

How Idealized Professional Identities Can Persist through Client Interactions

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Abstract

How can a professional identity persist when it is mismatched with the reality of work demands in one's first job? Existing theory suggests that new members of a profession should adapt their identities to align with their profession's and organization's goals. Using data from an ethnographic study of first-time hospital nurses, I develop the concept of *idealized professional identities*—identities rooted in the image and history of an occupation rather than in reality—and depict how these identities can persist through client interactions despite negative consequences. When left unchecked under the increasingly common conditions of weak on-the-job socialization, nurses in my study with idealized identities infantilized patients and purposefully avoided patients who denied their idealized identities even though these practices ran counter to the patient satisfaction and empowerment goals of the organization and nursing profession. The opportunity to enact cherished idealized identities with the few clients who granted them may have perpetuated these dynamics by supporting the retention of professionals who otherwise may have exited. This study suggests that socialization into a professional role may come not only from interactions with professional gatekeepers, peers, or organizational management but also from the internalization of idealized professional identities that may be kept alive through interactions with and about one's clients.

Keywords: occupations/professions, work, professional identity, hospitals and health care, mechanisms and processes, professional socialization, idealized identities, ethnography

New professionals often experience reality shock when their abstract professional identity expectations clash with modern work demands in their first jobs (Schein, 1971; Sorensen and Sorensen, 1974; Louis, 1980). Prior scholarship has suggested new professionals will likely shed unrealistic or romanticized professional identity expectations and adopt identities that align with goals espoused by their profession and that meet the demands of their work

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environments (Becker et al., 1961; Van Maanen, 1978; Pratt, Rockmann, and Kaufmann, 2006; Anteby, 2013). I find otherwise in my ethnographic study of first-time hospital nurses, which raises this question: how and when can a professional identity persist when it is mismatched with the goals of one's organization and modern profession? The perpetuation, rather than adaptation, of unsanctioned professional identities is critical to understand because it may result in the failure of organizations to achieve their aims or of professions to maintain their cultural legitimacy (Kellogg, 2012; Wright, Zammuto, and Liesch, 2017; Lifshitz-Assaf, 2018; Chan and Hedden, 2021).

Professional identities—self-defining beliefs, values, and assumptions about what it means to be a member of an occupational group—are central drivers of behavior at work (Van Maanen and Barley, 1984). Existing scholarship on professional socialization has suggested that identity-related expectations mismatched with work demands should trigger new professionals to resolve such “work-identity integrity violations” by adapting their identities to align with their work environments (Pratt, Rockmann, and Kaufmann, 2006; Ibarra and Barbulescu, 2010; Nelson and Irwin, 2013). This adaptation is largely expected to occur through on-the-job role modeling and mentorship from senior members of the profession (Bosk, 1979; Konner, 1988; Ibarra, 1999).

However, most of our theories of professional socialization were developed during the mid-twentieth century by studying members of a few elite professions, particularly physicians, who have unusually intensive apprenticeship socialization relative to the modal expert occupational group (Becker and Carper, 1956; Goode, 1957; Greenwood, 1957; Becker et al., 1961; Freidson, 1974; Bosk, 1979).¹ Forces of de-professionalization and the employment of professionals by bureaucratic organizations (Barley and Tolbert, 1991; Briscoe, 2006, 2007; Waring and Currie, 2009; Muzio, Aulakh, and Kirkpatrick, 2019) have reduced many professions' control over their new members' on-the-job socialization. For example, “[The formal apprenticeship] is all but dead in modern engineering” (Davis, Vinson, and Stevens, 2017: 2), as many new engineers go from college to first jobs without an apprenticeship (Wilson, 1965). New accountants and investment bankers now rarely start as protégé apprentices to senior professional partners in small firms and instead are often employed by a few large organizations (Covaleski et al., 1998; Anthony, 2021). Physician assistants and nurse practitioners, who are increasingly relied upon to deliver essential health care services, begin practicing without the residency apprenticeship that physicians experience (Rosoff, 1978). Many new architects and computer programmers bill clients on day one (Kowtha, 2008; Chappell and Willis, 2010). And teachers in popular programs like Teach for America are thrown into first jobs after only a brief crash course (Darling-Hammond et al., 2005).

The professions literature has acknowledged variation in the socialization experience of different occupational groups, as those previously labeled “semi-professions” or “para-professions” have shorter profession-controlled

¹ While early scholarship spent much ink defining what counts as a profession versus an occupation or semi-profession (Greenwood, 1957; Etzioni, 1969; Freidson, 1974), scholarship since Abbott's (1988) seminal work *The System of Professions* has supported an expanded focus to include those in any expert occupation that successfully lays claim to control a domain of work (e.g., Brint, 1994; Huising, 2015; Anteby, Chan, and DiBenigno, 2016; Karunakaran, 2022).

education, compared to elite professions (Etzioni, 1969; Elliott, 1972; Freidson, 1974). But even these studies do not fully reflect the new reality of weaker on-the-job professional socialization of those employed by bureaucratic organizations. We might therefore expect new professionals working in organizations to be vulnerable to organizational socialization efforts to shape their professional identities to support organizational goals (Van Maanen and Schein, 1979; Ashforth and Saks, 1996). However, organizations may be less likely to invest in costly training and socialization programs (Caldwell and Peters, 2018; Beane, 2019), given employment trends over time that see new hires less often remain at the organizations where they began their careers (Bidwell et al., 2013). An organization's managers may also be unaware of—or not incentivized to understand—the professional identity desires of entry-level hires who are often more easily replaceable; hence managers may not use their employees' professional identity desires as a form of organizational control (Anteby, 2008a, 2008b). Without lengthy profession-controlled apprenticeships or intensive organizational investment, the socialization of many new professionals today may be characterized as sink or swim: they are largely left on their own to adapt with less formal support from their profession or organization (Krause, 1999; Ashforth, 2000).

Reduced opportunities for intensive professional socialization may have an especially strong impact on newcomers in professions that are commonly idealized by aspiring members. Certain professions—e.g., firefighting, nursing, medicine, teaching, veterinary medicine, and military service—tend to be portrayed positively in popular culture, represented in children's literature, and listed as children's top occupational aspirations (Polavieja and Platt, 2014). These professions may thus be particularly likely to foster romanticized identity expectations that are out of sync with the current goals of organizations and professions.

In this article, I use data from an ethnographic study of first-time hospital nurses to demonstrate the importance and durability of *idealized professional identities*—identities rooted in an occupation's image and history rather than in reality—and depict how they can persist through interactions with and about one's clients even when those identities are mismatched with modern work demands. I show how, when they are left unchecked under the increasingly common conditions of weak on-the-job socialization from their profession and organization, newcomers with strong attachments to romanticized, identity-related dreams of who they will be as new professionals can find ways of enacting these unsanctioned identities in parts of their jobs in which they have greater discretion and relational opportunities to claim, and sometimes be granted, their desired identities. My study suggests that this enactment may occur during client interactions because clients are both a relatively captive audience, dependent on professionals' expertise and services, and are meaningful identity granters to professionals as beneficiaries of professionals' services. Since idealized identities exist outside the direct control of organizations or professions—in the cultural and historical image of an occupation—they may be especially durable even when their enactment results in negative consequences for the organization and its clients.

I develop a theoretical model depicting the process through which client interactions can perpetuate idealized professional identities, and I specify the conditions under which these identities ill-suited to modern work demands

may be most likely to persist. By tracing the origin of these identity claims to the idealized image of an occupation and unearthing the role of clients in enabling their enactment and persistence, this study advances our understanding of professional socialization in organizations. I suggest that socialization into a professional role may come not only from interactions with professional gatekeepers, peers, or organizational management but also from the internalization of an idealized professional identity that may be kept alive through interactions with and about one's clients. As more professionals' first job experiences are in organizations with sink or swim socialization, the clash between idealized professional identities and work reality may be increasingly prevalent and consequential.

PROFESSIONAL SOCIALIZATION IN ONE'S FIRST JOB

Theories of professional socialization suggest that when new professionals start their first jobs, they will shed unrealistic identity-related expectations under the watchful eye of senior members of the profession who oversee their ongoing education. These classic studies find that senior profession members exert strong normative and coercive controls to help first-time professionals craft identities consistent with their profession's aims and work demands (Becker et al., 1961; Bosk, 1979; Van Maanen and Barley, 1984; Konner, 1988).

While formal education in schools or academies is important for newcomers to master the knowledge base underlying a profession's exclusive claim to perform a domain of expert work (Abbott, 1988), one primarily develops and internalizes a professional identity when practicing the craft of one's profession, typically by modeling senior profession members during an apprenticeship period (Elliott, 1972; Riemer, 1977; Bosk, 1979; Konner, 1988; Ibarra, 1999). More-recent work by Pratt, Rockmann, and Kaufmann (2006) unpacks the process through which this professional identity development occurs during this apprenticeship phase of socialization, when new members update their fledgling identities to account for early violations of their expectations. For example, when surgical interns in the first year of their seven-year residency apprenticeships were confronted with low-status scut work, they incorporated this dirty work into their developing professional identities as being "the most complete doctors" (Pratt, Rockmann, and Kaufmann, 2006: 247). Profession members are largely expected to revise self-narratives about who they are to adapt to changes in their work environments that are endorsed by their profession (e.g., Jain, George, and Maltarich, 2009; Ibarra and Barbulescu, 2010; Nelson and Irwin, 2013; Noordegraaf, 2015; Bévort and Suddaby, 2016).

Professions' Waning Influence over the On-the-Job Socialization of Their Members

The professions literature has made great strides in explicating how new professionals develop identities that meet the demands of their work environment while upholding their profession's core values through intensive apprenticeship-based education. However, most theories of professional socialization were developed during the golden age of the mid-twentieth century, when professions had unparalleled cultural legitimacy and control over their work (Brint, 1994; Gorman and Sandefur, 2011). Since then, multiple forces

have reduced professions' control over their work and members, including declining trust in experts, increased competition from new technology, more state-level oversight, and greater bureaucratic control over professions from employment in organizations (Krause, 1999; Susskind and Susskind, 2015; Eyal, 2019; Muzio, Aulakh, and Kirkpatrick, 2019; Galperin, 2020). There is also a wider array of occupations claiming professional status, as today nearly one-third of occupations require a professional certification, compared with 5 percent in 1950 (Kleiner and Krueger, 2010). Extant scholarship on professional socialization has not yet fully accounted for the experience of this broader range of expert occupational groups with weaker socialization, compared to elite professionals like physicians. And even in classic professions such as engineering, accounting, and architecture, apprenticeship socialization is waning (Covaleski et al., 1998; Chappell and Willis, 2010; Davis, Vinson, and Stevens, 2017), such that our theories may be in critical need of updating.

Most professionals today work under the bureaucratic control of organizations (Alvesson and Willmott, 2002; Briscoe, 2006, 2007; Gorman and Vallas, 2020; Anteby and Holm, 2021), and the profession-controlled apprenticeship model is becoming rarer (Bailey and Barley, 2011). This change suggests that organizations may play a more prominent role in socializing new professionals. Since organizational and professional goals do not always align (Battilana and Dorado, 2010; Turco, 2012; Besharov, 2014; Huising, 2014; Truelove and Kellogg, 2016; DiBenigno, 2018, 2020), organizations may be motivated to ensure that new professionals adopt identities supporting their goals (Alvesson and Willmott, 2002; Chreim, Williams, and Hinings, 2007). Organizations have a host of tactics to shape newcomers into the people they need them to be (Allen and Meyer, 1990; Cable and Parsons, 2001), from formal onboarding to offering recreation opportunities at work that encourage employees to work long hours (Van Maanen, 1991; Michel, 2011). Organizations even seek to shape new members' inner emotional worlds to align with organizational goals by prescribing not only what they should do but also how they should feel to promote deep (versus surface-level) acting (Hochschild, 1983; Van Maanen and Kunda, 1989).

At the same time, scholars have noticed a decline in organizational investment in employees' training and development given the withering of internal labor markets, as new hires today are less likely to spend their careers with their first organization (Bidwell et al., 2013; Beane, 2019). Organizations may hesitate to invest in costly and lengthy training programs as they seek to extract as much productivity as possible from new hires from the start (Caldwell and Peters, 2018). Organizational managers may also be unaware of the unique identity-related desires of the professionals they hire (Turco, 2012; DiBenigno and Kerrissey, 2020) or unmotivated to attend to them, even though doing so can be an effective means of organizational control (Anteby, 2008a).

Idealized Professional Identities and Occasions for Their Enactment with Clients

Not every new professional enters their first job with an attachment to a romanticized vision of who they will be as a professional (e.g., Schabram and Maitlis, 2017). Some may choose their profession for instrumental reasons, while others' choices may be intermeshed with identity-related dreams of who

they will be and how they will be treated (Wrzesniewski et al., 1997; Cho and Jiang, 2021). Occupations that top children's lists of who to be when they grow up may be especially likely to foster romanticized professional identity-related aspirations and fantasies. Public and client service occupations, such as firefighting, medicine, nursing, teaching, policing, and military service (Polavieja and Platt, 2014), often top such lists and are frequently depicted in children's literature and popular culture.

While not examined by scholarship on professional socialization, imagined, fantasy-based, and desired-but-not-pursued forgone identities may exert a powerful hold over behavior (Markus and Nurius, 1986; Berg, Grant, and Johnson, 2010). For instance, Obodaru (2017) found that those who dreamed of working in one occupation but ended up in another, such as an accountant who wanted to be a musician, reportedly found ways of enacting these forgone identities in their work. When a child commits to a profession before experiencing the work, their expected professional identity is by necessity shaped by their imagination and developed through exposure to media, popular culture, family member accounts, and myths rather than direct experience (Polavieja and Platt, 2014).

Savvy managers might use knowledge of new professionals' identity desires as a form of organizational control, as depicted in Anteby (2008a, 2008b) when supervisors at an aeronautic plant selectively turned a blind eye to "good workers'" illegal production of "homers" at work—items made for their personal use—that allowed them to enact their desired master craftsmen identities. However, in Anteby's study, the organization depended on this group of experienced, unionized experts who could disrupt the plant's production schedule. Many organizations may not be as concerned with—or may be unaware of—the identity desires of more easily replaceable entry-level professionals, especially in organizations that employ members of many occupations with differing identity expectations. For new professionals without the close oversight of senior profession members to disabuse them of romanticized expectations or savvy managers able to use these identity desires as a form of control, such identities may be at risk of surfacing in the parts of the job in which professionals have both the discretion and relational opportunities to claim and be granted their desired identities.

While entry-level professionals rarely have much power over their working conditions, those who serve clients may have more discretion during one-on-one client interactions (Lipsky, 1983; Maynard-Moody and Musheno, 2003; Huising, 2015; Jiang, 2021). Since identities are inherently relational—one cannot claim an identity without it also being granted by an interactional partner (Mead, 1934; Bartel and Dutton, 2002; White, 2008; Chreim et al., 2020)—client interactions may provide opportunities for even entry-level professionals to enact desired professional identities (Vough et al., 2013; Cardador and Pratt, 2018). Literature on street-level bureaucrats and client labeling suggests that front-line employees can use their discretion to treat clients differentially (Roth, 1972; Lorber, 1975; Van Maanen, 1978; Lipsky, 1983; Maynard-Moody and Musheno, 2003; Canales and Greenberg, 2016). Opportunities for enacting cherished idealized identities with clients may even encourage new professionals to endure objectionable conditions that otherwise may have precipitated their exit from the organization and profession.

I build on these ideas to develop the concept of *idealized professional identities*—identities rooted in an occupation's image and history rather than reality. I develop grounded theory depicting how client interactions can provide the opportunity for such identities mismatched with modern work demands to be enacted and persist, despite countering the goals of one's organization and profession, and I identify enabling conditions under which these dynamics may be most likely to occur.

METHODS

Data Collection

The primary sources of data I collected were observations and interviews with nursing staff over a 12-month period on two medical-surgical units within the same large nonprofit teaching hospital in the northeastern United States. Medical-surgical units provide generalist training and are sites of one of the most common but notoriously challenging first jobs in the nursing profession (Bowles and Candela, 2005). These units served adult patients from all backgrounds and ages with a wide range of health conditions. These units provided an ideal setting to examine professionals adjusting to their first jobs with relatively weak professional socialization from both their profession and organization.

