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Changing Logics in Healthcare and Their Effects on the Identity Motives and Identity Work of Doctors

Graeme Martin
University of Dundee, UK

Stacey Bushfield
Edinburgh Napier University, UK

Sabina Siebert
University of Glasgow, UK

Brian Howieson
Edinburgh Napier University, UK

Abstract

Recent literature on hybridity has provided useful insights into how professionals have responded to changing institutional logics. Our focus is on how shifting logics have shaped senior medical professionals' identity motives and identity work in a qualitative study of hospital consultants in the United Kingdom's National Health Service. We found a binary divide between a large category of traditionalist doctors who reject shifting logics, and a much smaller category of incorporated consultants who broadly accept shifting logics and advocate change, with little evidence of significant ambivalence or temporary identity 'fixes' associated with liminality. By developing a new inductively generated framework, we show how the identity motives and identity work of these two categories of doctors differ significantly. We explore the underlying causes of these differences, and the implications they hold for theory and practice in medical professionalism, medical professional leadership and healthcare reform.

Keywords

doctors' professional identities, hybrid organizations, identity motives, identity work, senior professionals

Corresponding author:
Stacey Bushfield, Edinburgh Napier University Business School, Craiglockhart Campus, 219 Colinton Road, Edinburgh, EH14 1DJ, UK.
Email: S.Bushfield@napier.ac.uk

Introduction

Organization scholars have made insightful contributions to research into the impact of shifting institutional logics on professionals, sometimes explaining how they use different types of identity work to negotiate their way through these shifts (see, for example, Pratt, Rockman, & Kaufmann, 2006; Snow & Anderson, 1987; Sveningsson & Alvesson, 2003). Our interest lies in understanding how competing and coexisting logics have been interpreted, enacted and managed by medical professionals. Recent literature has focused on how doctors have attempted to integrate multiple logics into their professional role identities (Andersen & Vedsted, 2015; Reay & Hinings, 2009; Reay, Goodrick, Waldorff, & Casebeer, 2017). It has shown how doctors have been more or less successful in adopting a 'hybrid model' by assuming roles such as 'hybrid physicians', 'clinical leaders' or 'medical managers' (Andersson & Liff, 2018; Bartram et al., 2018; Kirkpatrick, Jespersen, Dent, & Neogy, 2009; McGivern, Currie, Ferlie, Fitzgerald, & Waring, 2015; Spyridonidis, Hendy, & Barlow, 2015). Indeed, some researchers have proposed hybridization as the 'new normal' model of professionalism (Noordegraaf, 2015) in asking doctors to cross over to the 'enlightened side' (Spurgeon, Clark, & Ham, 2011). Other literature, however, has been sceptical of doctors' success in integrating changing institutional logics into their identities (e.g. Bresnen, Hodgson, Bailey, Hassard, & Hyde, 2019), the consequences of failing to do so (Saks, 1995; Timmermans & Kolker, 2004), and the 'common-sense' acceptance of medical leadership as a legitimate role in the management of health services (Iliffe & Manthorpe, 2018). Our paper seeks to contribute to this debate by exploring the influence of logics on senior medical professionals' definition of themselves in role, and how and why they categorize themselves through their identity motives and identity work. We ask two questions: *do significant differences exist between the identity motives and identity work of doctors who fail to incorporate new logics into their professional role identities, and those who succeed in doing so? If so, why do these differences exist?* We believe our findings have theoretical and practical significance because the differences between identity motives and identity work among senior doctors have profound implications for future medical professionalism (Noordegraaf, 2015), the pace and scope of institutional change in healthcare systems (Micelotta, Lounsbury, & Greenwood, 2017) and the success of medical leadership, which has been widely proposed as essential to healthcare reform (Kirkpatrick, 2016).

Institutional Logics, Professional Identities and Identity Work in Healthcare

Changing logics and their effect on professional identities in healthcare

Institutional logics refer to 'organizing principles' (Friedland & Alford, 1991, p. 248) guiding individuals, groups and organizations' social construction and interpretation of their material and symbolic 'realities' and emotions (Durand & Thornton, 2018; Thornton, Ocasio, & Lounsbury, 2012). These logics shape organizational, individual and professional goals and identities, and the means of achieving them. However, this literature has also shown how institutional actors interpret and enact logics for different motives, at different times and in different ways (Gumusay, Smets, & Morris, 2019). Accordingly, it has provided valuable insights into healthcare change and the identity tensions created by multiple and coexisting logics (Cain, Frazer, & Kilaberia, 2019; Currie & Spyridonidis, 2016; Reay & Hinings, 2009). These insights have highlighted the coping mechanisms of clinical professionals, especially in developing hybrid professional roles as clinical leaders (Chreim, Williams, & Hinings, 2007; Kirkpatrick et al., 2009; McGivern et al., 2015; Waring & Bishop, 2013).

Table 1. Institutional logics operating in healthcare and their key features.

Institutional logic	Key features
Professional	• Expertise and autonomy • Quality of care is set by professional expertise
Market	• Laws of supply and demand determine the nature of the service provided • Quality is set by consumer demand
Corporate	• Bureaucratic rule-making by senior managers determines the nature and price of the service • Quality set by organizational targets and processes, and enforced by hierarchical managerial control
State	• Government determines the nature and price of the service in line with political priorities • Quality is set by legislation, government targets and accountable senior managers

Source: adapted from Reay et al., 2017.

In healthcare it has been usual to identify shifting combinations of three societal-level logics – professional, market and corporate – available to professions and professionals (Freidson, 2001; Reay et al., 2017). Historically, a medical professional logic, based on the expert knowledge of high-status and autonomous doctors, has dominated how individuals, groups and organizations have viewed healthcare systems worldwide and decision-making within them. During the 1980s, however, when healthcare demands in many western countries outstripped governments' willingness to fund them, market and corporate logics, associated with developments in bureaucratic control and new public management (NPM) (Fincham & Forbes, 2015; Iliffe & Manthorpe, 2018), became influential (Kirkpatrick, Kuhlmann, Hartley, Dent, & Lega, 2016) (see Table 1).

Contemporary research has pointed to greater institutional complexity, identifying other important field and organizational logics (Fincham & Forbes, 2015). In healthcare systems subject to strong governmental and legislative pressures, a state logic has become influential (Kyratsis, Atun, Phillips, Tracey, & George, 2017; Reay et al., 2017). This state logic has manifested itself in two ways. First, the adoption by clinicians of the principle of mutuality, which proposes that patients should co-produce healthcare in collaboration with clinical professionals rather than have diagnosis, goals and treatments 'done to them' (Howieson, 2016). Second, the influence of a care logic (Fincham & Forbes, 2015). This care logic de-emphasizes the dominant medical narrative that constructs health service users as patients to be treated in hospitals, and promotes the notion of service users as 'whole persons' to be cared for, preferably through health prevention and community-based social care strategies (Kyratsis et al., 2017). The care logic and mutuality are increasingly sponsored by governments as the only sustainable ways forward to meet the complex demands arising from ageing populations with multiple medical and care needs. Thus, a state logic that seeks to integrate health and social care services has become pervasive in the United Kingdom (Kaehne, Birrell, Miller, & Petch, 2017). This development is having a fundamental impact in transforming how services are delivered and financed by diverting increasingly scarce economic resources away from the acute sector, particularly from hospital doctors, to primary and social care professionals. Such trends are especially evident in NHS Scotland, the site of our empirical work, which is subject to more direct state and legislative control than the National Health Service systems in England, Wales and Northern Ireland (Bevan et al., 2014; Pearson & Watson, 2018).

