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HEALTH SYSTEMS IN TRANSITION: PROFESSIONAL IDENTITY WORK IN THE CONTEXT OF SHIFTING INSTITUTIONAL LOGICS

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We investigate how established professionals manage their identities in the face of identity threats from a contested shift in the professional logic that characterizes their field. To do so, we draw on interviews with 113 physicians from five European transition countries who faced pressure for change in their professional identities due to a shift in the logic of health care from a "narrow specialism" in primary care, which characterized the Soviet health system, to "generalism," which characterizes primary care in the West. We found three important forms of professional identity threats experienced by physicians during this period—professional values conflict, status loss, and social identity conflict. In addition, we identified three forms of identity work—authenticating, reframing, and cultural repositioning—that professionals who successfully transitioned to the new identity performed in order to reconstruct their professional identities so that they were aligned with the new logic. Based on these findings, we present a model of how established professionals change their professional identities as a result of a contested shift in the professional logic of their field, and discuss the underlying mechanisms through which this occurs.

Professionals play a central role in modern societies by performing critical tasks in areas such as health, education, law, and accounting. It is therefore unsurprising that professional identity—"an individual's self-definition as a member of a profession" (Chreim, Williams, & Hinings, 2007: 1515)—has been the focus of a significant stream of literature. Studies have explored a range of topics, including how new professionals construct their identities (Ibarra, 1999; Pratt, Rockmann, & Kaufmann, 2006), how changes in professional identity are legitimized over time (Goodrick & Reay, 2010, 2011), and how individuals balance their social and professional identities (Kreiner, Hollensbe, & Sheep, 2006).

Interestingly, scholars have increasingly connected professional identity at an individual level to the broader institutional context (Chreim et al., 2007). A number of studies have made an important contribution by conceptualizing the link between professional logics—the overarching system of symbols and practices that professionals use to make sense of their work—and professional identities (Marquis & Lounsbury, 2007; Rao, Monin, & Durand, 2003; Reay & Hinings, 2005). However, while these studies have described the link effectively, they have not

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fully explained the mechanisms through which a shift in logics at a macro level affects professional identity at a micro level. More specifically, despite calls for multi-level research to extend our understanding of these dynamics (Barley & Tolbert, 1997; Dacin, Goodstein, & Scott, 2002; Powell & Colyvas, 2008), we know little about how and why individuals adopt new professional logics or the mechanisms that underlie this process. In this study, we develop an initial answer to the following research question: *How do professionals manage their professional identities in the face of the threats that accompany a contested shift in the professional logic that characterizes their field?*

To answer this question, we draw on 113 field interviews and a substantial repository of archival data. More specifically, we inductively explore the process through which a shift in a professional logic influenced the professional identities of individual physicians in five transition economies: Estonia, Bosnia and Herzegovina, Slovenia, Moldova, and Serbia. Each of these countries has received substantial investment and technical assistance from multilateral agencies, including the World Bank, the World Health Organization (WHO), the European Union (EU) and bilateral donors (e.g., Canadian International Development Agency) through initiatives designed to support the transition from a Soviet to a Western health system model (Rechel & McKee, 2009; World Bank, 2003). Indeed, investment by the World Bank into health systems in these countries has exceeded $17 Billion since 1997 (World Bank IEG, 2009). The study benefited immensely from unfettered access to, and endorsement from, the countries' ministries of health, the World Bank, and the World Health Organization.

The countries in our sample shared a health system based on the logic of "narrow specialism" during the Communist, or Soviet, era, with physicians expected to be experts in a clearly defined area of medical knowledge. All of these countries experienced a profound social transition following the breakup of the Soviet Union in the late 1980s and the rolling back of the Iron Curtain, with comparable pressures for logic change in health systems at more or less the same time. For physicians, the result was pressure to adopt a new professional logic based on the principles of family medicine, which drew on a new logic of "generalism" that characterizes much of the health care in the West. This logic placed very different demands on physicians with respect to their expertise, their interaction with other professionals, and their overall approach to practicing medicine. Specifically, physicians' medical knowledge was expected to be much broader in scope so that they could think about a particular medical problem caring for the "whole person" in the context of their family and wider social environment, and to work collaboratively with other health professionals on a more equal footing. In other words, physicians were expected to adopt a holistic view of their patients and take overall responsibility for their care beyond simply the treatment of specific medical conditions.

The transition that these countries experienced provided us with a unique opportunity to investigate the micro-level effects of rapid and deep-rooted change in health system with a clear contrast between an "old" and a "new" professional logic. In particular, this change in professional logic had significant implications for the professional identities of physicians. We found that this shift led physicians to experience a distinct set of identity threats. Interestingly, some physicians engaged in discrete forms of identity work and successfully managed the transition to the new logic by constructing a new professional identity, while another group resisted the pressures to adopt a new professional identity and remained rooted in their "old" professional identity. We identify the specific identity threats that many physicians faced as part of this transition, and delineate the particular types of identity work deployed by physicians who successfully managed the transition to a new professional identity.

