumbents' discretion would benefit from attention to the institutional influences on level of discretion.

The study also draws attention to the importance of framing in professional role identity reconstruction and to the impact of an institutional environment on framing. Understanding how framing enables professional role identity reconstruction requires going beyond individual and organizational situations. Research would benefit from attention to the range of interpretive resources available in an institutional environment. Our findings indicate that physicians' framing of their reconstructed roles was associated with (1) alternative institutional discourses that enabled the employment of a change frame, and (2) traditional institutional discourses that fostered the employment of a continuity frame. Local interpretations of professional role identity changes derive in part from the institutional environment surrounding the changes.

The findings also point to the interrelations between organizational systems/structures and their institutional environment on the one hand, and microlevel actions and interactions enabling the reconstruction of role identity on the other hand. Past studies have attended to the impact of organizational context on role identity construction but have not given enough attention to the relation between institutional environment and organizational context. Future studies on role identity change may benefit from attention to how organizational changes that have an impact on role boundaries and role enactment are themselves facilitated by extraorganizational forces. Further, attention should also be given to how professionals' microlevel agency pulls discriminately from their institutional environment those resources that enable the construction of locally desired organizational structures and systems, which further facilitate role changes.

Our model also tentatively suggests that a focus on microlevel phenomena can illuminate the factors that influence actors to engage in entrepreneurial activities in institutional environments. In our study, personal life changes and dissatisfaction among the physicians motivated the search for more meaningful roles. When institutional theory attends to agency, it generally neglects meanings and interpretations of agents and focuses instead on actions of centrally located actors in institutional fields (Zilber, 2002). By moving the analytical lens to the meanings and experiences of agents, researchers can shed light on micro influences that enable change in established templates. Projecting

from the findings of our study, we suggest that a line of research that might enrich macrolevel theory would be analysis of the subjective experiences, interpretations, and motivations of individuals who act as institutional entrepreneurs and help destabilize the templates that prevail in institutional fields.

Another fruitful research avenue that incorporates the influence of microdynamics on macro elements would be to explore how a role change initiated by an actor (a microlevel dynamic) at a given organizational site may lead to change in the roles of other actors in the role set present at the site and the impact that such movements have on the prevailing overall organizational structure (a macrolevel element). Since role identity is relational (Ashforth, 2001; Stets & Burke, 2003; Stryker & Statham, 1985), one would expect that reconstruction of one role would lead to changes in other roles within a set. In our study, the physicians were the key drivers of the changes in their role; however, other actors who were partners in the changes aided them. The members of other occupational groups, such as the nurse practitioner, public health nurses, respiratory technicians, and others, assumed bigger roles in patient care and more accountability for patient health. Similarly, the increased focus on teaching and prevention was likely to impact patient role identity, as patients became more informed about their medical conditions and more capable of managing those conditions themselves. Such role reconstructions may contribute to substantial changes at the organizational level and, if diffused more widely, in the institutional order.

The study has a number of practical implications. Pressures for change in the health care system are strong, as are the pressures for professional groups operating in this system to change their practices and roles in order to provide more effective and efficient services. Understanding the dynamics that enable such change in practice is important. We show that, in contrast to changes in professional practice imposed by institutional actors, changes initiated by those whose practice is affected have a higher probability of success. This evidence does not, however, negate the role that institutional actors, such as professional associations and governments, can play in a change. Institution-level actors can facilitate microlevel changes by sanctioning role changes, redefining professional boundaries, reconfiguring incentive systems, and providing material resources. Ideally, such actors need to create a context that fosters initiative and buy-in from those occupational groups that need to change their practices. Careful attention by institutional actors to the impact of public policy on microlevel practices is needed.

Furthermore, the health care sector is a complex system involving delivery of services by multiple occupational groups. There needs to be recognition that a change in the role of one group affects the roles of other groups. Professional associations are protective of the rights and powers of their members. Associations speaking on behalf of professionals generally resist role changes that reduce the authority or power of those professionals. This means that those bodies (government agencies, professional associations) initiating a change that is likely to impact the authority and power of a certain group need to frame the change as providing more scope to the different parties, as opposed to taking scope away from a given party. Further, our findings indicate that physicians experienced some difficulties in divesting themselves of aspects of their roles ingrained through socialization processes. Thus, those who play a role in the socialization of professionals (e.g., professional associations, educational establishments) need to consider the issues those professionals face in changing work environments.

In conclusion, we would like to address the applicability of our findings to other cases or situations. Our study is based on one case. Although some may view this as a limitation impeding generalizability, it should be noted that naturalistic case studies should be judged not on the basis of generalizability, but on the basis of transferability and comparability (Denzin & Lincoln, 2000; LeCompte & Goetz, 1982; Lincoln & Guba, 1995, 2002). The aim is not to establish statistical generalization based on enumerating frequencies (Yin, 2003), but to determine whether "transference can take place between contexts A and B if B is sufficiently like A on those elements or factors or circumstances that the A inquiry found to be significant" (Lincoln & Guba, 2002: 207). We believe that the conceptual insights generated from our study apply to changes in the professional role identity of individuals who are in mid or late career stages and who operate at higher levels of the hierarchy in institutionalized fields such as accounting and law. Because we focused specifically on professionals in middle and late stages of their careers, some of the findings may not apply to entry-level professionals, who may have different motivations and experiences. In addition, since an individual's seniority in a highly institutionalized profession may be a determinant of her or his level of discretion, entry-level professionals may have limited control over the process and content of role changes, as Pratt and colleagues' (2006) study demonstrated. Fur-

thermore, the physicians we studied held a high position in an occupational hierarchy, which facilitated the exercise of a high level of control. It is likely that individuals in occupational groups that hold lower positions in an institutional hierarchy may resort to more subtle influence strategies in their attempts to reconstruct their roles, as a study by Reay, Golden-Biddle, and GermAnn (2006) suggested.

Moreover, the case we studied was situated in an institutional sector undergoing transition and characterized by the simultaneous presence of traditional and emerging templates. The physicians in our study availed themselves of emerging templates that were seen as granting professional and personal satisfaction, but professionals in more stable fields may face more restrictions when aiming for role reconstruction, as the institutional templates that define legitimate models of roles may be more restrictive than was the case in the field we studied. However, the evidence is that many professions are increasingly operating in turbulent, changing environments (Powell et al., 1999). This suggests that the findings from our study may be applicable to a wide range of professional fields.

We also believe that parts of our model are applicable to changes in work role identities in general (and not only to professional role identity reconstruction). For example, the macro organizational changes in physical structures, team mechanisms, and reward systems enabled micro changes in the patterns of interactions. It is conceivable that similar changes pursued by participants at other work sites might prompt individuals to question and redefine work role boundaries. Similarly, our findings indicate that reframing role changes enables role identity reconstruction and that such reframing is not entirely generated at a micro level, but is affected by discourses in the prevailing macro environment. Discursive studies have repeatedly demonstrated that the themes that permeate organizational discourse reflect, at least in part, the themes in the wider environment (Chreim, 2006), such as the themes of quality service, diversity, and social responsibility. Future studies may benefit from extending such findings to the realm of work role identity construction and reconstruction.

Finally, as we have repeatedly demonstrated throughout this study, crossing levels of analysis enables richer conceptualizations of phenomena of interest to students of organizations. We believe that it is through moving between levels of analysis that the next important steps in management research will be taken.

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