In this context, senior medical professionals in the acute sector are increasingly required to accommodate, reinterpret and integrate market, corporate and state logics into their professional identities and relationships with other clinical and care professionals (Pearson & Watson, 2018).

Nevertheless, while logics have become *central* to the running of healthcare systems and organizations, they are not always seen as *compatible* with medical professionalism (Besharov & Smith, 2014). In the past, the medical literature explored the specific problems faced by doctors, who have enjoyed substantial degrees of autonomy when interpreting their role identities as expert professionals (Christmas & Millward, 2011). This literature focused on doctors' interpretations and enactment of deprofessionalization, in which new logics were seen as *incompatible* with traditional medical-professional identities (Freidson, 2001; Pratt et al., 2006).

More recently, however, the identity work literature on doctors has pointed to three ways in which they exercise significant agency when responding to identity threats; that is, situations where they perceive that one or more of their preferred identity narratives are being challenged (Brown & Coupland, 2015). The first has emphasized how doctors have integrated new logics into their professional role identities – either willingly or incidentally – to become hybrid medical professionals (Chreim et al., 2007; Kirkpatrick et al., 2009; McGivern et al., 2015; Reay et al., 2017; Waring & Bishop, 2013). The second draws on the concept of co-optation, which refers to how institutional actors selectively adopt strategic elements from one logic that retains the essential features of their dominant logic (Andersson & Liff, 2018; Pache & Santos, 2013). In doing so, medical professionals may seek to regain control over their professional goals by borrowing the means from other logics. However, we should note that this integration may be smaller in scope and slower than some researchers assume (Bresnen et al., 2019; Spyridonidis et al., 2015; Von Knorring, Alexanderson, & Eliasson,, 2016) – a point to which we return in the discussion.

The third trend draws on the concept of liminality or being 'in-between' (Beech, 2011), whereby identity reconstruction undertaken by professionals is seen as partial under conditions of ambiguity. Thus, 'identities can be thought of as temporary "fixes" concocted by individuals to impose a degree of coherence in the face of assorted vulnerabilities. . .' (Brown, 2019, p. 10). To cope with such ambiguity and impermanence, doctors and other professionals engage in a dialogue with themselves and others (MacIntosh, Beech, & Martin, 2012) by experimenting with new identities, reflecting on the views of significant others, and recognizing new identities projected onto them by new discourses and logics (Beech, 2011). One good example of liminality is the 'incidental hybrids' in the study by McGivern et al. (2015) that highlighted a group of essentially traditionalist doctors temporarily occupying medical leadership roles.

Professional role identity motives, identity responses and identity work among doctors. Actors' responses to the conditioning effects of logic shifts are linked to choices they make regarding their professional role identities (Reay et al., 2017). This occupational identity refers to how professionals enact their position to provide a concept or definition of themselves in-role (Chreim et al., 2007). This enactment involves self-categorization (Ashforth & Mael, 1989; Durand & Thornton, 2018), representing broad agreement over the symbolic and material attributes of phenomena such as professional identities. The associated professionalization process, which inculcates goals, values, norms and modes of interaction into professionals, results in professional identities being deeply held and central to understanding how professionals behave at work (Pratt et al., 2006). Consequently, professional role identification frequently leads to conflict when organizations in healthcare seek to promote diverse identification targets (Cain et al., 2019), such as a requirement to identify with a business logic as well as a clinical logic.

Identity motives. We are familiar with the range of medical professionals' identity responses to healthcare reforms through their identity work, but less so about why doctors respond as they do, aside from how they interpret identity threats (for example, Kyratsis et al., 2017). One way of understanding this 'why' question is to see identity change as a two-stage process, with identity

work contingent on the reasons underlying doctors' desire to answer questions about who they are and who they are not (Brown, 2019). Such self-evaluation among professionals rests on their *professional identity motives*, defined as the pressures to accept certain identities and reject others when constructing their roles (Vignoles, Regalia, Manzi, Golledge, & Scabini, 2006, p. 1167). In turn, these motives shape their identity work, which refers to the often temporary 'fixes' used by individuals in response to situational triggers to construct desirable identities and reject others (Brown, 2019). These fixes link how professionals experience external triggers such as competing logics with key organizational outcomes, including the adoption of new forms of professionalism and culture change (Lepisto, Crosina, & Pratt, 2015). Research by social psychologists on identity motives has shown that individuals are motivated to hold self-concepts that enhance their, often culturally defined, *self-esteem*, provide *continuity* across time and situation, ensure their *distinctiveness* from others, enhance their *belongingness* with others, affirm their *efficacy* regarding competence and control, and create *meaning* or purpose for them. These motives hold for individual identities, and across relational and group levels of identity. Moreover, they are reflected in *sought for* and *feared* future selves – who I/we want to be or do not want to be – as well as in constructions of who I/we currently are. Finally, these motives sometimes coexist in tension. For example, individuals may seek to promote an identity of being distinctive from colleagues in a competitive selection process for a medical director position, while simultaneously seeking to create a sense of belongingness with these same colleagues under normal conditions.

An under-researched question is whether the same motives drive individuals to seek or fear future professional selves, and why this might be so. Initial research by Vignoles, Manzi, Regalia, Jemmolo and Scabini (2008) has suggested future selves are satisfied and frustrated by the same four motives of self-esteem, efficacy, meaning and continuity. However, work in other disciplines suggests that motives for acceptance and rejection of identities may be different. For example, information processing research on the 'endowment effect' and aversion to loss or ambiguity help explain 'status quo bias' in motivating certain types of decision-making (Kahneman, Knetsch, & Thaler, 1991, p. 193). Status quo bias is typically seen as an emotional rather than rational response to giving up something of value. Such bias is particularly acute when individuals feel a strong sense of identification with what has been gifted or 'endowed' to them, such as professional standing in the community. This endowment effect represents a marked tendency among individuals to avoid the pain of losses from giving up what they own (their current identities) rather than seek pleasure from gains (by adopting new identities), especially when the outcomes of so doing are risky or ambiguous (Kahneman et al., 1991). However, we can find no direct evidence of the underlying causes of why individuals feel more or less biased towards the status quo, or why they hold motives oriented towards acceptance. Two possible explanations, to which we return, reside in: (a) research on demographic differences regarding how members of professional groups manifest and use different logics – for example, doctors at different career stages (Cascon-Pereira, Chillas, & Hallier, 2016; Gordon, Rees, Ker, & Cleland, 2015; Pratt et al., 2006); and (b) doctors' experience of co-location with managers (Siebert, Bushfield, Martin, & Howieson, 2018).

Different types of identity work. Different identity motives generate different types of identity work (Lepisto et al., 2015). Although there are multiple definitions of identity work (Brown, 2015), most of these acknowledge the original definition by Snow and Anderson (1987, p. 14) who depicted it as 'the range of activities individuals engage in to create, present, and sustain personal identities that are congruent with and supportive of the self-concept'. Vignoles et al. (2006, 2008) added a dynamic, temporal twist, suggesting that these activities involve cognitive, affective and social interaction processes, which must be understood within changing cultural and local contexts. In the

Table 2. Response to threats through identity work.