CHANGING PROFESSIONAL LOGICS AND PROFESSIONAL IDENTITIES

Professional Identities and Identity Work

The concept of social identity was first introduced by Tajfel (1972: 292), who defined it as "the individual's knowledge that he [sic] belongs to a social group together with some emotional and value significance to him of this group membership." It is discursively constructed and involves the meanings that actors ascribe reflexively to themselves as they struggle with existential questions such as "'How shall I relate to others?' 'What shall I strive to become?' and 'How will I make the basic decisions required to guide my life?'" (Brown, 2015: 2).

One important stream of literature has focused on how individuals react when their identity is threatened. Identity threats can be defined as "experiences appraised as indicating potential harm to the value, meanings, or enactment of an identity" (Petriglieri, 2011: 645). Although identities can change, individuals

value their identities and seek to maintain stable identities over time (Shamir, 1991). When individuals experience a threat to their identity they can respond in one of two ways. First, they may perform "identity-protection responses" (Petriglieri, 2011: 647) that are directed toward the source of the threat and are intended to avoid changes to the individual's identity. Second, they may perform "identity-restructuring responses" (Petriglieri, 2011: 648), where identity changes are made in response to the threat.

In the management literature, an important distinction has been drawn between the social identities of individuals that are associated with group or organizational membership outside of work settings, and the social identities of individuals that are associated with membership of work organizations. Indeed, the role of social identity in work organizations is part of a growing body of research and has become a core element of organization theory (Ibarra & Barbulescu, 2010; Sveningsson & Alvesson, 2003). It has also spawned interest in a number of related ideas, such as organizational identification (e.g., Mael & Ashforth, 1992) and organizational identity orientation (e.g., Brickson, 2007).

More recently, organizational researchers have become increasingly interested in the concept of identity work: individuals' "active construction of identity in social contexts" (Pratt et al., 2006: 237). This has led to a distinct stream of literature focused on how and why individuals endeavor to make sense of their identities in particular ways (see Brown [2015] for a useful review). Researchers have conceptualized a range of strategies and resources that individuals draw upon as they engage in identity work (Ashcraft, 2007). For example, self-narratives—"stories that make a point about the narrator"—(Ibarra & Barbulescu, 2010: 135) and identity talk—"the verbal construction and assertion of personal identities" (Snow & Anderson, 1987: 1348)—have been shown to play a key role in how individuals construct and negotiate their identities.

A subset of this research has focused on professional identity. A profession arises when an "organized group possesses esoteric knowledge that has economic value when applied to problems. . . faced by people in society" (Pratt et al., 2006: 235). Professional identity is defined as "an individual's self-definition as a member of a profession and is associated with the enactment of a professional role" (Chreim et al., 2007: 1515). The dynamics of professional identity are different from other kinds of social identity. They are underpinned by a concern for professional autonomy and a commitment to professional values (Barbour & Lammers, 2015). Both factors have been shown to be particularly strong in the context of medical professionals, who continually seek to assert their "exclusive and monopolistic ability. . . to define illness and medical work" and who have been shown to fiercely resist attempts by nonclinical managers to encroach on their independence and threaten patient welfare (Doolin, 2002: 374).

A number of influential studies have examined different aspects of this important type of identity. For example, Pratt et al.'s (2006) research on medical students provided in-depth understanding of the processes through which professional identity is constructed by new members of a profession; Goodrick and Reay (2010) focused on registered nurses to discover the ways in which a new professional identity becomes discursively legitimated; and Chreim et al. (2007) explored how the institutional environment in a professional field provides resources that both constrain and enable professionals as they reshape their professional identities. Combined, these studies provide a good understanding of what a professional identity is, how it is constructed when new members join the profession, and the role of the broader social context in shaping professional identities. We seek to build on and extend this emerging work by considering how significant social change can influence the ways in which established professionals construct or reconstruct their identities. To do so, we draw on the concept of institutional logic.

Professional Logics and Professional Identity

Social behavior within organizational fields is shaped by institutional logics; that is, socially constructed, historical patterns of practices, assumptions, values, beliefs, and rules by which individuals and organizations produce and reproduce their material subsistence, organize time and space, and provide meaning to social reality (Friedland & Alford, 1991; Thornton & Ocasio, 1999). In other words, logics provide templates through which individuals categorize and give meaning to social activity, and offer a set of assumptions about what constitutes reality and how to interpret it. They comprise both material (structures, practices) and symbolic (meaning, ideation) elements.

Crucially for our purposes, logics connect field-level processes to individual-level actions (Friedland & Alford, 1991; Lok, 2010; Thornton & Ocasio, 2008). At the field level, institutional logics define a "choice

set" of appropriate norms and practices in a specific sociocultural context (Tracey, Phillips, & Jarvis, 2011). From this standpoint, logics provide actors with vocabularies, values, and beliefs that influence individual identities (Thornton, 2004). More specifically, "identity is thought to form an important link between institutional logics and the behavior of individuals" (Lok, 2010: 1305). Logics therefore shape the way that people define and categorize themselves as members of a social group (Stryker & Burke, 2000; Tajfel, 1982). Indeed, from an institutional perspective, identities are rooted in logics: when logics change, identities are assumed to become aligned with them (Thornton, Ocasio, & Lounsbury, 2012).