The prevalence of a sink or swim and "eating our young" approach to the socialization of new nurses is widely documented (e.g., Caristo and Clements, 2019: 45; Darbyshire, Thompson, and Watson, 2019) in a profession that decades ago shuttered its hospital-based apprenticeship nursing training programs in favor of theory-based, four-year baccalaureate degrees (e.g., Goode et al., 2001; Currie, Finn, and Martin, 2010; Goodrick and Reay, 2010). Both units were primarily staffed with first-time hospital nurses. For 82 percent of nurses studied, this was their first job out of nursing school; most of the others had worked less than two years in another hospital and were considered too inexperienced to work on a specialty unit. Sixty-nine percent of nurses in this study were in their first four years on the job.

I supplemented my observations and interviews with several secondary data sources. I collected archival data on the hospital, including quarterly nursing staff responsiveness scores from federally mandated Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient consumer satisfaction surveys, the nursing curricula and core textbooks from the three nursing schools attended by the majority of nurses studied, and readings on the history of nursing at the hospital studied and in the United States. I also attended a two-day nursing management conference. See Table 1 for a summary of my primary and secondary data sources.

Observational data. I conducted 81 observational sessions focused on 39 nurses working across all shift times and days of the week. Each session ranged from two to three-and-a-half hours. To ensure range in observational vantage points, I was paired with a member of each shift's nursing staff (either a nurse or nursing aide) to shadow them. This meant I dressed in scrubs and accompanied them while they worked, observing interactions with patients, other nurses and nursing aides, managers, and physicians, as well as group interactions. The pairings were randomly selected by the shift's resource nurse, a position that rotated among nurses; typically the staff member standing

Table 1. Data Sources and Usage

PRIMARY DATA		
Data Source	Description	How Used
Observations	81 observational sessions of nursing staff (2 to 3.5 hours each) across 2 units during all shift times, including 39 nurses observed for an average of 7 sessions each, with an average of 31 patient interactions observed per nurse	Depict typical nurse professional identity claims enacted through dress, language use, and demeanor for all 39 nurses studied Depict patient interactions of all 39 nurses studied, including extent to which patients were perceived to affirm or deny professional identity claims Depict typical service practices of 39 nurses (e.g., whether engaged in gossiping about, surface-level acting with, and avoiding of select patients) Depict hospital's and profession's on-the-job socialization efforts
Interviews	39 interviews (~30–45 minutes each) with nurses who were also observed	Discern whether each nurse's desired professional identity was idealized (overly positive and rooted in a romanticized image of nursing) or not Understand each nurse's expectations for becoming a nurse and whether or not they were met, as well as career aspirations and retention intent
SECONDARY DATA		
Secondary-source historical and other documents on nursing and the hospital studied	Historical books on nursing, one dissertation on nursing at the hospital studied, surveys on youth career aspirations for pursuing nursing	Understand the portrayal and public image of the nursing profession in popular culture and history Understand nursing's saliency as a top professional aspiration for girls during the time period when most nurses studied were children Understand how the nursing profession has changed over time and goals of the modern nursing profession
Nursing textbooks and nursing school curricula	Nursing school curricula and textbooks for required courses at the three nursing schools attended by the majority of nurses studied	Understand how nursing was portrayed in the nursing school core curriculum to understand possible contribution to idealized expectations Understand extent to which nurses apprenticed with senior nurse mentors during nursing school or not
HCAHPS patient "consumer" satisfaction survey scores	Quarterly patient "consumer" satisfaction scores on nursing staff responsiveness for both units, the hospital, and Medicare benchmarks	Provide outcome data on patient satisfaction with nursing staff responsiveness to their requests for help on the units studied relative to the rest of the hospital and compared to benchmarks for Medicare reimbursement
Hospital materials	Hospital magazines, website, Patient Welcome Packet, Patient Bill of Rights, hourly rounding initiative materials	Demonstrate how hospital materials and socialization initiatives portrayed patients as consumers and nurses as customer service agents Understand hospital goals and pressures to achieve patient satisfaction and efficiency
Attendance at two-day nurse manager conference	Detailed notes on presentations, plus archival materials from conference and vendors	Understand field-level challenges facing the nursing profession and the extent to which the hospital studied was experiencing similar pressures to achieve sufficiently high patient satisfaction survey (HCAHPS) scores while improving efficiency

closest to the resource nurse at the time of my arrival was selected. I observed each of the 39 nurses during an average of seven observational sessions and saw an average of 31 patient interactions per nurse over the course of the study. I typed extensive observation notes within 24 hours of each session.

Interview data. I conducted 39 interviews: one with each nurse whom I also observed one-on-one in the study. Interviews centered on nurses' motivation and timeline for becoming nurses, their experience at the hospital, career plans and retention intent, and recent staff or patient interactions. Interviews lasted 30–45 minutes. I typed extensive notes within 24 hours of each interview.

Archival and historical data. The first source of archival data was print and digital hospital-related data, such as hospital brochures, the patient welcome packet, forms nurses used in their daily work, the hospital magazine, the quarterly hospital nursing magazine, and online digital materials about the hospital. I also collected quarterly unit- and hospital-level HCAHPS patient satisfaction survey scores for nursing staff responsiveness, which reported the percentage of a randomly sampled group of discharged patients who indicated whether they "always received help as soon as they wanted." The second source of archival data collected was publicly available curricula for the three nursing schools attended by the majority of nurses studied, along with their introductory nursing textbooks for required classes. Finally, to contextualize my understanding of hospital nursing, I also read numerous books about the history of nursing (Reverby, 1987; Allen, 2001; Weinberg, 2004; Gordon, 2005; D'Antonio, 2010; Hallam, 2012; Judd and Sitzman, 2014), closely read an interview-based dissertation on the history of nursing at the hospital studied and corresponded with its author, and attended a two-day nursing management annual conference to understand trends in the broader nursing field.

I obtained ethical clearance for this study through the hospital and university institutional review boards. All staff and patients were informed that I was a researcher. To further safeguard confidentiality, I modified inconsequential descriptive details, used pseudonyms, removed dates, and used new numeric identifiers not linked to field note numeric identifiers.

Data Analysis

I analyzed data by iterating between puzzles inductively generated from my data and attempts to code for answers to these puzzles, while engaging with the literature (Glaser and Strauss, 1967; Bailyn, 1977; Grodal, Anteby, and Holm, 2021). Data analysis proceeded in four stages. The first stage occurred during fieldwork, when I wrote memos about puzzling dynamics, such as most nurses engaging in infantilizing professional identity enactments with their adult patients (e.g., using language like "pee-pee," patient pet names), despite hospital management's mandate to treat patients "with respect" and "without undue familiarity" and most patients' rejection of these enactments (e.g., "Don't talk to me like I'm a baby"). Such identity enactments also ran counter to the modern nursing profession's emphasis on advanced clinical skills and nurses engaging with patients as "partners" and "advocates" who are there to empower them (Price, 2009). In prior work, I examined how cross-cutting demographics impacted cross-occupational collaboration between nurses and nursing aides on the night shifts of the two units studied (DiBenigno and

Kellogg, 2014). In this paper, I examine nurses' infantilizing professional identity enactments with patients, which occurred during all shift times (day, evening, and night shifts) on both units, across the majority of nurses studied regardless of their demographic backgrounds.

In the second stage of analysis, I coded my observational data on the typical identity enactments and work practices of the 39 nurses studied. Given the salience of identity-related statements and behavioral enactments in my data (e.g., "What am I, a waitress?"), I turned to the literature on professional identity to develop codes for indicators of identity enactments. These included manifestations of professional identity claims as expressed through one's choice of dress, language use, and demeanor (Rafaeli and Pratt, 1993; DiBenigno and Kellogg, 2014; Lepisto, Crosina, and Pratt, 2015; Caza, Vough, and Puranik, 2018).

During analysis of my observational data, I coded all nurse interactions with and about their patients. I discovered that most patients were perceived by nurses as rejecting their infantilizing identity enactments; these patients were seen not as children grateful for their nursing care but as consumers entitled to quality service, casting nurses in affronting "waitress" or "maid" identities. I then coded the following dominant nurse work practices that emerged in response to most patients' routine denial of nurses' infantilizing identity enactments: (1) gossiping about patients' nonmedical characteristics to identify and negatively label those patients who rejected their infantilizing identity enactments, (2) using this gossip to calibrate their own emotional labor so they could engage in surface-level acting with these patients (when what they said they felt and what they expressed with patients audibly and visibly differed), and (3) avoiding these patients as much as possible, including delaying responses to their requests for help. I later labeled these practices "identity-protective practices" because they appeared to protect nurses from the identity threat these patients posed by rejecting their professional identity claims. I also noted that these nurses did not use these practices with the few patients who responded positively to their infantilizing identity enactments. Instead they engaged in what I later labeled "identity-affirming practices," which involved indulging (e.g., buying gifts or prioritizing requests), engaging in more-authentic emotional labor displays in which what they said they felt and what they expressed aligned, and eagerly seeking out these patients.

During this stage, I also closely examined data on a subset of nurses who did not engage in infantilizing professional identity enactments and identity-protective or identity-affirming work practices; this was the case even though this subset of nurses also interacted with some of the same patients in the same job and had the same socialization experiences as the other nurses. Thirteen of the 39 nurses enacted a professional identity and set of work practices aligned with the hospital's goals to engage with all patients as respected customers and the nursing profession's goals to engage with patients as "partners in their care" and "without undue familiarity." These nurses wore plain scrubs, contrasting with some of the other nurses' choices to wear scrubs with juvenile designs. These nurses addressed their patients as "sir" and "ma'am" as the hospital instructed, instead of using pet names for patients as the other nurses did. They did not avoid some of the same patients that other nurses gossiped about negatively, and some even thanked patients after encounters, as requested by the hospital.

The results of this comparison led me to my third stage of analysis, in which I matched my interview data for each of the nurses with my observational data of their typical identity enactments and work practices. I discovered that the main commonality among nurses engaging in infantilizing identity enactments, compared with those who did not, was a shared attachment to an idealized maternal caregiver identity prior to becoming nurses. Most of these nurses said they committed to a nursing career as girls, and they expressed a professional identity expectation casting themselves as respected maternal caregivers with power over helpless and grateful patients. In contrast, the subset of 13 nurses who did not engage in infantilizing identity enactments did not articulate these same idealized identity expectations for their nursing careers. Instead, they expressed having neutral or negative expectations for nursing and committed to the profession while in college or after first exploring other careers. Aside from their differing identity-related expectations, the two groups of nurses were not notably different in terms of nursing schools attended, age, or tenure.

In my final stage of analysis, I analyzed my secondary sources of archival data on the history and image of nursing to learn the possible root of this idealized and maternal professional identity expectation. I read books on the history of U.S. nursing, analyzed how nursing was portrayed in the textbooks the nurses in my study had used in college, and read accounts from leaders in the profession about their dismay at the inaccurate portrayal of modern nursing in the media. I also examined surveys assessing whether nursing was a top occupational aspiration for U.S. girls born around when the majority of nurses studied were growing up. My analysis of these data aligned with the idealized and respected maternal caregiver identity articulated by the nurses engaging in professional identity enactments that infantilized patients. This alignment led me to develop the concept of idealized professional identities as rooted in the cultural and historical image rather than reality of an occupation and to develop theory about how such identities may persist in one's first job through the identity-granting and -claiming opportunities that client interactions offer.

I then closely examined data on these nurses' socialization by senior members of the profession (nurse managers and educators) and by hospital management, such as during onboarding and training experiences, to understand the conditions that might enable idealized professional identities contradicting the organization's and profession's goals to persist. I analyzed archival data on the history of nursing to understand how the shuttering of hospital-based nurse apprenticeship programs may have contributed to new nurses not being disabused of unrealistic identity expectations. This analysis also helped me understand the extent to which organizational management, now increasingly responsible for new nurses' socialization and training than in the past, may have been in the dark about nurses' idealized identity desires. My analysis suggests that idealized identities may be most likely to persist in occupations in which new members (1) serve clients, such that there is an ample supply of dependent, identity-relevant interaction partners to claim idealized identities with; (2) have weak, sink or swim socialization from one's profession (without an apprenticeship); and (3) have managers who are not savvy about the idealized identity desires of their new professionals.

FINDINGS

Idealized Professional Identity Expectations

During interviews, the majority of nurses I studied expressed highly idealized professional identity expectations for being respected maternal caregivers to dependent yet grateful patients. Most nurses indicated that they committed to becoming nurses as girls, with many noting how they loved to “play nurse” while growing up and some even dressing up as nurses for Halloween. One first-year nurse explained, “My mom has always told me that I would make a good nurse. . . . She said I would play nurse with my baby dolls as a kid and everything” (RN67B). Another shared, “I wanted to be a nurse since I was five years old. . . . My cousin was a nurse, so I grew up seeing her get dressed up to go to work in her uniform, and I always looked up to her” (RN64B). Another shared a similar sentiment: “It’s the only thing I’ve ever wanted to do since I was a little girl was to become a nurse” (RN58B). Such early aspirations to pursue nursing may not have been uncommon, as multiple surveys placed nursing as a top-10 U.S. girl’s career choice when many of these nurses were growing up (Bobo, Hildreth, and Durodoye, 1998; Mortimer, 2009).

Because these nurses committed to nursing as children, their expectations for nursing were by necessity rooted at least partly in an imagined and fantasy-based image of nursing, given their limited exposure to nursing work in practice. The few nurses in this group who did not claim to commit to nursing as young girls still expressed an image-based expectation of what being a nurse would entail without having had direct exposure to nursing work. One such nurse had majored in the arts and, when she could not find a job, went back to school for nursing because she said she imagined “it would be fun dressing up and getting to take care of people” (RN104B).

There were two dominant elements of these nurses’ identity expectations. The first related to expressing the maternal value of caring. “Caring” and the related traditionally feminine attributes of “kindness,” “empathy,” and “compassion” were frequently named as important traits these nurses said they exemplified that made them well-suited to nursing. As one explained, “Nursing is fundamentally about caring” (RN64A). Another nurse shared that nursing was about providing “the gift of care” and that “to be a good nurse, you really need to be patient and kind and caring and empathetic” (RN54B). The emphasis on caring was striking given that the modern nursing profession also heavily emphasizes technical clinical skills and critical thinking since nurses today perform work physicians previously did (Goode et al., 2001; Institute of Medicine, 2011). At a national conference, nursing leaders spoke about efforts to rebrand “caring as competence,” as the profession sought to articulate its value relative to nursing aides who perform the majority of bedside “carework” in hospitals today (Lopez, 2006; Price, 2009). Yet heartfelt “caring” was heavily emphasized in nurses’ narratives of what they expected being a nurse to entail. As the lone magnet on one unit’s refrigerator read, “Nursing is the Art of Caring.” The image of the caring, maternal nurse can be traced to before the modern hospital’s advent, when women were obligated to “nurse” sick relatives, with payment in the form of gratitude (Reverby, 1987). As one textbook noted, “The nurse usually was the mother who cared for her family during sickness. . . . This nurturing and caring role of the nurse has continued to the present” (Taylor et al., 2006: 7).

The second integral element of these nurses' professional identity expectation was having power and autonomy over patients to positively affect their lives in ways that generated patients' adoration and respect in the most trusted profession in America (Reinhart, 2019). This relational identity expectation casts patients in a dependent, childlike state, with nurses in a paternalistic, authoritarian position of power over them, associated with the gendered mother–child relation. Indeed, although historically women have had limited formal power in society, they have consistently held power over their children. As stated by the immortalized founder of professionalized nursing, Florence Nightingale, who is regularly quoted in nursing textbooks, "Every woman . . . at one time or another in her life, is in charge of the personal health of somebody, whether child or invalid—in other words, every woman is a nurse" (Nightingale, 1898: 2). "Nursing is about helping people in their time of need, when they can't do things for themselves . . . (it's about) making a positive difference," explained one nurse (RN84A). The image of the needy and appreciative patient receiving care from a respected, maternal caregiving nurse aligned with portrayals in nursing textbooks. One textbook defined the nurse–patient relation this way: "The truly sick person was *weak and helpless*. . . . In whatever form the nurse took, the role was associated with compassion, health promotion, and kindness" (Masters, 2009: 3). Yet a tension existed in these textbooks, which also portrayed the modern nurse's power relations with patients as more egalitarian; nurses are expected to be advocates who empower patients (Goodrick and Reay, 2010), which conflicts with the "nurse knows best" paternalistic power relation articulated by the nurses I studied and reflected in historical accounts of the profession.