	Adding by:	*Retaining by*:	*Subtracting or letting go by*:
Lepisto et al., 2015	• Forming a new identity • Gaining a new identity • Enhancing an existing identity	• Maintaining an existing identity • Strengthening an existing identity • Affirming an existing identity • Stabilizing an existing identity	• Deleting an existing identity • Losing an existing identity • Eliminating an existing identity
Petriglieri, 2011		Identity restructuring by • Changing importance of identity • Changing its meaning • Identity protection by • Discrediting others • Concealing true identity • Creating a positive-distinctiveness of existing identity in relation to the sources	• Abandoning identity and associations
Kyratsis et al., 2017	• Incorporating new political/ social ideals	• New authentication claims • Reframing new identity in different lights	• Cultural repositioning
Reay et al., 2017		• Revealing the logics causing tension • Reinforcing the tensions • Reframing what it means to be a professional • Re-embedding the new logics	
McGivern et al., 2015	• Integrating managerialism and medical professionalism	• Maintenance of medical professionalism • Representing and defending the medical profession • Regulating medical professionalism	• Challenging medical professionalism

professional context, Lepisto et al. (2015) saw professionals' identity work involving three basic processes: *retaining* identities through maintaining, strengthening, affirming or stabilizing work; *adding* new identities by adopting, enhancing, embellishing or enriching work; and *subtracting* identities by deleting, losing or revising work. Thus, we define professional identity work as the cognitive, affective and social processes and tactics used by individuals, professional sub-groups and professions to add new identities, retain existing identities and abandon unwanted identities to form a dynamic and contextually bound self-concept. When professionals face identity threats arising from insecurities (Brown, 2019), they often draw on 'retaining' identity work to maintain continuity with the past, provide a continued sense of meaning or purpose, and build self-esteem. They may also use 'adding' and 'letting go' work (Brown, 2015; Petriglieri, 2011). Table 2 summarizes existing findings on responses to threats to professional identities, analysed according to 'adding', 'retaining' and 'subtracting' (or 'letting go') identity work.

What underlies most of these forms of identity work, however, is the notion of legitimacy, which has been defined as a 'generalized perception or assumption that actions of an entity are desirable, proper and appropriate within some socially constructed system of norms, values, beliefs and definitions (Suchman, 1995, p. 571). Legitimacy strategies lie at the heart of identity work

narratives identified by Kyratsis et al. (2017), McGivern et al. (2015) and Reay et al. (2017), which we explore in our findings.

In summary, the literature on institutional logics, identity motives and identity work helped us frame our questions on the differences between the identity motives and identity work of doctors who fail to incorporate new logics into their professional role identities, and those who succeed in doing so, and why these differences exist. In the next sections, we describe our methodology, present our findings and analyse them through a new, inductively generated framework showing the links between institutional logics as identity triggers, identity motives, identity work and potential identity work outcomes.

Research Methods

We analyse qualitative data from a mixed methods study of hospital consultants in NHS Scotland, the context of which was described above. These data were drawn from in-depth, semi-structured interviews with 68 consultants in different settings and with different backgrounds. The Scottish Consultants Committee (SCC) of the British Medical Association (BMA), the project sponsors, believed that several factors would explain variation in consultants' interpretations of how they responded to changing logics. These were specialty (e.g. general medicine, surgery, radiography, anaesthesia, etc.), size and geographical location of hospitals (small/large; urban/rural), and career stages of consultants (early with 1 to 4 years' experience, mid-career 5 to 9 years, later career 10 years plus). Consequently, we ensured that interviewees were represented in these demographic groups by recruiting volunteers from an SCC register of all consultant-grade doctors in Scotland. Interviews followed a semi-structured protocol (see online Appendix), informed by questions on doctors' changing experience of work, understanding of logics governing decisions, and responses to these logics. They typically lasted 60 to 90 minutes and were conducted face-to-face in the consultants' workplaces. All interviews were professionally transcribed.

Data analysis

The interviews were analysed inductively by members of the research team using a common method, employing NVivo 11 (QSR International, 2015), to move back and forth between the data, the relevant literature on institutional logics and professional identity work, and our emerging theoretical framework (see online Table 3: Data structure) (Gioia, Corley, & Hamilton, 2012). We began our analysis using open coding (Strauss & Corbin, 1998) of the interview transcripts to identify first-order codes, typically beginning with consultants' descriptions of issues they raised, which we occasionally recoded as a consequence of our knowledge of the relevant literature. This first-order coding was followed by axial coding into more abstract, second-order conceptual categories. Axial coding was assisted by our literature review of institutional logics, professional role identity motives and identity work in medicine and other professions (see online Table 4).

We aggregated these second-order conceptual categories into four theoretical dimensions to explain how and why consultants responded to pressures from changing logics. These dimensions were: (1) identity motives leading to the rejection of changing logics; (2) identity motives leading to the integration of changing logics; (3) identity work processes and tactics used to reject changing logics as part of their professional role identities; and (4) identity work processes and tactics to integrate new logics into their professional role identities. Finally, we analysed the backgrounds of consultants to compare them according to their identity motives and identity work (see online Table 5).

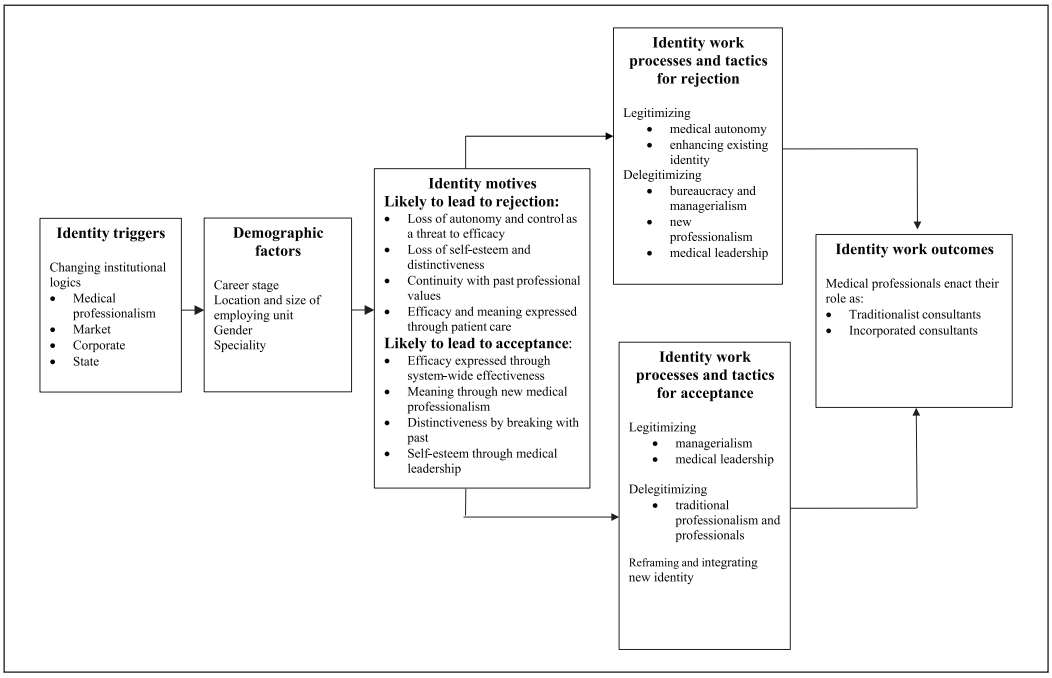

Figure 1. A Model of the Links between Shifting Logics and Identity Work.