In professional fields, professional logics provide the identities that professionals draw upon to make sense of who they are and what they do: the "agentic reconstruction of professional role identity is enabled and constrained by an institutional environment that provides interpretive, legitimating, and material resources that professionals adopt and adapt" (Chreim et al., 2007: 1515). Thus, professional identities are not simply an individual-level phenomenon but are linked to collective identity dynamics at the level of the professional fields (Rao et al., 2003). The concept of a professional logic therefore provides an important link between field-level processes and the micro activities of individual professionals (Thornton et al., 2012).

For example, a number of studies have highlighted a variety of ways in which professionals react to changes in professional logics. Researchers have investigated the resistance by banking professionals to national banks' acquisitions of local banks and the erosion of community banking (Marquis & Lounsbury, 2007); physicians' resistance to government-led health reform in Canada (Reay & Hinings, 2005); academics' contestation of the rise of university performance appraisal systems in the United Kingdom (Townley, 1997); and elite French chefs' abandonment of classical cuisine in favor of nouvelle cuisine, and their subsequent adoption of a hybrid identity that drew simultaneously on elements of both logics, each linked to a different cuisine type (Rao et al., 2003).

In these studies, the connection between professional logics and professional identity plays an important, if not always explicit, role. For example, Reay and Hinings (2005: 358) highlighted the change in logic of the Alberta health system from "medical professionalism" to "business-like health care" and the associated change in the role of physicians from "physicians are the only gatekeeper to the system, and decide how all services are provided" to "physicians are part of a team of health care providers, and consumers choose which provider to access." Similarly, Rao, Monin and Durand (2003: 806) explored how the appearance of nouvelle cuisine in France occurred when "activists exploited the ideas of simplicity and economy in classical cuisine to fashion a new logic and a new identity for chefs."

However, while institutional theorists have become increasingly interested in the professional logics that characterize professional fields (e.g., Meyer & Hammerschmid, 2006; Rao et al., 2003; Thornton & Ocasio, 1999; Townley, 1997), research to date has not yet looked explicitly at the link between shifting professional logics and professional identities. Thus, while we have a good idea of how nascent professional identities form (Pratt et al., 2006), and we have a good theoretical explanation for how individuals respond to shifting logics more generally (Lok, 2010; Meyer & Hammerschmid, 2006), we know little about how established professionals respond to pressures to shift their identities in the face of a contested change in logic at the field level and the challenges they face in doing so. This is surprising, as the dynamic that we study is common for professionals of all kinds—many professional logics are continually under pressure for change due to the actions of governments, NGOs, and professional associations. By examining how established professionals manage their professional identities in the context of shifting pressures at the field level, we therefore consider that we address an issue of considerable theoretical and practical significance.

METHODS

Research Setting

A world in transition: From command to market economies. The dissolution of the Soviet Union in 1991 triggered major political, economic, and societal transformations in Eastern Europe. Transition countries experienced a disruptive shift in political and economic paradigms that had been deeply institutionalized since the end of World War II. This shift precipitated radical steps toward establishing a market economy and political pluralism, and resulted in the former socialist countries transforming from heavily centralized, bureaucratic, collectivist social systems to systems underpinned by capitalism and liberal democracy (Deacon, 1992). For the first time in almost half a century, Eastern Europe saw the formation of new independent states, the emergence of parliamentary democracy, the establishment of

property rights, the development of private enterprise, and the creation of trade unions. The overarching strategic objective for the majority of transition countries was to become member states of the EU, which they considered critical for political stability and economic prosperity.

This setting provides an ideal context for exploring our research question. We focus here on physicians located in five transition countries: Estonia, Moldova, Bosnia and Herzegovina, Serbia, and Slovenia. Estonia and Moldova were states of the former Soviet Union, while Bosnia and Herzegovina, Serbia, and Slovenia were states of the former Federal Socialist Republic of Yugoslavia. In addition to the practicalities of access, the main reason that we selected these countries is that their health systems have undergone a parallel set of changes as part of the broader transition from Communism to a market economy. We outline the key aspects of these changes below.

Health systems prior to transition: The era of polyclinics and narrow specialism. Before the transition, the Estonian and Moldovan health systems were organized according to the principles of the "Semashko model," named after Nikolai Aleksandrovich Semashko, who served as People's Commissar of Public Health in Russia from 1918 until 1930. The model evolved to reflect the hierarchical, highly regulated, and centrally planned and controlled administrative system typical in the Soviet Union. A variation of the Semashko model had been established in the countries of former Socialist Yugoslavia and followed similar organizational principles; though, unlike the Soviet Union, the Yugoslav federal states had substantial autonomy in the organization and financing of their respective health systems.