Prevalent images of nursing in popular media may have also influenced the idealization of a maternal caregiver identity by the nurses studied. All occupations have stereotypes and images associated with them (Vough, 2012; Vough et al., 2013). As with other occupations that often top the lists of what children say they want to be when they grow up (Polavieja and Platt, 2014), nursing is a profession regularly (mis)represented in literature, TV sitcoms, and movies (Stanley, 2008; Carroll and Rosa, 2016). Numerous nursing leaders have lamented the unrealistic media representations shaping society's image of nursing, which associate nursing with stereotypically feminine values and may discourage men from becoming nurses (Kalisch, Kalisch, and Clinton, 1982; Buresh and Gordon, 1995; Dingwall and Allen, 2001; Cabaniss, 2011; Kearns and Mahon, 2021). For example, many Halloween costumes still represent nurses in white caps and dresses despite nursing uniforms consisting of loose-fitting scrubs for over 30 years.

Reality of First Jobs Mismatched with Idealized Professional Identity Expectations

Most nurses I studied reported feeling disillusioned upon starting their first jobs, after realizing the respected maternal caregiver identity they expected to enact was largely incongruent with their work demands. They expressed their disillusionment through strong emotional outbursts at work. For example, most nurses studied were observed to cry at work or shared in interviews that they had cried when starting out. As a nurse in her third year explained, "When you start out, it's bad. You want to cry all the time" (RN47A). The meaning they

hoped to get from “helping people” and exhibiting “caring” in their work was not realized. As one lamented, “Nursing is not as glorified as I thought it would be. I thought it would be more fun and that it would be nice spending my days making people happy. The reality is you spend your days pissing people off . . . [and doing] busy stuff like paperwork” (RN54B). They perceived their care being demeaned as an economic service that patients felt entitled to rather than a heartfelt gift inspiring gratitude. As another nurse explained, “Here, the patients think they are shopping at Macy’s. . . . In [home country], it’s nothing like this . . . the patients say, ‘Thank you so much nurse’” (RN52A). Many nurses expressed dismay at their perceptions of hospital managers and patients treating nurses as “waitresses” and “maids” rather than respected maternal caregivers, inverting their desired authoritarian power relation with patients that was central to their professional identity desires. “Here, the patients are disrespectful to all. . . . I didn’t do this to be your waitress or maid; I’m a nurse,” explained the same nurse. These nurses felt nursing school had not accurately portrayed the job; as one noted, “I mean you actually don’t use much of what you’ve learned in school” (RN54B). Nurses also referred to the unrealistic portrayal of nursing in the media. For instance, RN73B said, “This is real nursing, not nursing like you see on TV. Not like *House*,” to which RN88B added, “I like that show too even though it’s so unrealistic.”

Work demands in nurses’ first jobs. The hospital itself was under pressure to (1) operate as efficiently as possible to remain financially viable in a competitive local market while (2) achieving high patient satisfaction scores to uphold its reputation as a top teaching hospital (Scott et al., 2000; Reich, 2014; Valentine, 2018). At the time of the study, hospital rankings of HCAHPS scores assessing patient “consumer” satisfaction had been made publicly available, and hospital management was dismayed to learn that scores on certain units, including the two units I studied, were not only below those of competitor hospitals but also below the threshold for Medicare reimbursement. They aspired to increase patient satisfaction scores, especially nursing staff responsiveness scores. The patient rights movement had been sweeping the country for more than a decade, and linking financial incentives to patient satisfaction surveys was one way the United States was attempting to reduce preventable harm in hospitals, a leading cause of death often attributed to negligence in nursing care (Nembhard et al., 2009; Wears and Sutcliffe, 2019).

To achieve the hospital’s efficiency goals, nurses’ workload had increased over time (Weinberg, 2004). Numerous efforts sought to keep nursing staffing levels “optimal” by using Lean manufacturing principles to minimize slack (Brannon, 1994; Goodrick, Meindl, and Flood, 1997). For example, units were short-staffed in 25 percent of my observational sessions, and nurses were sent home or floated to other units whenever there were fewer patients on the units than expected. Patient loads increased by as much as 300 percent and patient length of stays dropped from two weeks to 36 hours over a 20-year period, as reported by two veteran nurses and documented in other historical studies of this hospital. One 20-year veteran nurse shared, “When I started out as a new nurse here, we were only given two patients [versus six now] . . . it used to be that you get more attached to patients. After someone would die, we would go to the funeral. It’s not like that anymore” (RN51B).

To achieve patient satisfaction goals, the hospital was an early adopter of creating a "Patient Bill of Rights," which sought to promote equity in health outcomes and dismantle the paternalistic "doctor/nurse knows best" mentality pervasive in health care by engaging with patients as respected "partners in their care" with "the right to be treated respectfully" and to "be addressed by [their] proper name" and "without undue familiarity." The patient rights movement aligned with efforts by nursing profession leaders to position the modern nurse's role as a patient advocate who was there to empower patients, as documented in my field notes from a major nursing conference. My analysis of hospital archival materials showed that, in line with these efforts, patients were sometimes referred to as "partners" and "customers." The hospital magazine publicized efforts to use "mystery shopper" patients and "Lean manufacturing" principles to "always keep the customer (patient) in mind," the Patient Bill of Rights and HCAHPS scores were publicly posted on both units, and the hospital put the Patient Bill of Rights in all patient welcome packets. The hospital also implemented a popular major training initiative to script and structure nurses' patient interactions to improve HCAHPS scores, as I describe below.

Limited On-the-Job Socialization to Disabuse New Professionals of Idealized Identities

Minimal senior profession-led socialization without apprenticeship.

Over 30 years ago, most nurses were trained through a three-year hospital-based apprenticeship, which was concurrent with their schooling and overseen by senior nurses; today most nurses are thrown directly into their first jobs after completing four-year degrees focused on critical thinking and advanced clinical skills (Goode et al., 2001; Simpson and Courtney, 2002; Currie, Finn, and Martin, 2010). Curricula from the nursing schools attended by the majority of nurses I studied revealed limited time spent developing hands-on patient bedside interaction skills in clinical rotations. At the hospital, new nurses received a short formal orientation of a few months of "precepting": a new nurse was assigned to shadow a slightly more senior nurse (often only a few years more tenured) before receiving a reduced patient load while having their paperwork evaluated by their nurse manager or nurse educator. Most nurses resented precepting newcomers because it slowed them down.

While each unit's nurse manager and two rotating nurse educators were technically responsible for helping new nurses adapt, their priorities aligned with the modern nursing profession's focus on ensuring proficiency in the clinical and bureaucratic facets of the job rather than on patient bedside interaction skills. The nurse managers also may not have been incentivized to invest heavily in socializing new nurses since medical-surgical units are thought to weed out those not able to cut it within a local labor market that had (at the time) a plentiful supply of nurses competing for coveted jobs at this top-ranked hospital. These senior profession members spent minimal time observing or providing feedback on new nurses' patient interactions, and as in other client-facing professions, close surveillance of nurses' hundreds of daily patient interactions was unfeasible or impossible. Nurse managers were notably absent from providing mentorship on both units; they were typically on their computers in their offices or away from their units in back-to-back meetings, as

indicated by printouts of their jam-packed Outlook calendar schedules posted outside their office doors.

The nurse educators were also often in their offices but did spend more time on the floor. However, they were largely unsympathetic to new nurses' struggles in a profession known for an "eating our young" and sink or swim culture (Sauer, 2012; Caristo and Clements, 2019: 45; Darbyshire, Thompson, and Watson, 2019). They regularly used humor to deflect nurses' attempts to share their disillusionment, such as saying "save the drama for your mama." The first year for nurses was generally filled with anxiety as they were thrown in and expected to prove their technical clinical proficiencies—accurately filling medications, inserting catheters, determining when to call a "trigger" to alert physicians that a patient is deteriorating, etc.—while managing the intense work pace. Nurses unable to demonstrate these technical skills and efficiencies at managing their workload were considered unfit. Two nurses left during the study, and both were described as "unable to cut it" by managers and peers.

Organizational socialization efforts not savvy about idealized identity expectations. The hospital's organizational socialization efforts to shape new nurses' professional identities focused on aligning those identities with the organizational goals of efficiency and improved patient satisfaction ratings. These efforts displayed little sensitivity to most nurses' idealized professional identity desires. In fact, by emphasizing patients' right to evaluate nurses, they did the opposite by inverting nurses' desired power-dependency relation with their patients.

To improve HCAHPS scores related to patients' assessments of nursing responsiveness, the hospital attempted to script nurses' patient interactions by launching a major training initiative, "hourly rounding," which encouraged nurses to be more "polite and present." Nurses were asked to address all patients by their surnames, required to sign a form indicating they had proactively visited their patients at least once every hour to ask a scripted set of questions (about pain, toileting needs, etc.), and told to conclude each encounter by "thank[ing] the patient for letting you work with him/her." Table cards were placed in patients' rooms advertising that nurses should ask patients these questions. All nurses were required to take a one-on-one training session with their nurse educator and watch a video depicting how nurses were to engage with patients. At a national nursing conference, I learned that other hospitals were implementing similar hourly rounding initiatives and were under similar pressure to achieve high patient satisfaction scores.

Nurses resisted work goals that threatened their idealized professional identity. All the nurses I studied incorporated their hospital's and profession's goals of achieving efficiency and exhibiting technical clinical competence into their fledgling professional identities. However, nurses with idealized identities resisted incorporating patient satisfaction and empowerment goals, which they perceived as threatening to their idealized identity expectations.

Nurses adapted to efficiency and technical goals by crafting professional selves that suited their fast-paced work environments on medical-surgical units, which demanded wide-ranging clinical expertise to address the varied needs of their patients' many conditions. Nurses reported that being a "good

nurse” meant being an “excellent multitasker” who could “handle stress well” and was “OCD” about ensuring accurate paperwork and medication dispensing. Nurses prized the technical clinical competencies valued in their education, such as accurately interpreting a patient’s lab results and administering the right doses of medications at the right time based on how a patient was responding. They regularly power-walked between rooms. Many arrived an hour early (unpaid) to their shift and stayed late to complete required paperwork. As one confided, “The secret is you can’t stop (moving)” (RN55B). These nurses appeared to have transformed to embrace the “modern nurse” identity in line with both organizational and nursing profession goals, which value technical skills over bedside carework that is now performed by lower-cost nursing aides (Barton, 1995; Weinberg, 2004).

But when it came to adapting their identities to embrace patient satisfaction and empowerment goals, for nurses with an attachment to an idealized professional identity, their socialization appeared incomplete. Patient satisfaction and empowerment goals provoked a strong emotional response among these nurses suggestive of a deep threat and affront (Petriglieri, 2011). For example, nurses expressed the sense of insult they felt over management inverting their desired authoritarian nurse–patient power-dependency relation, which was a core part of their idealized professional identities. Instead of patients expressing gratitude for the gift of care, the expectation became that nurses would express gratitude to patients. One noted, “I think [management has] crossed the line when they say we should say ‘thank you’ when we leave the room. . . . I know I’m not thanking a patient for letting me take care of them” (RN53A). Another nurse echoed this sense of personal affront, exclaiming, “What am I, a waitress?!? They . . . expect us to promise to see our patients every hour?!? . . . It was like a slap in the face” (RN64B).

Claiming Idealized Professional Identities during Interactions with and about Clients

My observation of nurses’ identity enactments with and about patients, including their dress, language use, and demeanor during patient encounters, revealed that many nurses claimed an idealized maternal caregiver identity that involved infantilizing patients and casting them in a paternalistic, dependent child role. In this way, nurses resisted the organization’s goal that patients be treated as valued “customers” and the nursing profession’s goal that patients be treated as equal “partners in their care.” For example, patients were regularly addressed by using infantilizing pet names, including “honey,” “sweet-heart,” “dear,” and “lovebug,” and were sometimes explicitly called “children” or “babies” in conversations with other nurses. For instance, I observed RN56B say, “How are our children today?” when referring to the unit’s patients at the start of her shift. Or consider how RN67B, a 23-year-old in her first year on the job, referred to her patient by a pet name even though she knew the patient’s name:

RN67B wears hot pink pants and a flower and heart cartoon top. . . . The thermometer keeps slipping out of the half-asleep patient’s mouth and RN67B says, “Love?

Honey? Can you close your mouth for me? Honey? Jennifer!" [she yells patient's name].²

Like this nurse, many wore juvenile-themed scrubs while caring for their patients, all of whom were adults. Nurses frequently used childlike language and euphemisms to refer to patient bodily functions ("pee-pee"), patient behavior ("acting fresh," "acting out"), and equipment ("big boy bed"). For example, RN49A said in front of a patient, "She just had a poo poo." Such infantilizing language was pervasive, as described in my field notes:

RN58B overhears that a ("bariatric") bed is being ordered for an obese patient and asks, "Are you getting a big girl bed?" They laugh and RN69B, who wears a hot pink scrub top covered in cartoon hearts and dogs says, "I thought we always called them a 'big boy bed' even if it's for a girl. In fact, I write that in my notes."

Nurses often spoke to patients as if they were children, i.e., slowly, loudly, or with exaggerated enunciation, and sometimes talked over them as if they were babies who could not hear or understand what the nurse was saying about them. For example, as recorded in field notes: "RN73B turns to me in front of the patient and says, 'Isn't he the cutest patient ever?'"

Nurse managers and educators seemed unaware of or unconcerned about nurses' pervasive maternal caregiver identity enactments that cast patients in an infantilized role, as such enactments largely occurred in patients' rooms or in backstage spaces such as the nursing station, break room, or locker room with likeminded colleagues. Publicly visible identity enactments, such as wearing scrubs with juvenile designs, were overlooked and may have seemed humorous and harmless. Without formal socialization from senior profession members or management, nurses' unrealistic idealized identity desires were left unchecked. Their socialization thus primarily occurred informally through interactions with likeminded peers in a context in which most nurses shared an attachment to the same idealized maternal caregiver identity, which may have helped amplify and sustain this identity and related work practices that I describe below.

Client Responses to Idealized Professional Identity Claims Shape Work Practices

The idealized identity claims of the majority of nurses were consequential because they shaped nurses' client service practices in ways that often went against the organization's and profession's goals. While these nurses enacted their idealized professional identities with all patients, their client service practices differed based on whether patients denied or granted their idealized identity claims.

Identity-protective practices with clients who denied the idealized identity. Most patients did not affirm nurses' idealized maternal caregiver identity claims that cast them in a childlike role. Some patients even called out their infantilization. For example, as noted in my field notes, "A bed alarm

² All names are pseudonyms throughout the paper.

sounds and RN61B runs to the room. The patient is on his cell phone, lying on his side. RN61B scolds him, saying, 'Don't roll like that. You know better!' The patient responds in an annoyed voice, 'I barely moved. I feel like a little kid for Christ's sake!'" Such infantilization ran counter to how the hospital conveyed to patients they should expect to be treated; the messaging in hospital materials portrayed patients as empowered consumers who are entitled to quality service as equal partners in their care experience.