Findings

Broadly speaking, our analysis pointed to a significant difference in patterns of identity motives and identity work between the consultant interviewees who were unable to integrate changing logics into their professional identities, and consultant interviewees who were able to integrate changing logics into their professional identities (see Figure 1). To help explain *why* their responses differed, we looked for demographic and background explanations of the identity motives of both categories of consultants. Our data showed the most important of these related to the career stage of consultants. Most traditionalist consultants, who numbered more than two-thirds of our interviewees, tended to be later-career consultants with more than ten years' consulting experience, which put them in the mid-40s+ age range. These consultants were markedly more likely to express traditionalist motives and identity work, possibly associated with more traditional socialization and training in medicine. Incorporated consultants, who numbered less than one-third of our interviewees, were more mixed in terms of career stage, with most in early to mid-career (early 30s to mid-40s), as well as later-career consultants. Somewhat surprisingly, differences in gender, specialty and experience of medical leadership, all of which might have been expected to have explained differences in responses to changing logics, played little or no part.[1]

Traditionalist consultants' identity motives

The most striking identity motive narrated by traditionalists was a threat to their *efficacy to treat patients* arising from a loss of medical autonomy and control. They narrated their sense of purpose purely as dedication to patient care:

> My motivation is patient-centred not management-centred. . .managers obviously have their targets and their waiting list targets but I have my thoughts on who needs the appointments the most, and those differ. (IntB1-LCPhys)

> I realize. . .the bottom line is largely financial; however, my bottom line is patient care. (IntC8-MCPhy)

Traditionalists interpreted the incursion of corporate and state logics as a threat to the overarching aim of the medical profession to prioritize patient care, while at the same time appreciating financial constraints on the health service. They regarded high-quality patient care as best guaranteed by traditional medical professionalism, defined by doctors' expertise, professional status and autonomy to make care decisions within the confines of an individual doctor–patient relationship (Reay & Hinings, 2009; Reay et al., 2017). Consequently, interviewees often narrated their accounts of their employers' actions as 'real and present' threats to their professional role identities:

> Traditionally doctors would have thought of themselves as relatively autonomous and I think we've lost most of the autonomy now. . .so we've put piles of management into it but it's not actually making the place efficient, so we're counting more, we're measuring more, we're manipulating things more. (IntA2-LCPhys)

Most criticism, however, arose from the direct influence of the Scottish government's policies and legislation. Performance-related, patient waiting-time targets in particular were cast as misguided 'populism', generating unrealistic expectations among the public and interpreted as an intrusion into consultants' professional independence and judgement. Stories of problematic and direct control by Scottish government were ubiquitous among these consultants, despite recognizing that the government had made manifesto commitments to improve service access and reduce healthcare inequalities, and that the media had a legitimate role in holding healthcare providers to account. The following extract shows how a strong political discourse and alleged government interference were appraised as incompatible with interviewees' identity motives to remain as autonomous medical professionals, especially notable in interviews with later-career consultants:

> The targets and the government standards are set, then the senior managers have things that they're then required to do and the things that they choose to do. . .but it doesn't translate at all well into patient care, face-to-face. . .the staff in general enjoy seeing patients and it demoralizes and demotivates them to have excessive bureaucracy. (IntA12-LCPsycML)

The above quote emphasizes traditionalist consultants' overriding sense of efficacy in caring for patients where targets often conflicted with consultants' judgements over which patients to treat and when to treat them. Thus, one later-career surgeon gave an account of the dysfunctional consequences of waiting times:

> Managers obviously focus on quite narrow targets. . .In medicine, you have ethics to think about and we know which patients we would like to treat earlier, but with the target culture of course, everyone is treated the same, irrespective of the. . .urgency of their condition. (IntA8-LCSurg)

Avoiding a loss of self-esteem is a key motive in professional projects (Suddaby & Viale, 2011). This motive is particularly evident in research on the status of doctors in healthcare and society (Bartram et al., 2018; Kyratsis et al., 2017). The aforementioned surgeon later explained how a corporate logic had diminished the status of the medical profession in his eyes:

> Medicine is no longer the profession it once was and. . .undoubtedly medical professionals have been devalued, not only directly and financially, but also in terms of their status within hospitals. . .Now, people can't wait to retire and I include myself in that. (IntA8- LCSurg)

Many traditionalists narrated similar diminishing self-esteem, both personally and professionally. The following quote also illustrates how traditionalists saw their expertise and professionalism being devalued compared with unqualified (in the medical sense) managers, unusually, this time, discursively related by an early-career consultant:

> I had a meeting with the Chief of Medical Staff, the Chief of Nursing Staff and the Hospital Manager about the concerns I'd raised with two aspects of care. One was the nursing staffing levels. . .and the other was the decanting of patients inappropriately overnight. . .So the bed manager overnight took the decision to move elderly, frail, fragile patients from those wards into the [. . .] unit and as a result three of those patients had delayed discharges. I brought that up and I was told to shut up. Literally told to shut up. . . despite the fact that I had the evidence. (IntC15-ECPhys)

Seeking continuity with a past era when medical professionals enjoyed autonomy and power is another widely discussed identity motive (McGivern et al., 2015). This continuity with the professional values of the past is evident in the following quote, evoking a 'world we have lost' narrative, redolent of later-career traditionalists:

> Twenty years ago there was much more self-determination, I think, by consultants. You were appointed to a job, you were there until you retired and you were left to get on with it and you shaped that job the best way you could to deliver the best service you could for your patients. . .whereas now everything that we do is micromanaged, it's inspected very closely and it's measured against targets. . .not targets that we would set ourselves as clinicians. . .one of the beauties of medicine is the fact that in the past certainly with so much clinical freedom there was very much more a challenge to each person as an individual to weigh up the evidence, talk to the patient, weigh up the patient, try and think of what was the best thing to do. . . The way that it is in medicine is that we qualify as doctors because we want to be doctors and we don't want to be managers, we didn't set out to do that. (IntB5-LCPhys)

Romanticization of the past was often accompanied by feelings that junior doctors currently do not experience the same type of professional development as their predecessors, which may influence their future views of medical professionalism.