Central to organization of the health system under Communism was the idea of state provision of universal health services to all, guided by the core values of equity and solidarity that stemmed from the dominant Communist ideology. Services were funded by the state (directly in the Soviet Union and through national health insurance in Socialist Yugoslavia), and were delivered free of charge by an extensive and exclusively state-owned network of highly specialized care facilities. All health care personnel were salaried, state employees. Clinical care was delivered primarily in local, district, or regional hospitals that also had outpatient facilities. Primary health care (first-contact care) was highly fragmented, consisting of specialized polyclinics that were often colocated in acute-care hospitals and staffed by a wide range of subspecialists. Private medical practice was not allowed. Patients could routinely access medical "narrow specialists" even in primary care (e.g., dermatologists, cardiologists, neurologists) without being enrolled with and cared for by a "generalist physician" (e.g., a general practitioner [GP] or family physician [FP]). These narrow specialists were located in both acute care settings such as hospitals, and primary care such as polyclinics and primary health care centers.

The fragmentation of medical practice became ubiquitous and led to *overspecialization* not only at the secondary and tertiary levels of hospital inpatient care, which became the norm in the West, but also in outpatient primary care. The work of the generalist physicians carried low prestige among medical practitioners and the general public, especially in urban areas. This was primarily due to the fact that these medical professionals were often nonspecialized physicians, whose work mainly consisted of referring patients to narrow specialists with very limited "hands-on" clinical work. In sum, the health care field in Eastern Europe prior to transition was *compartmentalized*—ordered through a professional logic of *narrow specialism* that fitted the prescriptions of the bureaucratic Communist state for coordinating activity. Central planning dictated strict and inflexible norms for staffing patterns, funding flows, and resource allocation.

Health systems in Western Europe evolved very differently. In the years following World War II, the emergence of new technologies and an explosion of medical knowledge resulted in the extensive segmentation of medical knowledge into discrete, narrow medical specialties. However, GPs or family physicians continued to provide the majority of health care outside hospitals as first-contact physicians. Unlike Communist countries, the first-contact physicians in many Western European countries received vocational training with a view to generating a cadre of "specialists" in family medicine and general practice. In addition, while medical universities in the Communist countries typically consisted of specialized faculties focused on developing a narrow skill base for medical graduates, medical curricula in universities in the West were much broader and specialists were expected to understand how their discipline connected with other areas of medicine. From the 1970s, data on major health indicators increasingly indicated that health systems in centrally planned economies were performing poorly vis a vis OECD countries (World Health Organization, 1997). In addition, an overreliance on curative and specialist-led care resulted in rising costs. At the same time, the perception regarding

quality of care among patients was low, and medical staff expressed considerable dissatisfaction with their working conditions and salaries (Figueras, McKee, Cain & Lessof, 2004).

Health care fields during transition: The era of holism and family medicine. In the 1990s and early 2000s, and in the context of the transition from Communism, the five focal countries in our study embarked upon major programs to reform their health systems. The reforms were triggered by a political imperative to move away from the Communist model and a corresponding desire to fashion their health systems along the lines of Western European countries. Policymakers sought to strengthen primary health care with the introduction of a "holistic model of care" based on family medicine. Their aim was to achieve more efficient and equitable health care and encourage the delivery of services outside hospitals and closer to the communities they served (Atun, 2004; Starfield, 1994; Starfield, Shi, & Macinko, 2005). Restructuring the health care field according to the principles of family medicine was strongly supported by the World Bank and the WHO, who argued that such an approach was both more cost-effective and led to improved health outcomes (Figueras et al., 2004; Macinko, Starfield & Shi, 2003; World Bank, 2005).

It is important to acknowledge that there are some differences between our study countries with respect to their implementation of the system of family medicine (FM), which reflects in part the varying roles played by the state, professional associations, and international bodies such as the WHO and the World Bank. Nonetheless, we contend that the health care systems of all five countries experienced a broadly similar set of policy changes and external pressure for change, which generated a broadly similar set of pressures on physicians. These pressures had profound implications for physicians' professional identities across our study countries, and it is these effects, and physicians' responses to them, with which our study is concerned.

The "old" and "new" professional logics. We conceptualize the changes outlined above as representing a switch between two discrete professional logics in the field of health care in Eastern Europe. Numerous archival sources, including studies conducted by academic researchers (e.g., Figueras et al., 2004), publications by professional bodies (WONCA Europe, 2002), international aid organizations (e.g., World Bank, 2005), and reports commissioned by governments, have described traditional and alternative ways of organizing and providing health care. These archival sources document differences between the "old" logic of narrow specialism and the "new" logic of generalism. Each logic offers a very different set of organizing principles for the field of health care. Thornton et al. (2012) specified a number of core dimensions along which institutional logics can be categorized. We used this framework to summarize and compare the core dimensions of the two professional logics that we study (see Table 1). We assume that each logic represents an archetype comprising cultural symbols and material practices that physicians can draw upon in order to construct and negotiate their professional identities (Thornton, 2004).