Another example comes from RN67B, who had worked on the unit for a year after graduating from a top nursing school. She had dreamed of becoming a nurse for as long as she could remember. Her mother was a nurse and shared stories with RN67B about how RN67B would wear a white dress and cap and "play nurse" with her dolls as a child. However, her first nursing job was not what she expected, and she had cried at work on multiple occasions. I observed RN67B enacting a maternal caregiver identity with her adult patients by infantilizing them through her dress, language use, and demeanor, even though this identity was regularly denied by most patients. She noted feeling treated "like a waitress," as most patients did not play the desired grateful child role but instead acted like consumers entitled to care. For instance, RN67B's attempts to enact a maternal caregiver identity were quickly dismissed by a patient who drew on the hospital's discourse of valuing consumer satisfaction to complain that he was "not satisfied with [his] care":

RN67B, who wears scrubs featuring cartoon frogs on lily pads, enters the room of a patient who recently requested his nurse. As RN67B begins to greet the patient, a White middle-aged businessman, he interrupts her by saying loudly, "It's so very cold in here. . . ." RN67B replies in an affected voice, ". . . we told Maintenance. . . I'm sorry. There's nothing I can do." She fixes his covers and says, "Want me to get more hot packs?" The patient replies angrily, "I'm not satisfied with my care. Can you do something?" RN67B replies, "I'm doing the best I can" to which he replies, "It's not enough. I'm one hour into this and I've called and said again and again it's cold." . . . RN67B changes the subject, asking brightly, "Do you want cream or sugar in your tea, honey?" . . . The patient ignores her and mutters under his breath about being unsatisfied. RN67B raises her voice and repeats slowly and in an exaggerated way, as if talking to a child, "Do you want cream or sugar in your tea?" The patient snaps back, "You don't have to raise your voice like that at me!" . . . We leave the room and RN67B says, deflated, "Honestly, he's driving me crazy." . . . Later in the shift, RN67B purposefully avoids going in his room.

I observed that in response to most patients' regular denial of their idealized respected maternal caregiver identities, nurses engaged in three identity-protective practices: (1) gossiping about patients to warn likeminded nurses about identity-threatening patients, (2) calibrating their emotional labor by engaging in protective, surface-level acting with these patients, and (3) delaying responding to these patients and avoiding them to the extent possible.

Gossiping about patients based on whether they affirmed or denied the idealized identity. Nurses regularly gossiped about patients' nonmedical characteristics in backstage spaces, labeling them as "good" or "bad" based on the extent to which they were perceived to affirm or deny nurses their desired respected maternal caregiver identity. "Good" patients were

considered both grateful and childlike, such as by appearing helpless but apologetic and excessively thankful and by showing familial-like affection to nurses. Common labels used privately between nurses to demarcate “good” patients were “cute,” “sweet,” “nice,” “adorable,” “my favorite,” and “lovely.” During many patient handoffs between nurses, the nurses spent as much time sharing these judgments as they did medical information. For instance, RN87B handed off a patient by saying, “She is cute. On 4 liters of rolling oxygen. She would be independent but has lots of anxiety. Otherwise totally fine. She is lovely. Oh, she is cute. You’re lucky.” Or consider the patient described below, who was labeled “sweet” and “cute” by RN67B and RN64B even though she made as many requests as the patient RN67B had labeled negatively during the same shift who had complained about being cold:

RN64B enters the room of a female elderly patient. The patient’s face lights up upon seeing RN64B, and says sweetly, “I missed you!” RN64B smiles and leans in close and says kindly, “My love, what do you need?” The patient replies sweetly, “I’m so glad you’re here! I was hoping you could raise the bed so that I could see the TV.” RN64B does this and the patient replies, “Thank you so much!” RN64B then asks, “And what else do you need?” The patient replies, “If it’s not too much trouble, I’d like some water.” RN64B says, “Of course!” and then follows up by asking, “Have you eaten?” The patient replies, “I am a little hungry.” RN64B asks her about what she’d like and advises on the menu and then tells her she’ll pre-order her dinner so she’ll be among the first patients to get food. The patient also asks for more blankets and when to expect her medications. RN64B leaves the room and sees RN67B and says, “Did you have [name of patient]? She’s so sweet.” RN67B replies, “I know she is so sweet and you know there’s nothing like a thank you every now and then, you know.” (She says this last part in a sarcastic tone of voice.) RN64B, “I know, she’s just so cute.” (Later in the shift) RN67B passes by this patient’s room (who is not RN67B’s assigned patient) and sticks her head in saying, “How you doing, love? I wish I had you again tonight. Can I get you anything?”

Such “good” patients were rare. In the majority of observational sessions, a nurse had one or two patients at most who were labeled positively. In many observational sessions, no patient was labeled positively. “Bad” patients were those perceived to cast nurses in a customer service role as waitresses or maids. These identities were threatening to the respected maternal caregiver identity most nurses desired, demeaning their care as an economic service rather than a sacred gift and denying nurses their desired paternalistic power-dependency relation. For example, RN84A complained about her patients in the break room, saying, “All my patients are bad. . . . My guy in 7 is just rude.” Nearby, RN52A chimed in saying, “Yes, I call them dictators.”

There were two types of patients gossiped about as “bad.” The first were those who nurses perceived to behave as consumers who acted entitled to rather than grateful for their care. These patients were called “VIPish,” “dictators,” “annoying,” “rude,” “dick,” “bitch,” “trouble maker,” “asshole,” and “from [Richville].” For example, RN64B complained about her patient to RN73B saying, “[Nickname for patient], he is not cute. He’s a dick.” The second type of “bad” patients were those perceived to treat nurses as maids; not only did they act like demanding consumers, but also nurses considered them physically or morally tainted in some way. Being treated as a “maid” rather than “waitress” was considered even more threatening, and these patients

were cast in dehumanizing roles as animals or psychopaths and labeled as “beasts,” “pigs,” “slugs,” “gross,” “addicts,” “crazy,” “psycho,” “coo-coo,” or “disgusting.” This category included patients considered “bogus”—suspected of “secondary gain” for potentially faking or exaggerating their symptoms to get unwarranted pain medications. For example, RN69B provided a handoff report on her patient by saying, “17, you know him. He’s disgusting . . . a pig. You can give him food and drink if he asks, but if he asks for anything weird, ask me first. . . . He is really gross though. Just disgusting.” This patient was derided on the unit both for being morally tainted for being obese and ordering a lot of food and also for being considered entitled rather than grateful for his care. For instance, he told RN73B that she “should be more polite” and, in response to a denied request, that he “would let it go this time” as if he were the one in charge. Gossiping about patients allowed nurses to warn one another about identity-threatening patients given that nurses often interacted with one another’s assigned patients and then handed off patients at the shift change.

Employing surface-level acting with clients who threatened the idealized identity. To calibrate their emotional labor, likeminded nurses regularly used gossip about patients’ nonmedical characteristics to protect themselves from identity-threatening patients by engaging in surface-level acting with them. Surface-level acting refers to a form of emotional labor in which how one feels and the emotional state expressed differ. Such acting is thought to protect one’s “true self” and is self-consciously adopted but is also linked to higher rates of burnout (Hochschild, 1979; Wharton, 1993). Nurses regularly engaged in identity-protective surface-level acting with patients perceived to grant nurses the affronting “waitress” and “maid” identities. Such surface-level acting was apparent in the disconnect between the vocal tone, pitch, and facial expressions nurses employed when speaking with me or other nurses in backstage spaces to express how they said they felt, compared with those used in front of patients. For example,

RN87B hands off her patient to RN68B at the shift change by saying, “03 is a new admit. She had [type of] surgery months ago. She’s bogus. It’s all in her head. She said her pain ‘is everywhere.’ (She rolls her eyes as she says this.) She won’t get out of bed. . . .” RN68B sighs loudly. . . . We walk into the patient’s room, and RN68B says in a high-pitched voice, “Hi! . . . I’m RN68B, and I’ll be your nurse.” . . . We leave the room and RN68B’s voice returns to normal, and she is visibly angry and says, “Something seems fishy. . . . Some of them just want to be pampered.” We return to the room later to help the patient walk to the commode. RN68B’s voice returns to a high falsetto pitch, as if she’s talking to a baby, and says, “You’re doing good. You’re doing a fabulous job. See? Your legs are strong.” RN68B turns to face me, away from the patient, and rolls her eyes and tips her head back dramatically.

Or consider the surface-level acting used by RN44A when interacting with a patient the nurses labeled as difficult:

RN44A says to Aide47A, “Let’s try giving her some ice cream. She’s being difficult. Let’s try ice cream.” . . . Aide47A grabs a cup of ice cream . . . as RN44A tries to calm the patient down, saying in a high-pitched voice that starkly differs from her

lower normal speaking voice, "How about some ice cream? Well, would you look at that! There's some right here." We leave as the patient yells out that she doesn't want any ice cream.

Nurses said they considered it too emotionally burdensome to directly confront challenging patients and engaged in surface-level acting to protect themselves. For example, RN52A said, when talking about how she handled "disrespectful" and "dictator" patients, "You can't change them or change the system. You have to be diplomatic and move on. If not, it will get to you."

Avoiding clients who threatened the idealized identity. The final identity-protective practice nurses used when patients denied their idealized maternal caregiver identity was to avoid interacting with these patients to the extent possible. They accomplished this by not walking by these patients' rooms, "hiding" in the break room or locker room, delaying responding to these patients' requests for help, and "dumping" these patients on nursing aides. For example, RN47A went to great lengths to avoid a patient labeled as "rude" by walking down the opposite hallway and cutting through the supply room, saying, "Let's go this way 'cause I don't want to walk by [patient]; she always wants something." At other times, nurses would hide in the break room or locker room to avoid being tracked down by "bad" patients. For instance, RN59A, who calls most patients "honey," avoided a patient regularly gossiped about on the unit for being "VIPish" and "a PITA" (pain in the ass) by hiding in the break room. Groaning to the other nurses also hiding from their patients, she said, "I don't want to go back out there." Another nurse moaned and said, "Me, too." RN59A continued, "I just want to stay hiding in here."

During night shifts, nurses could more easily avoid identity-threatening patients since there was no unit secretary to answer the call-light phone and page nurses. During these times, nursing aides or the nurse closest to the phone was expected to answer it, but nurses could glance at the computer screen to see which patient was calling, and they might walk by without answering. Or, if someone did answer, the nurse might delay visiting the patient or even choose not to go. For example, as recorded in field notes, "The call-light phone rings. Aide63B answers saying, 'Can I help you?' RN64B listens in because it's her patient. . . . Aide63B hangs up and RN64B says, 'She's obnoxious, just ignore her.'"

During the day and evening shifts, a dedicated unit secretary was assigned to pick up the phone to answer patient calls for help and send pages to let nurses know their patients were requesting them. While nurses still ignored these pages for identity-threatening patients, this behavior sometimes resulted in the unit coordinator paging them multiple times if patients continued to call for their nurse. One common way nurses avoided patients when this occurred was to "dump" the patient onto a nursing aide by forwarding the page to them or telling them to go in even if the patient requested the nurse. For example, RN69B used this patient avoidance tactic:

Upon learning that her patient is requesting her, RN69B scowls to show she is annoyed, sighs and turns to Aide68B and says in an irritated voice, "Can you go in there? He probably just needs to go to the bathroom and is asking for me." Aide68B nods and walks into the patient's room. The patient says upon seeing Aide68B,

"Where's RN69B? . . . Am I attached (to an IV)? . . . And when do I get my Tylenol?" Since these are questions only a nurse can answer, Aide68B replies, "Okay, I'll ask RN69B."

Identity-Affirming Practices with the Few Clients Who Granted the Idealized Identity

Nurses engaged in identity-affirming practices with the few patients who granted them their idealized maternal caregiver identity. Nurses indulged these patients (e.g., bought them gifts and prioritized their requests), engaged in authentic emotional interactions with them, and proactively sought them out. These patients were perceived to respond positively to nurses' infantilizing identity enactments by playing the dependent and adoring "grateful child" role, granting these nurses their desired identities. For example, consider one beloved patient, whom nurses on Unit A described as their "favorite" despite the intensive, low-status dirty work associated with his care:

One patient . . . we had a few weeks back, [was] sweet. He had Down syndrome, only 50 years old, and had constant diarrhea. . . . So he kept calling. . . . Each time he'd finish, a minute later he'd call again. . . . He would say each time, "Oh I'm so sorry! I can't help it. I'm so sorry to call again." Then he would say, "Thank you, thank you, I'm so sorry." . . . And he would show up naked in the hallway. (Naked?!) . . . Naked, and would shout, "I want to take a shower! I want a shower!" He was sweet though. We were sad to see him go. You know he was like a baby. 50 years old, but like a baby 'cause of the Down syndrome. Ohhh we loved him! . . . Some nurses took pictures with him. He was so sweet, and you know I bought him a Spiderman toy.

Such identity-affirming practices were also evident in how RN54B, who had dreamed of being a nurse since she was a young girl, affectionately spoon-fed a patient (despite the patient having use of her arms) and prioritized visiting this patient ahead of others, as described in field notes:

We enter the room again and RN54B playfully chastises the patient, warmly, "You are being a pain in my hulo (a euphemism for butt). . . . I'm just giving you a piece of my mind because I said, 'Okay it'd be a half hour'" (referring to when the patient called 10 minutes ago). The patient seems to almost respect RN54B for treating her this way and argues back playfully, like a scolded child, "Why am I the bad one?" RN54B replies affectionately, "I still love you. You just can't call so much. I told you a half hour, okay?" The patient replies sweetly, "Okay." RN54B continues, "I also have your [type of] medication" and opens the applesauce she mixed the crushed pills into and spoon feeds it to the patient. . . . RN54B turns to me to say, "She's pretty cute, huh?," as if the patient were a child who couldn't understand what we were saying. The patient smirks, closes her eyes and says, "I need sleep" to which RN54B says as if she were tucking in a child, "Well you got all your meds so now you can go night night. Sweet dreams."

Even though this patient had several non-urgent requests, RN54B labeled this identity-affirming patient positively. This patient received more visits than any other during the observation period, and RN54B interacted more authentically with this patient, such as by telling the patient how she felt by asking her to "be patient" and not call as much. RN54B did not indicate to me or others that

she was faking an emotional display as she had done with identity-threatening patients.

In contrast to identity-threatening patients who were avoided, identity-affirming patients were sought after, and nurses were visibly excited to interact with them. This was the case even for patients who had commonly devalued status characteristics or required lots of dirty work and resources that prior studies suggest put them at greater risk of mistreatment (Jeffery, 1979; Timmermans and Sudnow, 1998). For example, consider the field notes excerpt below about one of the nurses' "favorite" patients, an unkempt homeless man known as a "frequent flyer" for being on the unit multiple times for alcohol withdrawal and who made numerous demands:

RN67B gets a call from John, an unshaven homeless male patient. Her eyes light up as she power-walks to his room, seeming excited to enter, saying, "What can I do for you, John?" John replies, "Can I use the bathroom please? . . . I'm so sorry to be a pain." RN67B seems touched and says, "Oh, you're not a pain at all." John says, "I'm sorry again, I know I'm a pain. I'm sorry you girls have to do this all this work just so I can go to the bathroom." RN67B replies, "Oh it's nothing. You're a nice guy." She escorts him to the bathroom, closes the door, turns to me and whispers, "He's really cute, isn't he?" . . . After RN67B helps John back to bed, he calls again only 20 minutes later asking for valium. While patients requesting addictive pain medications are often considered suspect as abusers, his request is taken seriously, and we check on him multiple times.

First-Time Professionals without Idealized Identity Expectations Adopt Identity Consistent with Goals of the Organization and Modern Profession

A subset of the nurses studied (13 of 39) did not report an attachment to an idealized maternal caregiver identity prior to starting their first nursing jobs. When facing the same work demands as other nurses, caring for some of the same patients, and having the same on-the-job socialization, these 13 nurses molded their professional identities to align with their hospital's and profession's goals, including patient satisfaction and empowerment. These cases suggest that without romanticized, idealized identity expectations, new professionals may more easily craft professional selves that align with modern work demands.

Unlike their peers, these 13 nurses said they had not spent their childhoods imagining a maternal fantasy of becoming a nurse and instead had chosen nursing during or after college based on the financial security, flexible hours, and benefits. While these nurses attended the same nursing schools as the others I studied, had the same average tenure, and shared some similar background characteristics (such as similar age), they did not express an attachment to an idealized, identity-based expectation for nursing; see Table 2 for a comparison. Notably, six of these 13 nurses identified as men, suggesting that the nurse-as-customer-service-agent identity may have been preferable to the feminized nurse-as-mother idealized identity for them.