Traditionalist consultants' identity work

Traditionalists are engaged in delegitimizing and legitimizing identity work to affirm their professional identities as the principal guardians of patient care. Delegitimizing was underpinned by three narratives that sought to diminish or destroy the legitimacy of new logics. First, traditionalists engaged in constant discursive efforts to *discredit bureaucracy and non-clinical managerialism*, which arose from the incursion of corporate and state logics. Often these stories sought to distance themselves from non-clinical managers (Martin, Beech, MacIntosh, & Bushfield, 2015):

> The huge dislocation between managers and what actually happens on the ground so I might go to strategy meetings, I might go to health board meetings. . .we talk about strategy design. . .and the individuals in the room, I look around and I think they don't know what they're talking about, they don't know. (IntC1-MCPsyc)

> I would make a distinction between medical managers and non-medical managers. . .I've got no problem with the medical management side of things, it's the non-medical managers who are desperate to be seen

> to be doing something but it's not always the right thing and they don't always ask because we'll tell them that. . .Well I feel quite disempowered and less enthusiastic about my job, I would definitely like to be looking at service developments in line with the government's key priorities but I'm unable to do so because I've been sidelined. (IntC4-LCPhys)

Both of the above quotes can also be interpreted as consultants asserting their own traditionalist expertise by defining themselves by who they were not – as managers who 'don't know what they are doing', and so should make better use of clinicians' knowledge to improve patient experience.

A second narrative was used to *diminish the role of medical elite bodies*. One key explanation of deprofessionalization among doctors in the UK is the influence of medical elite bodies, such as the General Medical Council (GMC) and medical royal colleges, which seek to regulate the profession (Kirkpatrick, 2016). Traditionalists' narratives were frequently critical of their effectiveness, as illustrated by a later-career consultant:

> The GMC has [influenced my practice] a lot because it's stepped up the paperwork trail with revalidation. . . so it adds a lot more time. . .people now feel they have to spend a lot more time doing that and look at job plans. . .The colleges I think are used to regulate. . . there's a lot more demonstration that you are fit enough to be a trainer or a supervisor. . .you have to show that you are a suitable person to be trained, I think a lot of people feel the actual test that they provide doesn't actually mean very much because people have these qualities or they don't. (IntC5-LCPhys)

By characterizing these elite bodies, and their strategies of appraisal and revalidation, as a threat to medical professionalism, the above quote also illustrates important identity work in disconfirming the legitimacy of elite bodies and casting the process of internal regulation either as irrelevant or self-defeating in not sifting out 'the worst doctors'. Traditionalists frequently narrated stories of how 'adverse incidents' involving doctors were not prevented by increasing internal bureaucracy.

A third, and perhaps the most surprising, narrative strategy of delegitimization used by traditionalists was discursive attempts to *discredit medical leaders*. This narrative strategy was the most overt expression of resistance used to define traditionalists by who they were not, and in casting doubt on the widely promoted notion of medical professional 'leaderism' (Iliffe & Manthorpe, 2018) as a solution to healthcare reform. Some of the hybrid literature has pointed to medical leadership being seen positively by doctors, who are thought to wish for more doctors in leadership positions (Kirkpatrick et al., 2016; Numerato, Salvatore, & Fattore, 2012). Our data not only question the role of medical leaders in doctors' reprofessionalization, but also the motives of willing and incidental hybrids (McGivern et al., 2015). Few traditionalists provided accounts of medically trained leaders doing an effective job in improving service delivery or in representing patients' interests to senior managers. Instead, traditionalists' narratives were aimed at discrediting the professional and social identity changes that appointees to medical leadership positions were seen to undergo – literally becoming 'different people' when taking on these roles. The following quote illustrates this marked professional values conflict between traditionalists and those consultants who pursued medical leadership careers.

> There's a suspicion. . .some of the senior medical hierarchy will go with the flow or with the policy because they will be rewarded later on. At a local level, this can be with discretionary. . .awards but you see it even at high levels. Many doctors who help a government report will get an OBE [an honorary title conferred by the Queen], or if you sit on a certain committee and support government policy, you'll get a knighthood. As a result, I think many younger consultants feel their medical leaders. . .do not represent them. They get so high up in the system that rewards them that they become part of the management system rather than representing doctors. (IntB6-LCPhys)

The narrative of doctors having crossed to the 'dark' rather than the enlightened side, often attributed to their needs for personal gain and rewards or a failure to be a 'good doctor', was espoused by traditionalists, usually but not always by later career consultants without medical leadership experience. As part of this narrative, trust in medical leaders' competence, integrity and benevolence was frequently queried (Schoorman, Mayer, & Davis, 2007). Distrust was expressed over medical leaders' motivations and values because they had 'sold out' by accepting the centrality and compatibility of multiple logics:

> And then the management chip gets implanted in them and they forget about being a doctor. . .associate medical director and up. . .they then cease to be like doctors and then become part of management. (IntA2-LCPhys)

> If I have a leader, I like to be able to know that I trust the leader to make decisions. . .whereas with my medical colleagues who go into management I'm not sure that I do. (IntB9-LCPhys)

Though many traditionalists accepted the legitimacy of the 'office' of medical leadership, they were sceptical of the motives of doctors who chose to become medical leaders and were reluctant to follow them. Most saw those who sought and gained such positions as the 'wrong people for the wrong reasons at the wrong times' in their career:

> I think certain clinicians should go into leadership but not necessarily those clinicians that apply for the leadership roles. . .We've got a culture which. . .allows younger clinicians to be managers. . .The trouble is, it does encourage people who see it as a quick way to power and to self interest, and perhaps because they don't actually like their clinical jobs. . .for the reason that they can't do it. (IntA8-LCSurg)

Legitimizing. This form of identity work was underpinned by two narrative strategies. The first and most widely used was *legitimizing medical autonomy to improve patient care*. Such a narrative is anchored in traditionalists' identity motives to seek efficacy and meaning as the legitimate guardians of patient care. This traditional account of medical professionalism was frequently relayed as the 'gold standard' and as a justification for doctors' autonomy, expertise and status as first among clinical professional equals in delivering patient care. As the quote below illustrates, consultants would constantly use identity work to highlight their expert authority (Riaz, Buchanan, & Ruebottom, 2016) and justify medical judgement as the overriding logic in determining high-quality care.

> The micromanagement that goes on is unhelpful, and it diverts resources and effort. . .in a way which I don't think is to the advantage of patients. . .I think what might work better [is] if people would all play their part, which is a big if. If the authority rested more with the clinical leads in the clinical areas and the general manger was there in support, as opposed to the other way round. (IntA17-LCPhys)

The second narrative strategy lay in *enhancing their existing identity* (Lepisto et al., 2015). Although fundamentally seeing themselves as traditionalist, they were also keen to be seen to move with the times by co-opting the principle of mutuality into their identities. As noted earlier, mutuality had been widely espoused by medical bodies as a key element in the new care logic. The following quote from a later-career consultant exemplifies traditionalists' accounts of how much collaborative doctor–patient relationships had come to characterize medical practice:

> One of the things that I value in my job is the ability to equalize the power dynamics with patients and I think that has revolutionized the way that I practice, I think, and in many respects what I'm trying to do is to manage that by developing a partnership with them. (IntC10-LCPhys)

However, we also found evidence of some consultants expressing co-optation as a more defensive strategy (Andersson & Liff, 2018), as a way of heading off an increasing number of complaints:

> Patient-centred. . .stopping the patient from feeling like a number, is really, really important. I mean the source of all complaints is when a patient feels that way. (IntA11-ECSurg)