The emerging professional logic drew on a fundamental belief in the utility of holistic medical knowledge. It encouraged the provision of first-contact health care managed by generalist physicians who were trained and certified as specialists in family medicine. This alternative logic encouraged a more entrepreneurial and fluid role for physicians. It also allowed for the possibility of private sector involvement in the delivery of health care. Crucially, it emphasized disease prevention and the promotion of healthy behaviors, a patient- and family-centered approach to organizing health care, and a strong focus on involving local communities. These characteristics were combined with a more decentralized decision-making system, and with a funding model that relied on social insurance rather than direct funding from the state.

Study Design and Data Sources

We conducted an inductive study with the aim of building novel theory from rich qualitative data (Creswell, 1998). We became interested in the transition countries context because it features fundamental, disruptive institutional change in the health care field that created considerable pressure with respect to the professional identities of individual physicians. We found this theoretically intriguing, particularly given the limited attention that has been paid to the relationship between shifts in professional logics at the field level and professional identity at the individual level. We purposefully sampled cases of physicians located in various European transition countries. Specifically, we investigated the experiences of 113 physicians working in primary care in our five focal countries in order to understand the effects of professional logic change on their professional identity.

Physicians serve as a good example of highly institutionalized professionals (e.g., Chreim et al., 2007). While all physicians in our study were part of health systems that experienced radical change,

TABLE 1
Ideal Types of Professional Logics

Categories	Logic of *narrow specialism* (primary care via specialist polyclinics)	Logic of *generalism* (primary care via family medicine)
Root metaphor	Excellence in highly specialized medical knowledge—"vertical medical knowledge." Locus of excellence in large, technology-intensive, multi-specialty organizations able to provide highly specialized medical care.	Excellence in holistic medical knowledge about a patient and the health needs of the local community—"horizontal medical knowledge." Locus of excellence in community-based and patient-centered medical care.
Sources of legitimacy	Specialized expertise in medical practice cataloged by disease, technology, human anatomy, age, and sex; depth of expertise in a branch of medicine.	Comprehensive and context-informed medical practice; breadth of expertise; holistic patient care without breaking up knowledge about a patient into organs, body systems, age, sex, or technology.
Sources of authority	Head of polyclinic or primary health care center; local authorities; paternalistic relationship between doctor and patient.	Family physicians or family medicine teams in independent family medicine practices; recognition of the patient as autonomous agent and coproducer of own health and well-being.
Sources of identity	Specialist physician in a medical discipline; diagnostic and curative focus; physician considered primarily as provider of medical treatment and all-knowing "expert."	Generalist physician (claiming specialist knowledge); preventive and curative focus; physician considered primarily as patients' advocate and advisor on medical matters.
Basis of norms	Routinely referring patients to narrow specialists; limited clinical interventions by primary care physicians who are often nonspecialists; impersonal contact with different patients.	Treating, diagnosing and preventing ailments on site; apply best practice clinical guidelines; constant interface with patients and ongoing engagement to provide comprehensive, continuous, coordinated, personalized care.
Basis of attention	Episodic interaction with patients; providing expert specialist care.	Ongoing, unbroken interaction with patients; providing seamless care; providing holistic, generalist care.
Basis of strategy	*Organizational*: increase polyclinic or hospital activity. *Practitioner*: routine referring of patients to acute care and narrow specialists.	*Organizational*: increase family practice activity. *Practitioner:* manage own patient lists; assess health needs of the community; prevent potentially costly patient cases in the long term.
Informal control mechanisms	Expectations and preferences by health professionals, patients, and general public for specialist expertise and skills.	Expectations and preferences by health professionals, patients, and general public for holistic, patient-centered, family-oriented care.
Economic system	Centrally planned. State budget.	Double contracting: a) financiers—providers b) market—private practice.
Governance mechanism	Hierarchy and direct control; vertical accountability.	Vertical and horizontal accountability; patient lists, business management for private surgeries.

they had some degree of discretion over whether to accept or reject changes in their professional role and had scope to craft—at least to some extent—their professional identity. All the physicians in our study also experienced substantial changes in their day-to-day work routines (e.g., degree of patient contact, physical location of surgeries, organizational autonomy, administrative and clinical task profiles) as a result of the shift to a system of family medicine. Thus, our sample offers a unique opportunity to study the types of identity threats these physicians experienced in the context of a changing professional logic, and the forms of identity work they performed in response.

We drew on three main sources of qualitative data, which provided detailed information on what happened at the macro and individual analytic levels (see Table 2).