These nurses expressed neutral or even negative expectations about becoming a nurse rooted in more-instrumental rather than identity-related motivations. One shared, "I didn't think I'd like [nursing], but I really like the flexibility . . . the most appealing part is the hours" (RN51B). A first-year nurse explained how

Table 2. Comparison of Nurses Who Did versus Did Not Enact Idealized Professional Identities and Use Identity-Protective Service Practices

	Enacted Idealized Professional Identities & Used Identity-Protective Service Practices?			
	Yes (N = 26)		No (N = 13)	
	%	#	%	#
% Committed to nursing as children	77%	20	0%	0
% Committed to nursing in college	12%	3	62%	8
% Committed to nursing as second career	12%	3	38%	5
% First job out of nursing school	88%	23	69%	9
% Tenure < 4 years on unit	69%	18	69%	9
% Tenure > 5 years on unit	31%	8	31%	4
% Attended nursing school in local area	69%	18	62%	8
% Female	100%	26	54%	7
% Male	0%	0	46%	6
% With relatives in nursing	38%	10	8%	1
% Under age 30 (age 22–29)	65%	17	54%	7
% Over age 30	35%	9	46%	6
% Intend to stay at hospital studied	77%	20	69%	9
% Intend to stay in nursing profession	88%	23	92%	12
% Aspire to nursing management roles	4%	1	38%	5

she fell into nursing “by accident. It was the first week of classes in college. . . . One of the classes my friends were doing . . . was about nursing. . . . So then I just stuck with it” (RN89B). A few also said they had experienced a realistic job preview before committing to nursing: “My [relative] has [an advanced degree] in nursing and set me up to shadow a bunch of different people. . . . Nursing can also guarantee a certain lifestyle. I know I’ll have a job, especially in this economy” (RN63B). Finally, some, including all six male nurses studied, claimed to have become nurses when other career pursuits failed.

These nurses without an attachment to an idealized identity largely molded their professional identities to align with who they needed to be to meet their jobs’ demands. They did not engage in the infantilizing idealized identity enactments of the other nurses through their dress, language use, and demeanor with and about patients. They wore monochrome scrubs; none wore juvenile designs. Rather than use pet names like “honey,” these nurses typically addressed patients in line with the hospital’s training and Patient Bill of Rights by using “Sir/Ma’am” or “Mr./Ms.” followed by the patient’s surname. For example, the nurse introduced above who got into nursing by accident in college always wore plain scrubs and routinely greeted her patients using their surnames, such as by saying, “Hi, Mr. Jones. My name is RN89B and I’ll be your nurse.” This subset of nurses more often adhered to the hospital’s training for scripting nurse–patient interactions and proactively checking on patients hourly to improve patient satisfaction scores with responsiveness. Many of these nurses regularly thanked their patients at the end of encounters, in line with management’s training, something nurses with idealized identities refused to do. For instance, as recorded in field notes, “RN63B ends her patient visit by saying brightly, ‘Thank you very much’ as we leave the room.”

While these nurses also complained about management and the intensity of their jobs, they did not respond with the same emotional outbursts as nurses who had idealized identities. These 13 nurses never reported crying at work, and I never observed them doing so, in contrast with most of the idealized-identity nurses, who took these complaints more personally. As one third-year nurse who chose nursing for the flexible hours explained matter-of-factly, "I don't think management understands what we do. . . . They don't realize how much is on our shoulders. . . . Maybe they see us as waiters and waitresses?" (RN58A). Without a strong attachment to an idealized image or childhood dream of what being a nurse should entail, these nurses did not see the hospital's emphasis on patient/consumer satisfaction and positioning nurses as customer service agents as conflicting with strongly held preconceived notions of what it meant to be a nurse.

These 13 nurses largely rejected the infantilizing identity enactments and identity-protective work practices of their peers. During handoffs, these nurses labeled patients based on medical information and found judgments of patients as "good" or "bad" irrelevant. For example, RN71A, who committed to nursing in college for the pay and stability, rolled her eyes during a handoff when an idealized-identity nurse, RN41A, included what RN71A later said was "too much irrelevant information" about how "nice" and "cute" a patient was. Similarly, RN57A, an accounting major who never planned to become a nurse, rejected another nurse's labeling of a patient as "a very nice lady . . . real cute" by dismissing this information as irrelevant and responding in an annoyed tone of voice, "So?" He then greeted the patient formally by saying, "Good evening, Mrs. Barnett." He did not participate in gossip about patients with other staff, aside from sharing medical information, and he did not avoid patients who the idealized-identity nurses labeled as "bad."

This subset of nurses had interactions with some of the same difficult patients as the idealized identity nurses did, but the interactions were not considered identity-threatening personal affronts. RN94B, who said she became a nurse after not finding a job related to her major, was unfazed when interacting with a patient who other nurses had labeled negatively and who was being ignored by his assigned nurse that shift. After being yelled at by this irate patient, she shared that she did not take negative patient encounters like these personally: "Some people are in a really bad mood when they're at the hospital. You have to let it just roll off your back." In sum, data on these 13 nurses provide suggestive evidence that without an attachment to an idealized professional identity, new professionals may more easily adopt an identity congruent with the work demands of their profession and organization.

Organizational Implications of the Persistence of Idealized Professional Identities

The persistence of idealized professional identities enacted by the majority of new nurses I studied had implications for the achievement of valued organizational goals. Idealized identity enactments and related client service practices went against the hospital's goals to improve patient satisfaction related to (1) patient perceptions of nursing staff responsiveness and (2) providing equitable and respectful care to all patients.

Regarding the first goal, low patient satisfaction with nurses' responsiveness plagued both units and did not improve despite the hospital's expensive hourly rounding training initiative to improve these scores. In both units across the year-long study, only 40–52 percent of patients reported in quarterly surveys that they "always received help as soon as they wanted"—below Medicare's 62 percent reimbursement threshold at the time. A committee of front-line nurse managers, including those on the units studied, was convened to solve the problem. These managers appeared largely unaware of nurses' identity-protective practices and their potential influence on these low scores. No manager said they thought low scores might be related to nurses purposefully avoiding or delaying responding to identity-threatening patients' calls for help. Instead, the problem was assumed to be technological, as managers researched vendors to consider upgrading their call-light systems. Because these idealized identity enactments and practices occurred largely outside of management's awareness during private patient visits or in backstage spaces, it was challenging to sanction nurses or even to identify how the mismatch between the hospital's approach to patient satisfaction and the idealized professional identity desires of nurses may have contributed to these low scores.

Regarding the second goal, the differential treatment of patients based on nurses' perceptions that they affirmed or denied nurses' idealized identity went against tenets of the hospital's Patient Bill of Rights to treat *all* patients with "respect" and "without undue familiarity." Using pet names and buying gifts for, prioritizing requests of, and seeking out identity-affirming patients, while gossiping about and deliberately delaying visits to identity-threatening patients, went against the equity and patient-respect components of the hospital's patient satisfaction goals. Such equity goals also relate to a profession's mandate to act in clients' best interest, which underlies a profession's right to self-regulate (e.g., Brint, 1994; Wright, Zammuto, and Liesch, 2017). Ironically, nurses' commitment to idealized professional identities undermined these goals.

Finally, the persistence of idealized professional identities through select client encounters may have influenced the retention of nurses with identities inconsistent with organizational goals. Prior scholarship has suggested that professionals who fail to mold their identities to suit work demands will likely exit (Schabram and Maitlis, 2017). The opportunity to enact idealized identity claims and sometimes have them granted by clients willing to play the grateful child role may help explain why most of the disillusioned nurses stayed in the job and profession past their first year and beyond. Yet retaining those with professional identities inconsistent with organizational goals may not be in their organization's or profession's best interest. Even though nearly all idealized-identity nurses expressed disillusionment over their first nursing jobs, 88 percent said they planned to stay in nursing and 77 percent said they planned to stay at the hospital studied, with the majority hoping for greener pastures within other units or specialties in the hospital where they might be able to enact a maternal caregiver identity (e.g., labor and delivery, pediatrics, and neonatal intensive care). These data suggest that the chance to claim an idealized identity and have it granted, even if infrequently, may help sustain those in a profession and organization that has goals mismatched with professionals' identity-related expectations. As one nurse noted after sharing that a patient told her he loved her after she said good night and turned out

the lights, “You’re ready to finally quit, and then they say ‘I love you’ and you can’t” (RN59B).

DISCUSSION

Theoretical Model: How Idealized Professional Identities Can Persist

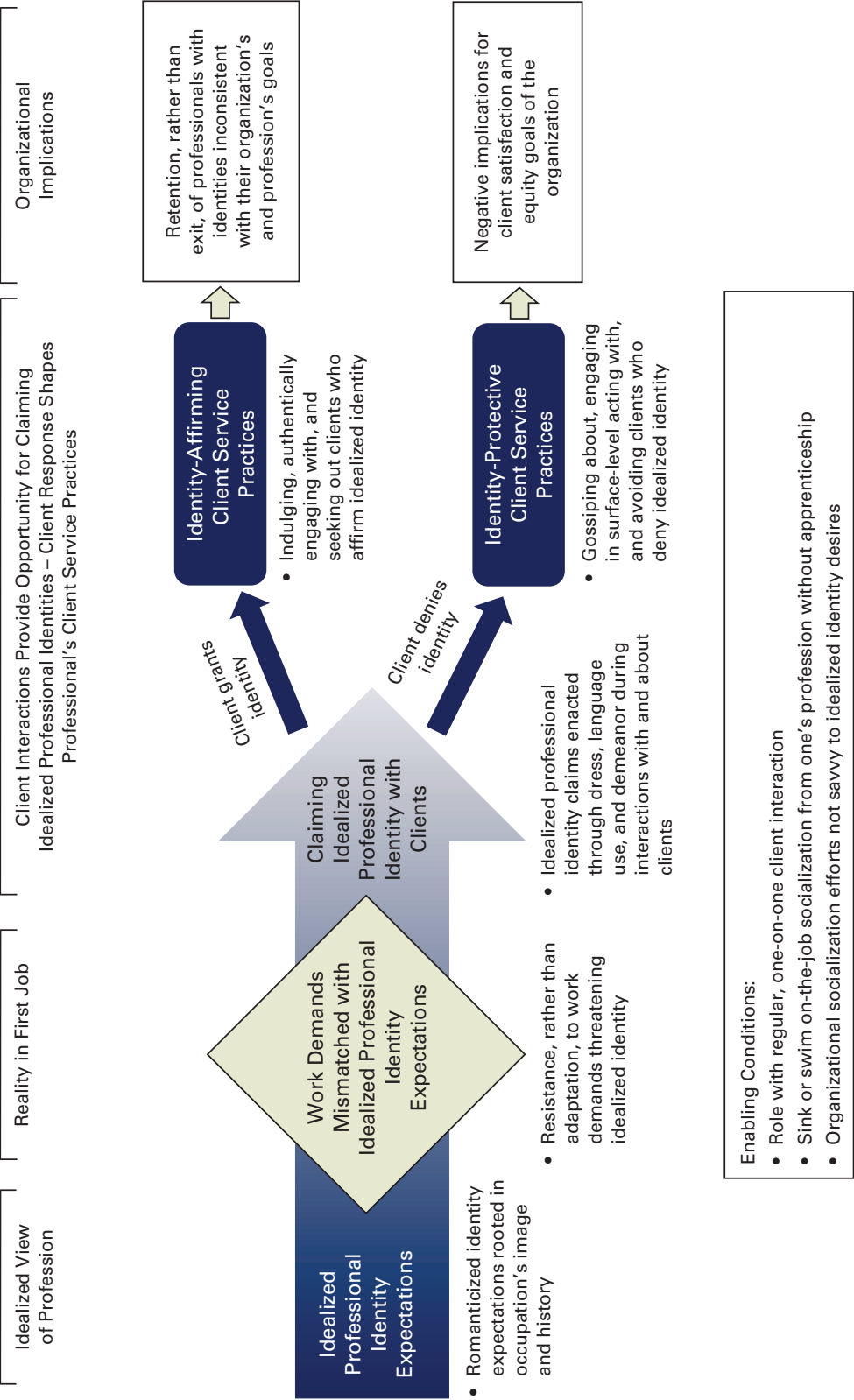
I develop a theoretical model, shown in Figure 1, of how idealized professional identities—identities rooted in the image and history of an occupation rather than reality—can persist through new members’ client interactions despite running counter to the goals of both their organization and profession.

As depicted on the left of Figure 1, since an idealized identity is by definition unrealistic and romanticized, it will necessarily be mismatched with the reality of work demands in one’s first job. While existing scholarship suggests that this mismatch should trigger new professionals to resolve such inconsistencies by adapting their identities to align with the demands of their work environments (e.g., Pratt, Rockmann, and Kauffman, 2006; Jain, George, and Maltarich, 2009; Ibarra and Barbulescu, 2010; Nelson and Irwin, 2013), I find that this adaptation may not fully occur when work demands provoke resistance by threatening cherished and deeply held idealized professional identities. I theorize that such resistance will occur when three enabling conditions are present: (1) the new professionals serve clients, such that they have an ample supply of largely captive and dependent yet identity-relevant interaction partners with whom to claim their idealized professional identities; (2) the profession has sink or swim socialization without a structured profession-controlled apprenticeship to disabuse new members of unrealistic identity expectations that are not aligned with the profession’s aims; and (3) new members have organizational managers who are not savvy about using idealized identity desires as a form of organizational control. I expect that new professionals without idealized professional identity expectations, or who have strong on-the-job socialization from their profession or organization or do not work with clients, will more easily adapt their identities to better align with work demands as prior literature expects.

The middle of Figure 1 illustrates the process through which idealized professional identities may persist through client interactions. Such interactions can provide an outlet for meaningful but unsanctioned idealized identities to be claimed by professionals and sometimes granted by clients. New professionals may claim idealized professional identities with clients by enacting the identities through their dress, demeanor, and language use. When professionals perceive that clients are granting their idealized professional identity claims, professionals may engage in identity-affirming client service practices by (1) indulging, (2) authentically engaging with, and (3) seeking out these clients. In contrast, when professionals perceive that clients are denying their idealized professional identity claims, professionals may experience an identity threat and attempt to protect their idealized professional identity by (1) gossiping about, (2) engaging in surface-level acting with, and (3) avoiding these clients to the extent possible.

These practices have important organizational implications for retention and client satisfaction goals, which are listed on the right side of the model. Even if infrequent, meaningful identity-affirming client interactions may promote the

Figure 1. How Idealized Professional Identities Can Persist through Client Interactions



retention, rather than exit, of professionals with identities inconsistent with their organization's and profession's goals. And identity-threatening client service practices may negatively impact organizations' client satisfaction and equity goals when professionals avoid or differentially treat clients who threaten their idealized identities.

In our service-based economy, amid trends in which many professionals serving clients are part of professions that have decreasing control over new members' socialization and work in organizations that invest less in training, the persistence of idealized professional identities may be increasingly prevalent and consequential. Below I discuss the theoretical implications of this model for advancing our understanding of professional socialization and identity development in organizations.

Contributions to Theories of Professional Socialization in Organizations

The importance of client–professional interactions for professional identity development. This study advances knowledge about professional socialization by demonstrating the central role clients can play in the persistence of idealized professional identities not desired by one's profession or employing organization. Extant theories of professional identity formation focus on interactions with socializing agents within the profession, such as senior profession members or peers (e.g., Van Maanen and Barley, 1984; Pratt, Rockmann, and Kauffman, 2006), or on pressures from organizational management (e.g., Noordegraaf, 2015; Bévort and Suddaby, 2016). I build on this work by proposing that a professional's interactions with another important relation—their clients—may be critical for early identity development, particularly for perpetuating unsanctioned idealized professional identities.

Prior research has suggested that new professionals will respond to mismatched expectations by aligning their identities with the demands of their work environments (Becker et al., 1961; Van Maanen, 1978; Pratt, Rockmann, and Kaufmann, 2006; Anteby, 2013). I find that such adaptation may be disrupted when work demands threaten idealized professional identities and when professionals have an outlet for expressing their idealized identities during client interactions. This finding suggests that idealized professional identities may not be as easily abandoned as socialization theories suggest (Van Maanen and Schein, 1979; Ashforth and Saks, 1996; cf. Wittman, 2019) if client interactions offer an occasion for their enactment. It is therefore critical that future scholarship on professional socialization examine client interactions to more fully understand the professional identity development process and its impact on professional practices and associated outcomes.