Incorporated consultants' identity motives

Incorporated consultants were the mirror image of traditionalists in their identity motives and identity work. We believe this finding might be explained by them having a more mixed, career-stage background – but not, surprisingly, from a greater likelihood of experience of medical leadership roles. One noteworthy theme emerging from the interviews with incorporated consultants lay in their narration of the efficacy motive as *efficacy for system-wide effectiveness* rather than purely patient care. In contrast to traditionalists, incorporated consultants narrated a motive to 'move with the times': to create a different healthcare system that recognized the contribution of managers, medical leaders, and service-user expectations. The following extract from a later-stage consultant showed how he was motivated to accept a more pluralistic view of the health service and to work with managers and service users to improve the healthcare system:

> I knew that nowadays. . .to change things, to improve your service. . .there is no way you can do it on your own. There is no way that you can make anything better for patients without engaging with your managers. . .the relationships with your service managers are much better, which ultimately allows you to bring all your services together. (IntC11-LCSurg)

Another identity motive that characterized incorporated consultants was their *changed sense of meaning* expressed through *new medical professionalism*. Incorporated consultants' identities were typically characterized by a version of medical professionalism that embraced changing logics, especially in legitimizing doctors' needs to be responsive to the management of an increasingly resource-constrained service. Their narratives usually showed they were more inclined to integrate the multiple logics underpinning the values, strategies and organization of modern healthcare organizations into their role identities. A later-career consultant reasoned:

> I'm not in the least bit anti-manager. . .a lot of doctors, they're anti-manager. I've worked as a manager. I think some of them [think]. . .nobody has it as hard as doctors and managers have it easy. Yet, when you go into medical management you realize. . .the stresses are different, but they are just there in just exactly the same way. The idea that an organization as big and as complex as the NHS shouldn't be managed is just ludicrous. (IntD8-LCPsycML)

Therefore, his identity motives were consistent with his taking up a medical leadership position and to accept the need of a managerialist health service. Alongside incorporated consultants' needs to seek new meaning was the motive for *distinctiveness by breaking with the past's* 'outdated' medical professionalism. The following quote shows how one mid-career consultant defined his distinctiveness beyond a focus on patient care to seek diversity in his roles:

> I definitely feel more engaged in the process as I have a vested interest. That doesn't mean there's not days when I feel demoralized and feel I'm banging my head against a brick wall. . .I think the more you feel you've got buy-in and you work together, I think the more committed you become to the job. . .I do a lot of teaching and education, leadership, clinical practice. . .what gives me pleasure is the diversity. (IntC1-MCPsyc)

Another early-career consultant set out some of the managerial and bureaucratic role prescriptions for new consultants, which showed his early acceptance of multiple logics and distinctiveness from traditional professionalism:

> So we're working hard on being more recognized. . .we have a good few young consultants here, who are very dynamic. . .One, in particular, is an excellent manager, you could call him, almost. He's got a very good understanding of the NHS politics, and government politics, and he's a very good advocate. (IntA1-ECPhys)

Incorporated consultants occasionally invoked the baseball metaphor of 'stepping up to the plate' to transform a healthcare system constrained by 'old-style professional power'. These consultants distanced themselves from traditionalist colleagues by articulating a version of medical professionalism that embraced managerialism. One mid-career medical leader opined this could be achieved by 'gently giving more managerial responsibility to clinicians as they mature through their career' (IntA19-MCPhysML).

Incorporated consultants' experiences of working with changing logics also led them to voice *a new sense of esteem* derived from being leaders of their profession. Although recognizing shifting logics sometimes resulted in tensions, they rarely saw these as threats to their professional identities, status or wider social standing. Most suggested that working in medical leadership had allowed them to influence change positively for the benefit of patients and emphasized the need for leadership as part of doctors' training. This new narrative was particularly evident among early and mid-career incorporated consultants but, as the nextquote shows, was also evident among some later-career leaders.

> Clinical leadership is going in the right direction, but more thought has to be given to getting the right or best ones in post and also getting people at the right time. . .building in training when doctors are in their 30s (mid-career) would be beneficial. This would mean that they can develop these skills over time before having to deal with the pressures of a dual role. (IntD2-LCPhys)

Incorporated doctors sought to co-opt elements of managerialism into their new professional role identities and used phrases such as 'stepping up', 'driving the vision' and 'taking the lead'. Indeed, some consultants saw obtaining a position as a medical leader either as a natural progression or as a way out of the routine nature of medical practice.

Incorporated consultants' identity work

Incorporated consultants also engaged in delegitimizing and legitimizing identity work, but it was a mirror image of traditionalists' efforts. These types of identity work build on the ideas of Besharov and Smith (2014) and Lepisto et al. (2015) on integrating new identities.

Legitimizing drew on two narrative strategies. The first was a narrative in *support of managerialism*, which was seen as being necessary to reform healthcare systems. Incorporated consultants' identity work often attempted to legitimize the role of non-clinical managers and to articulate why consultant colleagues needed to change their approach by working in partnership with them:

> I think as clinicians with the patients that we have autonomy. . .We are occasionally approached to say, does this person need to come in today or not. . .that's not an unreasonable thing to do and [managers] do listen to what you say. . .it comes back to that partnership and if partnership works well it's a good team and if it doesn't work well you will always be clashing. (IntD6-LCPhys)

Incorporated consultants discursively related how easy it was to blame managers because they had responsibility for implementing difficult financial and political decisions, but argued that mutual respect between doctors and managers was essential to deliver effective healthcare:

> There is a closer liaison with doctors and managers. . .when you're able to explain your position to them, generally speaking managers are able to respect you for your opinion and take you on side. . .Doctors still have a degree of standing, at least in my experience, I am still leading the team. . .every team I suppose has to have a leader who is able to take things forward and take the patient's side. (IntB13-MCPhys)

In contrast to the distrust expressed by traditionalists, the above quote highlights how incorporated consultants were more trusting of the motives of managers. Moreover, it illustrates the view held by incorporated consultants that leadership was integral to their identity as a consultant. This leads to a second narrative strategy of legitimization, which lay in relating *medical leadership as new medical professionalism*. Thus, as several participants suggested, medical leadership sought to temper traditional medical professionalism by taking multiple stakeholders' interests into account:

> My job is to be the patients' advocate and the advocate for my staff. I think the manager's job is to work for the organization. . .it's important there are good relationships. (IntD6-LCPhys)

Delegitimization also drew on two narrative strategies. The first lay in a need to *reframe medical professionalism* in a different light (Kyratsis et al., 2017). Incorporated consultants related that gaining a new identity meant letting go of traditional identities, one of which surrounded the traditional hierarchical relationship between medical professionals and other clinical professions, especially nursing staff. Discarding hierarchy and status among clinical professionals, and also within medicine itself, was frequently articulated as essential for medicine to reprofessionalize itself:

> The word deprofessionalization has a. . .connotation of 'we think we're the best and we should be in charge of everything'. . .There is a historical view of doctors and I think there is still a lot of senior consultants around. . .those are the people I mean who are struggling with the idea that you can sit in a [specialist] team meeting and for two of the nurses to say, we don't like the way you are running your clinics because we don't think it's best for the patients. . .[Some consultants] find that very challenging. . . personally that's not an issue for me. (IntB12-LCPhys)

Reframing medical professionalism, therefore, lay in effective collaboration and mutual respect between professionals and managers, which was crucial to effective patient care.