First, and most importantly, we conducted 113 in-depth interviews with physicians in primary health care located in our five focal countries during the period 2004–2008 (with additional unstructured observation notes taken during field visits). The majority of informants (73 out of 113) were female; no age related information was captured for our participants. We employed purposive sampling (Lincoln & Guba, 1985; Miles & Huberman, 1994), covering diverse types of roles as first-contact physicians (e.g., physicians in

TABLE 2
Overview of Data Sources

Data sources dynamics	Sources of data
Macro—Field-level institutional logic dynamics	• Face-to-face interviews • Government reports and legislation • Reports by international organizations • Studies in published literature • Field notes • Publications by medical associations
Micro—Professional identity restructuring dynamics	• Face-to-face interviews with 113 physicians • Field notes • Naturalistic unstructured observations

primary care working as family physicians, different types of narrow specialists required to be retrained to become family physicians, and academic clinicians) as well as different levels of seniority and professional physician experience. We were fortunate to have excellent access to informants in all five countries. A detailed breakdown of key informants interviewed across the five countries is summarized in Table 3.

The interviews were semi-structured, and administered by the first author with the assistance of professional interpreters who translated between English and the local language when the informant did not speak English (66 out of 113 interviews). The interviews lasted between 45 minutes and 1.5 hours, were conducted at each informant's place of work, and were taped and transcribed. Informed consent was obtained for all interviews. Each interview began with a standard set of questions to facilitate comparative analysis. Physicians were asked about: (a) their perceptions of their professional identity (what did it mean to them to be physicians, how did they feel about their profession, what did they do as physicians, how did they view themselves compared to other types of physicians); (b) the motivation behind their decision to become the type of physician they were; (c) their views regarding the changes that were happening in their immediate organizational setting and the wider health system; (d) their roles and tasks before and after the changes, especially for those informants who retrained as family physicians—this included their relationships and interactions with patients and other clinicians (e.g., nurses, narrow specialists); and (e) their views of the family medicine reforms.

Second, we conducted unstructured naturalistic observations of primary care surgeries and drafted notes during the field visits. In particular, we made general observations of how the primary care practices functioned and how physicians interacted with patients. We also observed the physical workspace and equipment, and compared the settings in which physicians were working as family physicians with settings in which the reforms had not yet been implemented. These observations augmented physicians' descriptions of their interactions and tasks but also revealed additional data that complemented the identity narratives of the physicians. For example, we noted changes in the appearance of physicians and in their physical workspaces, an observation that helped us to develop the concept of "relabeling," which we describe in our analysis.

Finally, we drew upon a range of secondary data sources. These comprised documentary and archival data, including published research articles, relevant policy documents, and reports by national and international organizations. The secondary data complemented the interviews that we conducted and played a key role in helping us to identify and specify the nature of the two archetypical logics that we rely on in our study. These secondary data sources also provided a richer context for understanding and interpreting the responses of the individual physicians.

Data Analysis

We analyzed the data iteratively, going back and forth between our data and an emerging structure of

TABLE 3
Characteristics of Key Informants

Informants/category countries	Estonia (E-1-18)	Serbia (SR-1-14)	Slovenia (S-1-19)	Moldova (M-1-18)	Bosnia and Herzegovina (B-1-44)	Total
Family medicine academics/educators	3	3	3	2	7	**18**
Family medicine physicians (GPs)	8	7	10	11	24	**60**
Narrow specialists	7	4	6	5	13	**35**
Total	**18**	**14**	**19**	**18**	**44**	**113**

themes and theoretical arguments (Strauss & Corbin, 1990). This "ground-up" approach to data analysis helped us to develop theory that is closely linked to our data (Golden-Biddell & Locke, 1997). Crucially, we relied on the language used by our informants to frame issues and concepts in our findings. In doing so, we sought to discern patterns relating to multiple themes that were consistent across interviewees (Lee, Mitchell, & Sablynski, 1999).

This process enabled us to identify three key professional identity threats faced by physicians as a result of logic change at the field level. We also observed that some physicians were more successful in reconfiguring their professional identity to fit the new logic, while the professional identity of others remained rooted to varying extents in the old logic. In examining these data, we were able to identify particular forms of identity work performed by the physicians who successfully changed their identities, each linked to one of the three identity threats, and which underpinned the transition from the old to the new professional identity. Figure 1 summarizes the process of data analysis that we followed, and includes our first-order themes, second-order theoretical categories, and aggregate theoretical dimensions (see, Gioia, Corley, & Hamilton, 2012). We explain the stages shown in Figure 1 in more detail below.

Stage 1: Constructing first-order themes. We began by identifying statements regarding our informants' views of the pressures for change in their role as physicians, how they saw themselves as professionals, and their subjective understandings of family medicine through a process of open coding (Locke, 2001). We focused on data fragments that specifically related to issues of professional identity. We then sought to compare and contrast these open codes in order to cluster them into first-order themes. To illustrate, statements about differences in professional status between generalists and specialists occurred frequently in our data and we coded these with a first-order theme: "status of generalists versus narrow specialists" (theme 2a in Figure 1). In contrast, statements about how physicians were perceived by various audiences were coded under the theme "status evaluation by medical peers and patients" (theme 2b in Figure 1).