While prior work has acknowledged that identities are relational and must be granted by others during interaction (Bartel and Dutton, 2002; White, 2008; DeRue and Ashford, 2010; Chreim et al., 2020), clients have been underexplored as critical stakeholders capable of shaping new professionals' identities by granting (or denying) idealized identity expectations. Most work on identity privileges professionals' self-perceptions (who they think they are; e.g., Ibarra, 1999; Pratt, Rockmann, and Kaufmann, 2006) and their professional peers' acceptance or rejection of them (e.g., Van Maanen and Barley, 1984). Client encounters may provide an occasion for new professionals, who

generally have limited power and discretion, to claim and enact meaningful but unsanctioned idealized identities. Idealized identity-affirming client encounters, even if infrequent, may sustain professionals in their occupation rather than prompting their exit and may also prevent them from fully adapting their identities to suit modern work demands by discarding romanticized elements. Such identities may then persist when they are granted by select clients. By taking client interactions seriously, this study advances the “relational turn” in the study of occupations and professions (Eyal, 2013; Huising, 2015; Anteby, Chan, and DiBenigno, 2016), demonstrating the importance of clients and other audiences for intimately shaping professionals’ work practices (Ramarajan and Reid, 2020; Satterstrom, Kerrissey, and DiBenigno, 2020; Anteby and Holm, 2021; Chan and Hedden, 2021; Chen, Christianson, and Zhong, 2021; Karunakaran, Orlikowski, and Scott, 2022).

In two critical ways, client relations are theoretically distinctive as an additional identity-granting relation of new professionals. First, clients often depend on professionals’ expertise and the services they are uniquely credentialed to provide (e.g., Hughes, 1963; Abbott, 1988). Clients are hence relatively captive interaction partners for professionals to make identity claims outside the gaze of managers or senior profession members. Second, as the beneficiaries of professionals’ services, clients are often central to what makes professionals’ work meaningful and socially valuable (Grant, 2007, 2012; Vough et al., 2013; Cardador and Pratt, 2018; Jiang, 2021). Thus client interactions, and whether clients grant or deny professionals’ idealized identity claims during them, are especially consequential.

Yet, as this study demonstrates, clients—especially paying customers—may be unruly (e.g., Roth, 1972; Lorber, 1975; Van Maanen, 1978; Nielsen and Colbert, 2021) and not cooperate (Huising, 2015; Chan and Hedden, 2021) in granting professionals’ idealized identity desires. Future research is needed to explore clients’ points of view. We might expect clients to grant professionals their idealized identity claims when they share the same idealized professional identity expectations (in this case, expecting nurses to “mother” them), perhaps from exposure to the same dated cultural images of occupations (Vough et al., 2013). Other clients might grant idealized identity claims for instrumental reasons upon learning, perhaps through repeat interactions, that doing so can result in preferential treatment. In my study, it is notable that the few patients who nurses cared for repeatedly (“frequent flyers”) benefited from identity-affirming client service practices after granting nurses’ idealized maternal caregiver identities even when those clients had stigmatized status characteristics that prior research has found to increase mistreatment, such as homelessness, drug addiction, or needs that required extensive dirty work (e.g., Jeffery, 1979; Timmermans and Sudnow, 1998).

Clients may be most likely to deny professionals their idealized identities when they have the power to evaluate professionals’ services and/or when organizations actively promulgate client roles that run counter to professionals’ idealized identity expectations. When organizations align their interests with clients’ interests instead of their professional employees’ interests, as depicted in theory on the “service triangle,” this alignment is expected to come at employees’ expense (Lopez, 2010; Chan and Hedden, 2021; Karunakaran, Orlikowski, and Scott, 2022). This study suggests, however, that such an alliance can negatively impact organizations and their clients by generating denied

idealized identity claims for professionals that result in identity-threatening client service practices, which ultimately undermine organizations' client satisfaction goals. This type of unintended consequence may be on the rise as market-based logics reshape institutional fields to increase clients' power relative to professionals', such as positioning patients and students as "consumers" (e.g., Scott et al., 2000; Bromley and Powell, 2012; Reich, 2014; Chen, Christianson, and Zhong, 2021; Reay, Goodrick, and D'Aunno, 2021).

This study also sheds new light on classic studies in sociology on client–professional interactions by proposing a novel explanation for differential client service practices observed in prior work. While these studies have found that front-line professionals can use their discretion to treat clients differentially (Roth, 1972; Lorber, 1975; Van Maanen, 1978; Lipsky, 1983; Maynard-Moody and Musheno, 2003; Canales, 2014; Canales and Greenberg, 2016), this scholarship has not identified the etiology underlying the classification schemas guiding and justifying why some clients are treated better than others. Prior research has proposed that client typologies and differential treatment stem from client characteristics (e.g., perceived moral worth, socioeconomic status, race, gender) and behavior (e.g., disruption to workflow, level of dirty work) in conjunction with work environment pressures (e.g., Lorber, 1975; Emerson, 1991). My study extends this work by suggesting that the etiology of some client-labeling typologies may be rooted in the idealized image of an occupation and whether clients affirm or deny professionals' idealized identity claims. This perspective may help explain why even highly demanding patients who require low-status dirty work and have devalued characteristics could still receive preferential treatment (e.g., prioritized requests, gifts) by granting nurses' idealized professional identity claims.

The importance and durability of idealized professional identities. This study also contributes to our understanding of professional socialization by demonstrating the surprising durability of unsanctioned idealized professional identities. Because idealized professional identities exist in the cultural and historical image of an occupation, which is outside the direct control of organizations or professions, they may endure even when their enactment has negative consequences for the organization and its clients. Existing research positions professional identities as residing within the profession, at the macro level, controlled by senior profession members and gatekeepers (Hughes, 1963; Abbott, 1988). I contribute to this body of work by showing how the content of a professional identity may come not only from one's actual profession (Van Maanen and Barley, 1984; Abbott, 1988) or organization (Van Maanen, 1978; Ashforth and Saks, 1996) but also from prior internalization of outdated images rooted in the history of one's occupation that can be kept alive through select client interactions. This finding suggests that it is critical for future scholars of professional identity to examine the historical and cultural image of an occupation, as well as client interactions, as sites where such outdated identities can be enacted through one's dress, demeanor, and language and can impact client service practices.

When people commit to a profession before experiencing the work, their expected identity may be idealized—shaped by their imaginations and developed through exposure to media, popular culture, family member accounts,

and myths. Related scholarship on occupational prototypes suggests that stereotypes, particularly gender stereotypes associated with ideal worker images, affect occupational gender segregation (Ashcraft, 2013; Bartel and Wiesenfeld, 2013; Seron et al., 2016) and gendered forms of collaboration (Cardador, Hill, and Salles, 2021; Koppman, Bechky, and Cohen, 2021). My study finds that occupational images or prototypes may also impact how professionals enact their roles with clients, even when their organizations and professions do not endorse such outdated depictions of the occupation or when their enactment results in negative outcomes. Thus scholars of occupational prototypes might examine client interactions as another site for reproducing or disrupting outdated or gendered occupational prototypes at work.

Contributions to Our Understanding of Meaningful Work Identities and Callings

While related research has found that meaningful imagined and forgone, fantasy-based identities may exert a powerful hold over behavior, this work has examined imagined identities unrelated to the occupation one pursues (Markus and Nurius, 1986; Berg, Grant, and Johnson, 2010; Obodaru, 2017). While this scholarship articulates the positive outcomes associated with enacting such identities at work to achieve “value fulfillment” (Obodaru, 2017), my research suggests a downside to unchecked identity fantasies about one’s own profession. When identity fantasies about one’s profession are claimed but regularly denied by clients, the result may be client service practices that negatively impact organizational goals.

My findings also contribute to scholarship on when people perceive work as a meaningful calling rather than as a job or career (e.g., Wrzesniewski et al., 1997; Cho and Jiang, 2021; Jiang, 2021). While much research has emphasized the positive benefits of engaging in meaningful work (e.g., Hall and Chandler, 2005; Rosso, Dekas, and Wrzesniewski, 2010), this study joins with research unearthing the dark side of callings (Bunderson and Thompson, 2009; Cardador and Caza, 2012; Oelberger, 2018; Cech, 2021). My findings suggest that the source of one’s calling—whether the calling is rooted in identity-based idealized narratives of being destined for an occupation before experiencing the work or develops from performing the work itself—is vitally important for shaping how someone enacts their calling (Wrzesniewski, 2015). I find that those for whom callings involve strong identity-based commitments (versus callings to the actual work, such as examined by Ranganathan, 2018, or Jiang, 2021) may be at risk of not only experiencing negative individual-level effects (Schabram and Maitlis, 2017) but also engaging in work practices that undermine their organizations’ client satisfaction goals. Thus it seems critical for future studies to examine the source of one’s calling and the extent to which identity-based callings require clients’ cooperation.

Practical Implications

As more professionals work in organizations under bureaucratic control (Muzio, Aulakh, and Kirkpatrick, 2019; Adams et al., 2020; Chown, 2021) and experience weaker profession-controlled socialization (Etzioni, 1969; Krause, 1999;

Bailey and Barley, 2011), they may be at increasing risk of enacting idealized identities during client interactions based on outdated images of their professions. Organizations may increasingly be responsible for socializing new professionals (Van Maanen and Schein, 1979; Ashforth and Saks, 1996), and attending to professionals' identity desires can be an effective form of organizational control (Anteby, 2008a). But managers may not recognize the importance of managing professionals' idealized identity expectations or may hesitate to invest in costly apprenticeship training given increasing employee turnover (Bidwell et al., 2013; Caldwell and Peters, 2018; Beane, 2019). Thus managers may not take appropriate action even though unchecked idealized identities may shape professionals' work practices with clients in ways that run counter to organizational goals.

The apprenticeship model has been waning even for elite professions such as engineering, accounting, and finance as organizations take more responsibility for the socialization of the professionals they employ (Covaleski et al., 1998; Davis, Vinson, and Stevens, 2017; Anthony, 2021). New expert occupations have proliferated in recent decades (Brint, 1994), many of which also lack lengthy profession-controlled apprenticeship socialization; examples include physician assistants, nurse practitioners, and service designers (Rosoff, 1978; Fayard, Stigliani, and Bechky, 2017). Other occupations such as social work, policing, and firefighting (Van Maanen, 1975, 2010; Foldy and Buckley, 2010; Pratt, Lepisto, and Dane, 2018) have long used a sink or swim approach to on-the-job socialization. Leaders of professions with weak on-the-job socialization need to be cognizant of how outdated images of their profession may shape selection into their profession and negatively impact client service practices when modern work demands are mismatched with idealized expectations.

Organizations may be wise to attend to idealized professional identity expectations to help channel them toward supporting rather than undermining organizational goals. Since client satisfaction is increasingly important in many industries (Coupland, Currie, and Boyett, 2008; Lepisto, Crosina, and Pratt, 2015; Vogus et al., 2020), understanding idealized professional identities may be especially consequential for organizations serving clients. If managers of the hospital studied better understood nurses' idealized identity desires, they may have reconsidered their approach to improving patient satisfaction. For example, instead of asking nurses to thank patients after each encounter, they might have given patients blank thank-you cards to fill out for nurses or have given nurses more slack time to develop meaningful patient relationships to promote identity-affirming service practices.

Limitations and Opportunities for Future Research

Single-site, inductive ethnographic studies are valuable for developing new theory and concepts, but future work is needed to test and refine the model developed in this article in other contexts and with other occupations. Although health care contexts and professionals are increasingly recognized as important to study in their own right (Kerrissey, Mayo, and Edmondson, 2021; Mayo, Myers, and Sutcliffe, 2021; Reay, Goodrick, and D'Aunno, 2021; Sangal et al., 2021), I would also expect my theoretical model to generalize to other organizational contexts featuring client-facing occupations that aspirants are likely to idealize based on positive, salient public images—especially if those

occupations have weak on-the-job professional socialization. For example, teaching is a top professional aspiration of many children. According to my study, new teachers with minimal profession-led socialization, such as those thrown into struggling schools in Teach for America–style programs, may be at greatest risk of enacting idealized professional identities and identity-protective practices in response to students who deny them the commonly romanticized “teacher-as-savior” identity. Or consider a new firefighter who, since childhood, dreamed of enacting an idealized hero identity by valiantly rescuing grateful fire victims. They may discover that modern firefighting involves minimal time rescuing appreciative fire victims (Pratt, Lepisto, and Dane, 2018) and more time responding to opioid overdose victims who, if identity-threatening, might be differentially treated (Schneider and O’Keeffe, 2018).

The theory developed here should also be considered in conjunction with several boundary conditions. First, nurses with idealized professional identity expectations were the majority on both units across all shift times, such that a shared culture may have supported the persistence of these practices with clients. With reduced formal professional socialization from senior gatekeepers of the profession or management, informal socialization from peers who share the same unrealistic idealized identity expectations may amplify and sustain the persistence of these identities. In professions often idealized by children, many new members may be exposed to similar cultural images of the profession and hence may share the same idealized identity expectations. Nonetheless, future work is needed to assess whether idealized identities persist when only a minority of work group members share an idealized identity.

Another important boundary condition is that most nurses I studied were in their first jobs. One strength of my data is that I observed the persistence of idealized identities among nurses in their fourth year on the job and beyond; I did not focus only on first-year professionals. However, future research is needed to study whether idealized identities persist or fade away as professionals move on in their careers. Given the imprinting of early experiences (Marquis and Tilcsik, 2013), new professionals’ first jobs may be especially consequential for shaping enduring professional identities and work practices.

Future research is also needed to examine how to disrupt the perpetuation of idealized professional identities and their enactment with clients amid conditions of weak socialization. Research on realistic job previews (Meglino, Ravlin, and DeNisi, 2000) suggests one route, yet it is unclear that idealized identities result from a knowledge gap since many of the nurses with idealized identities in this study had relatives in nursing or previously worked as nursing aides, and all completed clinical rotations at hospitals during nursing school. Other studies might examine what exacerbates or reduces idealized identity attachments, particularly for new generations saturated with images of occupations on social media. Future work might also explore additional outcomes associated with idealized professional identities, such as burnout and mental health issues, especially in light of female nurses having a high suicide rate relative to other occupational groups (Peterson et al., 2020).

Idealized professional identities may be increasingly prevalent in the many occupations that serve clients given the decline in apprenticeship socialization and tendency for organizations to invest less in training new hires. Under these conditions, new professionals may grapple with reality shock and use client

interactions to enact idealized identities that are ill-suited to modern work demands. Idealized images of a profession may attract new members but can result in negative consequences when they generate unfulfilled identity expectations. To support the most idealistic among us who commit to a profession with the noblest of motives may require creating work environments that better deliver on professionals' expectations or invest more in helping them adapt. Such efforts may benefit not only new professionals but also their employing organizations and clients.

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Supplemental Material

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REFERENCES

- Abbott, A.
1988 *The System of Professions: An Essay on the Division of Expert Labor*. Chicago: University of Chicago Press.
- Adams, T. L., I. Kirkpatrick, P. S. Tolbert, and J. Waring
2020 "From protective to connective professionalism: *Quo vadis* professional exclusivity?" *Journal of Professions and Organization*, 7: 234–245.
- Allen, D.
2001 *The Changing Shape of Nursing Practice: The Role of Nurses in the Hospital Division of Labour*. London: Routledge.
- Allen, N., and J. Meyer
1990 "Organizational socialization tactics: A longitudinal analysis of links to newcomers' commitment and role orientation." *Academy of Management Journal*, 33: 847–858.

Alvesson, M., and H. Willmott

2002 "Identity regulation as organizational control: Producing the appropriate individual." *Journal of Management Studies*, 39: 619–644.

Anteby, M.

2008a "Identity incentives as an engaging form of control: Revisiting leniencies in an aeronautic plant." *Organization Science*, 19: 202–220.