A second delegitimizing narrative was underpinned by a need to *let go of traditional identities* (Lepisto et al., 2015). This narrative not only discredited the concept of traditional medical professionalism but also distanced incorporated consultants from traditionalist colleagues who were hanging on to a 'world we have lost' by responding negatively to reform of healthcare systems in their hospitals:

> I wouldn't call them deprofessionalized; I would call them thoroughly unprofessional. They have obligations to the organizations which pay them, and they just don't get it. (IntA22-LCPhysML)

Often these became narratives of despair over the general state of affairs in their hospitals and the lack of engagement among their consultant colleagues in bringing about change and innovation in their clinical practice. These accounts were frequently accompanied by identity work to lay claims to leadership and change of the profession:

> So we met [senior doctors on a development programme] and we brought them together to hear how their learning, this investment we'd made in them over the year, was making a difference. . .It was just devastating actually because. . .it was this tale of woe that nobody was coming to them and asking for their help and support. . .There was this business of waiting to be invited in, whereas my experience had always been, see the problem, map out two or three potential solutions. (IntA19-MCPhysML)

Finally, Besharov and Smith (2014) point to *integrative work* as a key strategy in coping with multiple logics. By integrative work, they meant the ability to combine the effects of logics and integrate them into the day-to-day functioning of individuals and groups, as illustrated here by an early-career consultant:

> There's the two extremes, I guess. The very critical person, who checks everything that you're suggesting, and then the other person, who is, 'Whatever you say, Doctor', and just do it. . .That's a very important part to patient care. . .we're talking about patient-centred care. You're trying to respect their wishes, as much as you can – and their habits, their character. (IntA1-ECPhys)

The notion of patient-centred care was common across the interviews, with many incorporated consultants emphasizing the need to involve patients in mutual decision-making:

> Society, patients in general feel that they should be more involved with their treatment, rightly so. . .The changes that have taken place in the NHS in the last twenty years have been stellar. . .The number-one priority has always been the patient. . .not our professional self-esteem, nor our professional standing, nor our financial remuneration. (IntD10-LCPhys)

The above extract further emphasizes the desire to involve patients, along with the view that contemporary professionalism involves speaking out for patients rather than self-interest.

Discussion and Conclusions

Medical professional bodies and leading doctors have sought to redefine medical professionalism to integrate new institutional logics into their daily functioning (Keijser & Martin, 2019). However, even this literature and proponents of hybrid medical leaders recognize the hold of traditional medical professionalism on doctors (McGivern et al., 2015; Spurgeon et al., 2011). Therefore, Kyratsis et al. (2017) concluded that it was necessary to study the experiences of professionals who did not manage the effects of changing logics of their professional identities effectively and 'who clung to their existing professional identity rooted in the old logic' (p. 43). We attempt to contribute to the debate over how professionals deal with shifting logics by examining the responses of the most senior grade of doctors in the challenging context of the UK NHS. To do so, we posed two questions, with important theoretical and practical significance, which, to our knowledge, have not previously been answered: do significant differences exist between the identity motives and identity work of doctors who fail to incorporate new logics into their professional role identities, and those who succeed in doing so? If so, why do these differences exist?

Recent literature has highlighted variation and complexity in medical professional responses. For example, the study by McGivern et al. (2015) found a significant group of ambivalent or 'incidental' hybrid leaders, who differed from 'willing' hybrids in their role use, role claims and identity work. Our analysis, however, drawn from a representative sample of the most senior grade of hospital doctors in the UK NHS, told a different story of a binary and oppositional divide between a small group of hybrid, incorporated medical professionals, who broadly welcomed change, and a much larger group of traditionalists who resisted or avoided change. Although we looked for

ambivalent groups, we found little such evidence in consultants' narratives. Instead, the degree of ambivalence we found was consistent with the normal variation one might expect to find within categories, which was much less than between categories.

This binary divide should not be surprising because it is consistent with earlier studies in the role identity literature pointing to continuity with the past and distinctiveness as important identity motives (Vignoles et al., 2006, 2008) and in individuals self-categorizing by using identity work to define themselves by who they were definitely not (Ashforth & Mael, 1989). A binary finding is also consistent with literature linking institutional logics and categorization theory (Durand & Thornton, 2018). Categories are shared agreements, in this case, over what it means to be a medical professional. They are also used to distinguish among groups of professionals in medicine, such as between surgeons and physicians (Leicht & Fennell, 2001). High levels of agreement led these categories to become institutionalized, so producing an institutionalized status quo bias (Kahneman et al., 1991). Such bias leads doctors and their professional bodies to resist the scope and pace of change as it shapes their evaluations, expectations and the material and symbolic exchanges (Durand & Thornton, 2018, p. 637).

Figure 1 summarizes our findings. We found important differences in consultants' identity motives and the nature of their identity work, suggesting a binary divide that may be difficult to bridge theoretically and practically. More than two-thirds of our interviewees expressed traditionalist identity motives and identity work. This group narrated how a loss of autonomy and control threatened their efficacy motive, expressed singularly as patient care. Loss of autonomy also led them to express a declining sense of esteem and distinctiveness arising from changing logics, which reinforced their motivation to seek continuity with past traditional medical professional identities. Incorporated consultants, representing a little under a third of interviewees, typically defined themselves by who they were not – usually in opposition to *traditionalist consultants*. These doctors had come to accept a need to integrate changing logics into their functioning. Their identity motives focused on creating a new medical professional identity, incorporating new logics to meet a pluralistic, multi-stakeholder and multi-discipline definition of system-wide efficacy rather than the singular goal of improving patient care through medical autonomy and control. Incorporated consultants were also motivated by a desire to be distinctive from traditional medical professionalism and to enhance their self-esteem by being seen as leaders of new medical professionalism and healthcare reform. With regard to the identity work, both groups of consultants undertook legitimizing and delegitimizing strategies. However, these were mirror-image forms of identity work intended to enhance their own identities and diminish the claims of the 'other'.

Our findings also go a step further in suggesting why these differences might occur. Pratt et al. (2006) and Kyratsis et al. (2017) both discuss and call for studies of professionals at various stages in their career, proposing that career stage may be an important explanation of why professionals might respond differently to shifting logics. Our study provides evidence that career stage was the most important, indeed the only, demographic difference relevant in explaining traditionalists' responses and management of changing logics. We looked for other likely background explanations, such as gender and specialty, but these did not emerge from our interviewee data. Later-stage career consultants dominated the traditionalist category, pointing to earlier socialization into a particular healthcare system (Kyratsis et al., 2017), a 'hidden curriculum' of ethical, moral and values-based teaching (Hopkins, Saciragic, Kim, & Posner, 2016) and previous expectations being unfulfilled or violated as a cause of their motives and identity work (Zuger, 2004). In contrast, incorporated consultants were a more 'mixed bag' in terms of career stage, suggesting a multi-factorial explanation for such incorporation, but one that is not wholly inconsistent with being at an earlier career stage than most traditionalists. A rather obvious explanatory factor was current or previous experience of medical leadership roles, in line with the 'willing hybrid' thesis (McGivern et al., 2015). To a certain

extent, this was borne out by our data. Less than 10% of traditionalist consultants in our sample had formal leadership experience, whereas 25% of incorporated consultants claimed such a background. We also searched for other possible explanations, one of which is hinted at in our data – the role of place and co-location. There was evidence that doctors in smaller hospitals were more inclined towards incorporation, especially if they were co-located near non-clinical managers (Siebert et al., 2018), which suggests a further line of enquiry. Yet a further explanation arose, which lay more in speculation, summarized by an observation from a senior medical director, who proposed that many hospital doctors become 'bored with their jobs' or highly dissatisfied (Zuger, 2004) in their mid-40s and seek fresh challenges in either research or education, or in leadership. This mid-life career transition explanation is common in other professions, resulting in large numbers of 'drift-outs' and 'bow-outs' (Burns, 2013). Thus, it is one that deserves further research in medicine because it may also help explain why many traditionalists delegitimize the identity motives of consultants seeking medical leadership positions as characteristic of 'failed doctors'.