Stage 2: Integrating first-order themes and creating second-order theoretical categories. We consolidated the first-order themes into theoretical categories through a process of axial coding. Here, we aimed to answer the question "what is going on here?" (Gioia et al., 2012: 20) and to move beyond descriptive statements about our data. In doing so, our specific aim was to create conceptual connections between the first-order themes. For example, the previous codes about the status of physicians were grouped together under the same second-order theme, since they were clearly related. However, the actual second-order theme was labeled "status loss" rather than simply "status," as this more accurately captured our interpretation of the anxiety that physicians felt about the reduced esteem in which they were held as they engaged with the new logic of generalism.

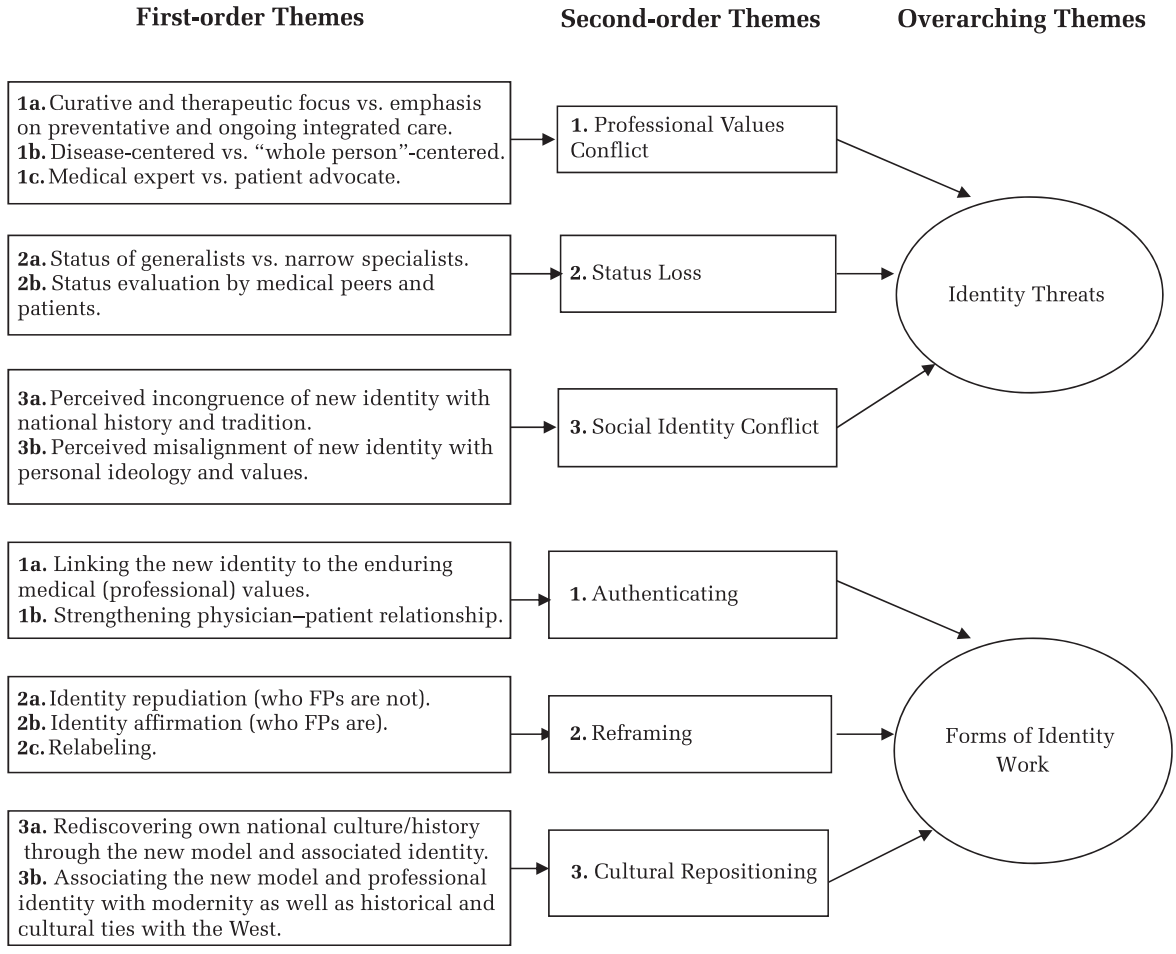
Stage 3: The delineation of aggregate theoretical dimensions. The third and final stage of the analysis involved looking for aggregate theoretical dimensions underlying our second-order categories in an attempt to understand how different categories might fit together into a coherent overarching picture (Corley & Gioia, 2004). We brainstormed alternative conceptual models that described how these themes related to one another and to existing organizational theories. Once we had identified a possible framework, we reexamined the data's fit or misfit with our emergent theoretical understanding (e.g., Glaser & Strauss, 1967; Locke, 2001). In the findings that follow, we intersperse our analysis with salient quotations in order to illustrate our interpretation of the data. We display additional illustrative quotations in separate data tables (see Tables 4, 5, and 6).