Anteby, M.

2008b *Moral Gray Zones*. Princeton, NJ: Princeton University Press.

Anteby, M.

2013 *Manufacturing Morals: The Values of Silence in Business School Education*. Chicago: University of Chicago Press.

Anteby, M., C. Chan, and J. DiBenigno

2016 "Three lenses on occupations and professions in organizations: Becoming, doing, and relating." *Academy of Management Annals*, 10: 183–244.

Anteby, M., and A. L. Holm

2021 "Translating expertise across work contexts: US puppeteers move from stage to screen." *American Sociological Review*, 86: 310–340.

Anthony, C.

2021 "When knowledge work and analytical technologies collide: The practices and consequences of black boxing algorithmic technologies." *Administrative Science Quarterly*, 66: 1172–1212.

Ashcraft, K. L.

2013 "The glass slipper: 'Incorporating' occupational identity in management studies." *Academy of Management Review*, 38: 6–31.

Ashforth, B.

2000 *Role Transitions in Organizational Life: An Identity-Based Perspective*. New York: Routledge.

Ashforth, B. E., and A. M. Saks

1996 "Socialization tactics: Longitudinal effects on newcomer adjustment." *Academy of Management Journal*, 39: 149–178.

Bailey, D. E., and S. R. Barley

2011 "Teaching–learning ecologies: Mapping the environment to structure through action." *Organization Science*, 22: 262–285.

Bailyn, L.

1977 "Research as a cognitive process: Implications for data analysis." *Quality & Quantity*, 11(2): 97–117.

Barley, S. R., and P. S. Tolbert

1991 "Introduction: At the intersection of organizations and occupations." In P. S. Tolbert and S. R. Barley (eds.), *Research in the Sociology of Organizations*, 8: 1–13.

Bartel, C., and J. Dutton

2002 "Ambiguous organizational memberships: Constructing organizational identities in interactions with others." In M. A. Hogg and D. J. Terry (eds.), *Social Identity Processes in Organizational Contexts*: 115–130. New York: Psychology Press.

Bartel, C. A., and B. M. Wiesenfeld

2013 "The social negotiation of group prototype ambiguity in dynamic organizational contexts." *Academy of Management Review*, 38: 503–524.

Barton, M.

1995 "A nurse's place is at the bedside." *BMJ: British Medical Journal*, 311(7000): 325.

Battilana, J., and S. Dorado

2010 "Building sustainable hybrid organizations: The case of commercial microfinance organizations." *Academy of Management Journal*, 53: 1419–1440.

Beane, M.

2019 "Shadow learning: Building robotic surgical skill when approved means fail." *Administrative Science Quarterly*, 64: 87–123.

Becker, H. S., and J. W. Carper

1956 "The development of identification with an occupation." *American Journal of Sociology*, 61: 289–298.

Becker, H. S., B. Geer, E. C. Hughes, and A. Strauss

1961 *Boys in White: Student Culture in Medical School*. Chicago: University of Chicago Press.

Berg, J. M., A. M. Grant, and V. Johnson

2010 "When callings are calling: Crafting work and leisure in pursuit of unanswered occupational callings." *Organization Science*, 21: 973–994.

Besharov, M. L.

2014 "The relational ecology of identification: How organizational identification emerges when individuals hold divergent values." *Academy of Management Journal*, 57: 1485–1512.

Bévort, F., and R. Suddaby

2016 "Scripting professional identities: How individuals make sense of contradictory institutional logics." *Journal of Professions and Organization*, 3(1): 17–38.

Bidwell, M., F. Briscoe, I. Fernandez-Mateo, and A. Sterling

2013 "The employment relationship and inequality: How changes in employment practices are reshaping rewards in organizations." *Academy of Management Annals*, 7: 61–121.

Bobo, M., B. L. Hildreth, and B. Durodoye

1998 "Changing patterns in career choices among African-American, Hispanic, and Anglo children." *Professional School Counseling*, 1(4): 37–42.

Bosk, C. L.

1979 *Forgive and Remember: Managing Medical Failure*. Chicago: University of Chicago Press.

Bowles, C., and L. Candela

2005 "First job experiences of recent RN graduates: Improving the work environment." *JONA: The Journal of Nursing Administration*, 35(3): 130–137.

Brannon, R. L.

1994 "Professionalization and work intensification: Nursing in the cost containment era." *Work and Occupations*, 21(2): 157–178.

Brint, S.

1994 *In an Age of Experts: The Changing Roles of Professionals in Politics and Public Life*. Princeton, NJ: Princeton University Press.

Briscoe, F.

2006 "Temporal flexibility and careers: The role of large-scale organizations for physicians." *ILR Review*, 60: 88–104.

Briscoe, F.

2007 "From iron cage to iron shield? How bureaucracy enables temporal flexibility for professional service workers." *Organization Science*, 18: 297–314.

Bromley, P., and W. W. Powell

2012 "From smoke and mirrors to walking the talk: Decoupling in the contemporary world." *Academy of Management Annals*, 6: 483–530.

Bunderson, J. S., and J. A. Thompson

2009 "The call of the wild: Zookeepers, callings, and the double-edged sword of deeply meaningful work." *Administrative Science Quarterly*, 54: 32–57.

Buresh, B., and S. Gordon

1995 "Taking on the TV shows." *The American Journal of Nursing*, 95(11): 18–20.

Cabaniss, R.

2011 "Educating nurses to impact change in nursing's image." *Teaching and Learning in Nursing*, 6(3): 112–118.

Cable, D. M., and C. K. Parsons

2001 "Socialization tactics and person–organization fit." *Personnel Psychology*, 54(1): 1–23.

Caldwell, C., and R. Peters

2018 "New employee onboarding—Psychological contracts and ethical perspectives." *Journal of Management Development*, 37(1): 27–39.

Canales, R.

2014 "Weaving straw into gold: Managing organizational tensions between standardization and flexibility in microfinance." *Organization Science*, 25: 1–28.

Canales, R., and J. Greenberg

2016 "A matter of (relational) style: Loan officer consistency and exchange continuity in microfinance." *Management Science*, 62: 1202–1224.

Cardador, M. T., and B. B. Caza

2012 "Relational and identity perspectives on healthy versus unhealthy pursuit of callings." *Journal of Career Assessment*, 20: 338–353.

Cardador, M. T., P. L. Hill, and A. Salles

2021 "Unpacking the status-leveling burden for women in male-dominated occupations." *Administrative Science Quarterly*, 67: 237–284.

Cardador, M. T., and M. G. Pratt

2018 "Becoming who we serve: A model of multi-layered employee–customer identification." *Academy of Management Journal*, 61: 2053–2080.

Caristo, J. M., and P. T. Clements

2019 "Let's stop 'eating our young': Zero-tolerance policies for bullying in nursing." *Nursing2020 Critical Care*, 14(4): 45–48.

Carroll, S. M., and K. C. Rosa

2016 "Role and image of nursing in children's literature: A qualitative media analysis." *Journal of Pediatric Nursing*, 31(2): 141–151.

Caza, B. B., H. Vough, and H. Puranik

2018 "Identity work in organizations and occupations: Definitions, theories, and pathways forward." *Journal of Organizational Behavior*, 39: 889–910.

Cech, E. A.

2021 *The Trouble with Passion: How Searching for Fulfillment at Work Fosters Inequality*. Oakland, CA: University of California Press.

Chan, C. K., and L. Hedden

2021 "The role of discernment and modulation in enacting occupational values: How career advising professionals navigate tensions with clients." *Academy of Management Journal*. DOI: 10.5465/amj.2020.1014.

Chappell, D., and A. Willis

2010 *The Architect in Practice*. Chichester, UK: Wiley-Blackwell.

Chen, S., M. Christianson, and C. B. Zhong

2021 "Art for whose sake? Audience relational orientation work in the 'Porcelain Capital' of China." Working paper, Rotman School of Management.

Cho, Y., and W. Y. Jiang

2021 "If you do what you love, will the money follow? How work orientation impacts objective career outcomes via managerial (mis)perceptions." *Academy of Management Journal*. DOI: 10.5465/amj.2020.0841.

Chown, J.

2021 "The unfolding of control mechanisms inside organizations: Pathways of customization and transmutation." *Administrative Science Quarterly*, 66: 711–752.

Chreim, S., A. Langley, T. Reay, M. Comeau-Vallee, and J. L. Huq

2020 "Constructing and sustaining counter-institutional identities." *Academy of Management Journal*, 63: 935–964.

Chreim, S., B. E. Williams, and C. R. Hinings

2007 "Interlevel influences on the reconstruction of professional role identity." *Academy of Management Journal*, 50: 1515–1539.

Coupland, C., G. Currie, and I. Boyett

2008 "New public management and a modernization agenda: Implications for school leadership." *International Journal of Public Administration*, 31: 1079–1094.

Covaleski, M. A., M. W. Dirsmith, J. B. Heian, and S. Samuel

1998 "The calculated and the avowed: Techniques of discipline and struggles over identity in Big Six public accounting firms." *Administrative Science Quarterly*, 43: 293–327.

Currie, G., R. Finn, and G. Martin

2010 "Role transition and the interaction of relational and social identity: New nursing roles in the English NHS." *Organization Studies*, 31: 941–961.

D'Antonio, P.

2010 *American Nursing: A History of Knowledge, Authority, and the Meaning of Work*. Baltimore: Johns Hopkins University Press.

Darbyshire, P., D. Thompson, and R. Watson

2019 "Nursing's future? Eat young. Spit out. Repeat. Endlessly." *Journal of Nursing Management*, 27: 1337–1340.

Darling-Hammond, L., D. J. Holtzman, S. J. Gatlin, and J. V. Heilig

2005 "Does teacher preparation matter? Evidence about teacher certification, Teach for America, and teacher effectiveness." *Education Policy Analysis Archives*, 13: 1–48.

Davis, P., A. Vinson, and R. Stevens

2017 "Informal mentorship of new engineers in the workplace." Nottingham Repository. <https://nottingham-repository.worktribe.com/preview/867873/informal-mentorship-of-new-engineers-in-the-workplace.pdf>.

DeRue, D. S., and S. J. Ashford

2010 "Who will lead and who will follow? A social process of leadership identity construction in organizations." *Academy of Management Review*, 35: 627–647.

DiBenigno, J.

2018 "Anchored personalization in managing goal conflict between professional groups: The case of U.S. Army mental health care." *Administrative Science Quarterly*, 63: 526–569.

DiBenigno, J.

2020 "Rapid relationality: How peripheral experts build a foundation for influence with line managers." *Administrative Science Quarterly*, 65: 20–60.

DiBenigno, J., and K. C. Kellogg

2014 "Beyond occupational differences: The importance of cross-cutting demographics and dyadic toolkits for collaboration." *Administrative Science Quarterly*, 59: 375–408.

DiBenigno, J., and M. Kerrissey

2020 "Structuring mental health support for frontline caregivers during COVID-19: Lessons from organisational scholarship on unit-aligned support." *BMJ Leader*, 4: 124–127.

Dingwall, R., and D. Allen

2001 "The implications of healthcare reforms for the profession of nursing." *Nursing Inquiry*, 8(2): 64–74.

Elliott, P. R. C.

1972 *The Sociology of the Professions*. London: Macmillan International Higher Education.

Emerson, R. M.

1991 "Case processing and interorganizational knowledge: Detecting the 'real reasons' for referrals." *Social Problems*, 38(2): 198–212.

Etzioni, A.

1969 *The Semi-Professions and Their Organization: Teachers, Nurses, Social Workers*. New York: Free Press.

Eyal, G.

2013 "For a sociology of expertise: The social origins of the autism epidemic." *American Journal of Sociology*, 118: 863–907.

Eyal, G.

2019 *The Crisis of Expertise*. New York: John Wiley and Sons.

Fayard, A. L., I. Stigliani, and B. A. Bechky

2017 "How nascent occupations construct a mandate: The case of service designers' ethos." *Administrative Science Quarterly*, 62: 270–303.

Foldy, E. G., and T. R. Buckley

2010 "Re-creating street-level practice: The role of routines, work groups, and team learning." *Journal of Public Administration Research and Theory*, 20(1): 23–52.

Freidson, E.

1974 *Professional Dominance: The Social Structure of Medical Care*. New York: Transaction Publishers.

Galperin, R. V.

2020 "Organizational powers: Contested innovation and loss of professional jurisdiction in the case of retail medicine." *Organization Science*, 31: 508–534.

Glaser, B. G., and A. L. Strauss

1967 *The Discovery of Grounded Theory*. Chicago: Aldine Publishing Company.

Goode, C. J., S. Pinkerton, M. P. McCausland, P. Southard, R. Graham, and C. Krsek

2001 "Documenting chief nursing officers' preference for BSN-prepared nurses." *Journal of Nursing Administration*, 31(2): 55–59.

Goode, W. J.

1957 "Community within a community: The professions." *American Sociological Review*, 22: 194–200.

Goodrick, E., J. R. Meindl, and A. B. Flood

1997 "Business as usual: The adoption of managerial ideology by US hospitals." In J. J. Kronenfeld (ed.), *Research in the Sociology of Health Care*, 14: 27–50. Greenwich, CT: JAI Press.

Goodrick, E., and T. Reay

2010 "Florence Nightingale endures: Legitimizing a new professional role identity." *Journal of Management Studies*, 47(1): 55–84.

Gordon, S.

2005 *Nursing against the Odds: How Health Care Cost Cutting, Media Stereotypes, and Medical Hubris Undermine Nurses and Patient Care*. Ithaca, NY: Cornell University Press.

Gorman, E. H., and R. L. Sandefur

2011 "Golden age, quiescence, and revival: How the sociology of professions became the study of knowledge-based work." *Work and Occupations*, 38: 275–302.

Gorman, E. H., and S. P. Vallas

2020 "Introduction: Expertise and the changing structure of professional work." In *Professional Work: Knowledge, Power and Social Inequalities*: 1–8. Bingley, UK: Emerald Publishing Limited.

Grant, A. M.

2007 "Relational job design and the motivation to make a prosocial difference." *Academy of Management Review*, 32: 393–417.

Grant, A. M.

2012 "Leading with meaning: Beneficiary contact, prosocial impact, and the performance effects of transformational leadership." *Academy of Management Journal*, 55: 458–476.

Greenwood, E.

1957 "Attributes of a profession." *Social Work*, 2: 45–55.

Grodal, S., M. Anteby, and A. Holm

2021 "Achieving rigor in qualitative analysis: The role of active categorization in theory building." *Academy of Management Review*, 46: 591–612.

Hall, D. T., and D. E. Chandler

2005 "Psychological success: When the career is a calling." *Journal of Organizational Behavior*, 26(2): 155–176.

Hallam, J.

2012 *Nursing the Image: Media, Culture and Professional Identity*. New York: Routledge.

Hochschild, A. R.

1979 "Emotion work, feeling rules, and social structure." *American Journal of Sociology*, 85: 551–575.

Hochschild, A. R.

1983 *The Managed Heart: Commercialization of Human Feeling*. Berkeley, CA: University of California Press.

Hughes, E. C.

1963 "Professions." *Daedalus*, 92: 655–668.

Huising, R.

2014 "The erosion of expert control through censure episodes." *Organization Science*, 25: 1633–1661.

Huising, R.

2015 "To hive or to hold? Producing professional authority through scut work." *Administrative Science Quarterly*, 60: 263–299.

Ibarra, H.

1999 "Provisional selves: Experimenting with image and identity in professional adaptation." *Administrative Science Quarterly*, 44: 764–791.

Ibarra, H., and R. Barbulescu

2010 "Identity as narrative: Prevalence, effectiveness, and consequences of narrative identity work in macro work role transitions." *Academy of Management Review*, 35: 135–154.

Institute of Medicine

2011 *The Future of Nursing: Leading Change, Advancing Health*. Washington, DC: National Academies Press.

Jain, S., G. George, and M. Maltarich

2009 "Academics or entrepreneurs? Investigating role identity modification of university scientists involved in commercialization activity." *Research Policy*, 38: 922–935.

Jeffery, R.

1979 "Normal rubbish: Deviant patients in casualty departments." *Sociology of Health & Illness*, 1(1): 90–107.