In summary, our findings make three contributions to the literature on how institutional logics are experienced by professionals, particularly those in medicine. First, they have allowed us to produce an inductive framework, depicted in Figure 1, showing how and why changing institutional logics are interpreted by medical professionals through their identity motives. In turn, these motives provide a generating mechanism for doctors to undertake identity work consistent with their motives. Doctors then combine their different motives and identity work by self-categorizing and enacting their roles in different ways. We found such enactment was best characterized as binary and oppositional across a broad range of senior doctors in hospitals, more consistent with earlier literature on professionalization in medicine (Freidson, 2001). Although we found some limited evidence of hybrid identities, we regard this as normal intra-category variation and as less important for theory and, in this case, practice in the scope and pace of change in healthcare reform. Most importantly, we found career stage to be the most important source of variation in how they self-categorized, echoing the findings of Pratt et al. (2006).

Second, our findings are consistent with the view that for medical professionals to become effective hybrid leaders, holding incorporated-style identity motives – rather than formal development in leadership – may be a necessary pre-condition (McGivern et al., 2015; Reay et al., 2017). Consultants who expressed a desire for change and for doctors to be at the heart of leading and reforming a system narrated identity motives and identity work consistent with claims to leadership and reform. They did so by laying down claims for themselves as individual leaders and for medicine as a profession to embrace leadership. This finding is consistent with theory that sees such identity claims as a necessary condition for developing an effective relationship between leaders and followers (De Rue & Ashford, 2010; Smith, Haslam, & Nielsen, 2018). It also supports the view that adopting and making convincing claims to identities are more important for professionals going into management and leadership positions than formal preparation through management education (Montgomery, 2001).

Our third contribution is to the literature and practice on how we bring about an increase in the scope and pace of institutional change in healthcare reform through medical leadership (Martin et al., 2015; McGivern et al., 2015 etc). Our research points to the limitations of this project, especially in current financial and demographic contexts when professions articulate widespread deprofessionalization, and regard themselves as being under threat from other disciplines and technology (Numerato et al., 2012). These interpretations are refracted through material and symbolic low-trust initiatives, including targets, job plans and other performance measures, which are rarely seen as meaningful to doctors' professional mission. Therefore, our findings question the hybridity-as-a-new-normal thesis. They are, however, consistent with other research that has focused on change and hybridity, but has found a significant degree of traditionalism in medicine. For example, the

study by Spyridonidis et al. (2015) of physicians involved in a collaborative leadership exercise showed a quarter of their sample remained sceptics, with a further 50% being late innovators. Similarly, Von Knorring et al. (2016) suggested that even among hybrids, traditional professional identities and discourse remained dominant when talking about their managerial roles. Finally, Bresnen et al. (2019) pointed to a long period of transition between shifts from professional to hybrid identities, even for willing hybrids.

Our study shows that while traditionalists may have accepted (a) the need for more doctors to become medical leaders, and (b) the 'office' of medical and clinical directors, they deeply distrusted the motives of doctors who took on such roles. Therefore, claims to leadership made by incorporated consultants and non-clinical managers were not granted by traditionalists, so reinforcing a pre-existing low trust dynamic between them. This picture is reminiscent of a workplace relations era when pluralism and managerialism as workable solutions came under much greater scrutiny than they currently do, which perhaps shows the extent to which shared leadership in healthcare has become an institutionalized method of reform over recent decades (Martin et al., 2015).

In conclusion, our study shows that doctors who fail to integrate changing logics into their identities tend to be at a later career stage, have different motives and use different types of identity work from those who are able to incorporate logics shifts. This finding is important because the outcomes point to two groups of doctors – the most powerful of which is traditionalists – who are significantly divided over how to reform healthcare systems and their willingness to accommodate a reform agenda. Potentially this finding may be tempered by the limitations of our sample, the majority of which had no experience of formal medical leader roles. Arguably, this lack of experience makes their reflection on formal medical leadership a less valid proposition. However, the counter-argument is that all consultants are required to exercise leadership in clinical teams, even though they may not interpret their role in these terms. Consultants experience leadership on a day-to-day basis as leaders – and equally importantly, in being led – so giving them a good basis on which to reflect on their identities as leaders and medical professionals. We also acknowledge the limitations of our case study in generalizing to other healthcare systems operating in different financial contexts. The NHS is unique in many respects, as is its history of shifting logics and professional power. Nevertheless, we contend that future research in this field of hybridity and hybrid professionals needs to be more reflexive of its pluralist assumptions and ambitions, and the limitations of professional leadership. We also believe that our framework has the potential to guide further quantitative research to assess the extent of our claims to a binary divide and how this divide will stand up to changes in professional development for medical careers, when greater numbers of doctors become socialized into leadership positions at earlier stages in their careers. Until then, however, we contend that hybridity as the new normal is a threat rather than an opportunity.

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ORCID iD

Stacey Bushfield https://orcid.org/0000-0001-8747-1873

Supplemental material

Supplemental material for this article is available online.

Note

1. As part of our study we undertook a survey of over 1,000 consultants in NHS Scotland, representing nearly a third of the population of Scottish-based consultants. These qualitative findings on the importance of career stage and the lack of importance of specialty and gender were strongly supported by the survey data.

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Author biographies

Graeme Martin is Professor of Management at the University of Dundee School of Business and Visiting Professor at the Centre for Global HRM, University of Gothenburg. He has published in journals such as *Organization Studies, Human Resource Management Journal, Work, Employment and Society, Social Science and Medicine* and *Sociology of Health & Illness*. He is also a non-executive Board Member of NHS Tayside and works with its medical and HR directorates.

Stacey Bushfield is Associate Professor in Management at Edinburgh Napier University Business School. Her research focuses on healthcare management and organizational change, as well as professional and leadership identities. She has recently researched the role of identity workspaces in development, hybrid professional-leader narratives, and the different disconnects that can arise in distributed leadership. She has published in *Work, Employment and Society* and *Sociology of Health & Illness*.

Sabina Siebert is Professor of Management in the Adam Smith Business School, University of Glasgow. Her research focuses on organizational change, organizational trust and the study of professions. She has recently researched trust and distrust in secret organizations, trust in science and differentiation in elite professions. She has published in the *Academy of Management Journal, Organization Studies, Human Resource Management Journal, Sociology* and *Work, Employment and Society*.

Brian Howieson is Head of the Management Group at Edinburgh Napier University Business School. He is the author of *Leadership: The current state of play* (Emerald) and Editor in Chief of *Journal of Management Development.* He was a full Council Member of the Foundation for Management Education and a previous Non-Executive Member of the Medical Directorate within NHS Scotland.