Jiang, W. Y.

2021 "Sustaining meaningful work in a crisis: Adopting and conveying a situational purpose." *Administrative Science Quarterly*, 66: 806–853.

Judd, D. M., and K. Sitzman

2014 *A History of American Nursing: Trends and Eras*. Burlington, MA: Jones & Bartlett Publishers.

Kalisch, P. A., B. J. Kalisch, and J. Clinton

1982 "Nursing on prime time television, 1950 to 1980." *Nursing Research*, 31: 358–363.

Karunakaran, A.

2022 "Status–authority asymmetry between professions: The case of 911 dispatchers and police officers." *Administrative Science Quarterly*, 67: 423–468.

Karunakaran, A., W. Orlikowski, and S. V. Scott

2022 "Crowd-based accountability: Examining how social media commentary reconfigures organizational accountability." *Organization Science*, 33: 170–193.

Kearns, T., and P. Mahon

2021 "How to attain gender equality in nursing—An essay." *British Medical Journal*, 373(1232). DOI:10.1136/bmj.n1232.

Kellogg, K. C.

2012 "Making the cut: Using status-based countertactics to block social movement implementation and microinstitutional change in surgery." *Organization Science*, 23: 1546–1570.

Kerrissey, M. J., A. T. Mayo, and A. C. Edmondson

2021 "Joint problem-solving orientation in fluid cross-boundary teams." *Academy of Management Discoveries*, 7: 381–405.

Kleiner, M. M., and A. B. Krueger

2010 "The prevalence and effects of occupational licensing." *British Journal of Industrial Relations*, 48: 676–687.

Konner, M.

1988 *Becoming a Doctor: A Journey of Initiation in Medical School*. New York: Penguin Books.

Koppman, S., B. A. Bechky, and A. Cohen

2021 "Overcoming conflict between symmetric occupations: How 'creatives' and 'suits' use gender ordering in advertising." *Academy of Management Journal*. DOI: 10.5465/amj.2020.0806.

Kowtha, N. R.

2008 "Engineering the engineers: Socialization tactics and new engineer adjustment in organizations." *IEEE Transactions on Engineering Management*, 55: 67–81.

Krause, E. A.

1999 *Death of the Guilds: Professions, States, and the Advance of Capitalism, 1930 to the Present*. New Haven, CT: Yale University Press.

Lepisto, D. A., E. Crosina, and M. G. Pratt

2015 "Identity work within and beyond the professions: Toward a theoretical integration and extension." In A. Desilva and M. Aparicio (eds.), *International Handbook of Professional Identities*: 203–222. Rosemead, CA: Scientific and Academic Publishing.

Lifshitz-Assaf, H.

2018 "Dismantling knowledge boundaries at NASA: The critical role of professional identity in open innovation." *Administrative Science Quarterly*, 63: 746–782.

Lipsky, M.

1983 *Street-Level Bureaucracy: The Dilemmas of the Individual in Public Service*. New York: Russell Sage Foundation.

Lopez, S. H.

2006 "Emotional labor and organized emotional care: Conceptualizing nursing home care work." *Work and Occupations*, 33: 133–160.

Lopez, S. H.

2010 "Workers, managers, and customers: Triangles of power in work communities." *Work and Occupations*, 37: 251–271.

Lorber, J.

1975 "Good patients and problem patients: Conformity and deviance in a general hospital." *Journal of Health and Social Behavior*, 16: 213–225.

Louis, M. R.

1980 "Surprise and sense making: What newcomers experience in entering unfamiliar organizational settings." *Administrative Science Quarterly*, 25: 226–251.

Markus, H., and P. Nurius

1986 "Possible selves." *American Psychologist*, 41: 954–969.

Marquis, C., and A. Tilcsik

2013 "Imprinting: Toward a multilevel theory." *Academy of Management Annals*, 7: 195–245.

Masters, K.

2009 *Role Development in Professional Nursing Practice*. Burlington, MA: Jones & Bartlett Learning.

Maynard-Moody, S., and M. Musheno

2003 *Cops, Teachers, Counselors: Stories from the Front Lines of Public Service*. Ann Arbor, MI: University of Michigan Press.

Mayo, A. T., C. G. Myers, and K. M. Sutcliffe

2021 "Organizational science and health care." *Academy of Management Annals*, 15: DOI: 10.5465/annals.2019.0115.

Mead, G. H.

1934 *Mind, Self and Society*. Chicago: University of Chicago Press.

Meglino, B. M., E. C. Ravlin, and A. S. DeNisi

2000 "A meta-analytic examination of realistic job preview effectiveness: A test of three counterintuitive propositions." *Human Resource Management Review*, 10: 407–434.

Michel, A.

2011 "Transcending socialization: A nine-year ethnography of the body's role in organizational control and knowledge workers' transformation." *Administrative Science Quarterly*, 56: 325–368.

Mortimer, J. T.

2009 "Youth development study, 1988–2011." Interuniversity Consortium for Political and Social Research. DOI: 10.3886/icpsr24881.

Muzio, D., S. Aulakh, and I. Kirkpatrick

2019 *Professional Occupations and Organizations*. Cambridge: Cambridge University Press.

Nelson, A. J., and J. Irwin

2013 "'Defining what we do—all over again': Occupational identity, technological change, and the librarian/internet relationship." *Academy of Management Journal*, 57: 892–928.

Nembhard, I. M., A. J. Alexander, T. J. Hoff, and R. Ramanujam

2009 "Why does the quality of health care continue to lag? Insights from management research." *Academy of Management Perspectives*, 23: 24–42.

Nielsen, J. D., and A. E. Colbert

2021 "It's not always sunny in relationally rich jobs: The influence of negative beneficiary contact." *Academy of Management Journal*. DOI: 10.5465/amj.2019.1288.

Nightingale, F.

1898 *Notes on Nursing: What It Is, and What It Is Not*. New York: Appleton-Century.

Noordegraaf, M.

2015 "Hybrid professionalism and beyond: (New) forms of public professionalism in changing organizational and societal contexts." *Journal of Professions and Organization*, 2: 187–206.

Obodaru, O.

2017 "Forgone, but not forgotten: Toward a theory of forgone professional identities." *Academy of Management Journal*, 60: 523–553.

Oelberger, C.

2018 "The dark side of deeply meaningful work: Work-relationship turmoil and the moderating role of occupational value homophily." *Journal of Management Studies*, 56: 558–588.

- Peterson, C., A. Sussell, J. Li, P. K. Schumacher, K. Yeoman, and D. M. Stone**
2020 "Suicide rates by industry and occupation—National Violent Death Reporting System, 32 states, 2016." *Morbidity and Mortality Weekly Report*, 69(3): 57–62.
- Petriglieri, J. L.**
2011 "Under threat: Responses to and the consequences of threats to individuals' identities." *Academy of Management Review*, 36: 641–662.
- Polavieja, J., and L. Platt**
2014 "Nurse or mechanic? The role of parental socialization and children's personality in the formation of sex-typed occupational aspirations." *Social Forces*, 93(1): 31–61.
- Pratt, M. G., D. A. Lepisto, and E. Dane**
2018 "The hidden side of trust: Supporting and sustaining leaps of faith among firefighters." *Administrative Science Quarterly*, 64: 398–434.
- Pratt, M. G., K. W. Rockmann, and J. B. Kaufmann**
2006 "Constructing professional identity: The role of work and identity in the customization of identity among medical residents." *Academy of Management Journal*, 49: 235–262.
- Price, S. L.**
2009 "Becoming a nurse: A meta-study of early professional socialization and career choice in nursing." *Journal of Advanced Nursing*, 65(1): 11–19.
- Rafaeli, A., and M. G. Pratt**
1993 "Tailored meanings: On the meaning and impact of organizational dress." *Academy of Management Review*, 18: 32–55.
- Ramarajan, L., and E. Reid**
2020 "Relational reconciliation: Socializing others across demographic differences." *Academy of Management Journal*, 63: 356–385.
- Ranganathan, A.**
2018 "The artisan and his audience: Identification with work and price setting in a handicraft cluster in Southern India." *Administrative Science Quarterly*, 63: 637–667.
- Reay, T., E. Goodrick, and T. D'Aunno**
2021 *Health Care Research and Organization Theory*. Cambridge: Cambridge University Press.
- Reich, A. D.**
2014 *Selling Our Souls: The Commodification of Hospital Care in the U.S.* Princeton, NJ: Princeton University Press.
- Reinhart, R. J.**
2019 "Nurses continue to rate highest in honesty, ethics." Gallup. Accessed at <https://news.gallup.com/poll/274673/nurses-continue-rate-highest-honesty-ethics.aspx>.
- Reverby, S.**
1987 *Ordered to Care: The Dilemma of American Nursing, 1850–1945*. Cambridge: Cambridge University Press.
- Riemer, J. W.**
1977 "Becoming a journeyman electrician: Some implicit indicators in the apprenticeship process." *Work and Occupations*, 4(1): 87–98.
- Rosoff, N.**
1978 "Physician assistants and nurse practitioners: New educational models for new professionals." *The Journal of Applied Behavioral Science*, 14: 335–347.
- Rosso, B. D., K. H. Dekas, and A. Wrzesniewski**
2010 "On the meaning of work: A theoretical integration and review." *Research in Organizational Behavior*, 30: 91–127.
- Roth, J. A.**
1972 "Some contingencies of the moral evaluation and control of clientele: The case of the Hospital Emergency Service." *American Journal of Sociology*, 77: 839–856.

- Sangal, R. B., A. Wrzesniewski, J. DiBenigno, E. Reid, A. Ulrich, B. Liebhardt, A. Bray, E. Yang, E. Eun, A. K. Venkatesh, and M. King**
2021 "Work team identification associated with less stress and burnout among front-line emergency department staff amid the COVID-19 pandemic." *BMJ Leader*, 5: 51–54.
- Satterstrom, P., M. Kerrissey, and J. DiBenigno**
2021 "The voice cultivation process: How team members can help upward voice live on to implementation." *Administrative Science Quarterly*, 66: 380–425.
- Sauer, P.**
2012 "Do nurses eat their young? Truth and consequences." *Journal of Emergency Nursing*, 38: 43–46.
- Schabram, K., and S. Maitlis**
2017 "Negotiating the challenges of a calling: Emotion and enacted sensemaking in animal shelter work." *Academy of Management Journal*, 60: 584–609.
- Schein, E. H.**
1971 "The individual, the organization, and the career: A conceptual scheme." *The Journal of Applied Behavioral Science*, 7: 401–426.
- Schneider, C., and M. O'Keeffe**
2018 "Dealing with drug overdoses takes toll on first responders." *Newsday*. Accessed at <https://www.newsday.com/long-island/first-responders-opioids-futility-1.20294768>.
- Scott, W. R., M. Ruef, P. J. Mendel, and C. A. Caronna**
2000 *Institutional Change and Healthcare Organizations: From Professional Dominance to Managed Care*. Chicago: University of Chicago Press.
- Seron, C., S. S. Silbey, E. Cech, and B. Rubineau**
2016 "Persistence is cultural: Professional socialization and the reproduction of sex segregation." *Work and Occupations*, 43: 178–214.
- Simpson, E., and M. Courtney**
2002 "Critical thinking in nursing education: Literature review." *International Journal of Nursing Practice*, 8(2): 89–98.
- Sorensen, J. E., and T. L. Sorensen**
1974 "The conflict of professionals in bureaucratic organizations." *Administrative Science Quarterly*, 19: 98–106.
- Stanley, D. J.**
2008 "Celluloid angels: A research study of nurses in feature films 1900–2007." *Journal of Advanced Nursing*, 64: 84–95.
- Susskind, R. E., and D. Susskind**
2015 *The Future of the Professions: How Technology Will Transform the Work of Human Experts*. Oxford: Oxford University Press.
- Taylor, C. R., C. Lillis, P. LeMone, and P. Lynn**
2006 *Fundamentals of Nursing: The Art and Science of Nursing Care*, 6th ed. Philadelphia, PA: Lippincott, Williams & Wilkins.
- Timmermans, S., and D. Sudnow**
1998 "Social death as self-fulfilling prophecy: David Sudnow's *Passing On* revisited." *The Sociological Quarterly*, 39: 453–472.
- Truelove, E., and K. C. Kellogg**
2016 "The radical flank effect and cross-occupational collaboration for technology development during a power shift." *Administrative Science Quarterly*, 61: 662–701.
- Turco, C.**
2012 "Difficult decoupling: Employee resistance to the commercialization of personal settings." *American Journal of Sociology*, 118: 380–419.
- Valentine, M. A.**
2018 "Renegotiating spheres of obligation: The role of hierarchy in organizational learning." *Administrative Science Quarterly*, 63: 570–606.

Van Maanen, J.

1975 "Police socialization: A longitudinal examination of job attitudes in an urban police department." *Administrative Science Quarterly*, 20: 207–228.

Van Maanen, J.

1978 "People processing: Strategies of organizational socialization." *Organizational Dynamics*, 7: 19–36.

Van Maanen, J.

1991 "The smile factory: Work at Disneyland." In P. J. Frost (ed.), *Reframing Organizational Culture*: 58–76. London: Sage.

Van Maanen, J.

2010 *Identity Work and Control in Occupational Communities*. Cambridge: Cambridge University Press.

Van Maanen, J., and S. R. Barley

1984 "Occupational communities: Culture and control in organizations." In B. M. Staw and L. L. Cummings (eds), *Research in Organizational Behavior*, 6: 287–365.

Van Maanen, J., and G. Kunda

1989 "Real feelings. Emotional expression and organizational culture." In L. L. Cummings and B. M. Staw (eds.), *Research in Organizational Behavior*, 11: 43–103. New York: Elsevier.

Van Maanen, J. E., and E. H. Schein

1979 "Toward a theory of organizational socialization." In B. M. Staw (ed.), *Research in Organizational Behavior*, 1: 209–264. Greenwich, CT: JAI Press.

Vogus, T. J., A. Gallan, C. Rathert, D. El-Manstrly, and A. Strong

2020 "Whose experience is it anyway? Toward a constructive engagement of tensions in patient-centered health care." *Journal of Service Management*, 31: 979–1013.

Vough, H.

2012 "Not all identifications are created equal: Exploring employee accounts for workgroup, organizational, and professional identification." *Organization Science*, 23: 778–800.

Vough, H. C., M. T. Cardador, J. S. Bednar, E. Dane, and M. G. Pratt

2013 "What clients don't get about my profession: A model of perceived role-based image discrepancies." *Academy of Management Journal*, 56: 1050–1080.

Waring, J., and G. Currie

2009 "Managing expert knowledge: Organizational challenges and managerial futures for the UK medical profession." *Organization Studies*, 30: 755–778.

Wears, R., and K. Sutcliffe

2019 *Still Not Safe: Patient Safety and the Middle-Managing of American Medicine*. Oxford: Oxford University Press.

Weinberg, D. B.

2004 *Code Green: Money-Driven Hospitals and the Dismantling of Nursing*. Ithaca, NY: ILR Press.

Wharton, A. S.

1993 "The affective consequences of service work: Managing emotions on the job." *Work and Occupations*, 20: 205–232.

White, H. C.

2008 *Identity and Control: How Social Formations Emerge*. Princeton, NJ: Princeton University Press.

Wilson, C.

1965 "Economy and society." *The Economic History Review*, 18: 183–198.

Wittman, S.

2019 "Lingering identities." *Academy of Management Review*, 44: 724–745.

Wright, A. L., R. F. Zammuto, and P. W. Liesch

2017 "Maintaining the values of a profession: Institutional work and moral emotions in the emergency department." *Academy of Management Journal*, 60: 200–237.

Wrzesniewski, A.

2015 "Callings and the meaning of work." In D. B. Yaden, T. D. McCall, and J. H. Ellens (eds.), *Being Called: Scientific, Secular, and Sacred Perspectives*: 3–12. Westport, CT: Praeger.

Wrzesniewski, A., C. McCauley, P. Rosin, and B. Schwartz

1997 "Jobs, careers, and callings: People's relations to their work." *Journal of Research in Personality*, 31: 21–33.

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