FINDINGS

The physicians in our study were forced to reflect upon who they were (or aspired to become) as professionals in the face of the shift in professional logics. As noted above, in response to the pressure to change their professional identity, some physicians adopted a new identity that was consistent with the new logic of generalism, while other physicians resisted the pressures to construct a new identity and their professional identity remained—to varying degrees—aligned with the old logic of narrow specialism. The first outcome represents what Petriglieri (2011) termed identity-restructuring responses, while the second outcome represents what she termed identity-protection responses. We focused our analysis on those physicians who enacted an identity-restructuring response—we were particularly keen to learn more about the process through which professionals transitioned "successfully" from a professional identity rooted in a formerly dominant professional logic, to one rooted in an incoming professional logic.

Our analysis revealed three main identity threats faced by the physicians in our study: *professional*

FIGURE 1
Data Structure



values conflict, *status loss*, and *social identity conflict*. Our analysis further revealed that, when salient for physicians, each of these threats precipitated a corresponding form of identity work designed to address them. Specifically, professional values conflict precipitated a form of identity work that we term *authenticating*, status loss precipitated a form of identity work that we term *reframing*, and social identity conflict precipitated a form of identity work that we term *cultural repositioning*. In this section, we consider each identity threat–identity work relationship in turn.

Identity Threat 1: Professional Values Conflict

The first identity threat that we identified was rooted in the professional values associated with the two logics. These values had a profound effect on how medical practice was organized and clinical duties defined. Perhaps unsurprisingly, physicians who were most deeply socialized into the values associated with the old system—normally physicians with longer tenures and who had worked under the previous system for many years—felt this threat particularly keenly.

Three core conflicts were described by our respondents. First, there was the conflict between the idea that physicians should be focused on curing disease, which was a core value of the specialist logic, versus the idea that physicians are responsible not only for curing disease but also for providing ongoing, long-term care and for preventing illness for a patient. For example, according to a former internal medicine specialist who retrained as a family physician:

> When I was asked to retrain as a family doctor I felt some kind of pressure to change my perspective on medicine. [As an internal medicine specialist] I was

TABLE 4
Identity Threats Experienced by Individual Physicians

Identity Threats	Description	Exemplary Quotations
1a. Curative and therapeutic focus versus emphasis on preventative and ongoing integrated care.	Statements of perceived conflict between the idea that physicians should be focused on treating or curing patients, which was a core value of the specialist logic versus the idea that physicians are responsible not only for treating or curing patients but also for providing ongoing, long-term, coordinated care and be responsible for preventing illness.	[In the work of family doctors] we emphasize the preventive aspects of care, which were not present before. In the old Soviet system patients were treated by different specialists each time in large institutions, it was rather institutions treating patients. . .nobody was taking care of them [patients] over time. . .the family doctor is responsible for a certain patient, [a defined] population and this doctor has an interest to search for new cases, identify early difficult cases that were usually passed unnoticed in the past. . .[The FP] is the personal doctor who takes care of them [patients]. . .doing things differently makes you think differently and is not easy, it takes time to adjust. [FM educator—M-3] The transition has not been easy for many of us that used to work as specialists. . .we [as narrow specialists] had to change the way we work. . .[FPs] not only cure patients or treat symptoms but also work on prevention and long-term care for patients from all age groups. . .it is easier to say than do and there has been a lot of frustration. [FP, former school pediatrician—B-20] A family physician views patients holistically rather than as segments or parts, and this is a basic difference in how you think about medicine and how you build relationships with your patients. It is a fundamentally different philosophy from subspecialist care in hospitals or polyclinics. [FM academic—B-11]
1b. Expertise in particular diseases/ organs/systems of the human body versus the idea that physicians should look at the "whole person."	Statements of perceived conflict between the idea that physicians were experts in particular diseases, ailments and/or organs/systems of the human body, which is a core value of the specialist logic, versus the idea that physicians should look at the "whole person" when diagnosing, treating and caring for patients.	Family medicine is more holistic model [of care]. It is very dangerous to separate medicine in[to] segments, because then there will always be spiders or viruses that disturb the whole system. If medicine is separated into eyes, nose, legs, then we lose the entity, we lose the man, and that was often the case in the old system. . .for many of us it was a choice of adopting a value system that sets a strong foundation not just for individual doctors but for the whole health system based on a holistic approach to medicine rather than the segmented and piecemeal approach of subspecialization. . .when you ask a narrow specialist to become an expert on the whole person instead of specializing in one type of disease or system, that has been quite challenging for most. [FM educator—B-28] . . .as an FP you need to adopt a different set of values, a new philosophy. . .for a trained specialist to respecialize on whole-person medicine is quite awkward because it clashes with their established medical mindset. [FM academic—S-14] I trained as a family physician because I want to care for the "whole person" rather than focusing on specific organs. . .Hospital specialists for example still follow a segmented approach in practicing medicine, but medicine in general follows a similar segmented approach in generating new clinical knowledge, so caring holistically

TABLE 4
(Continued)

Identity Threats	Description	Exemplary Quotations
		for a person can be problematic from the dominant biomedical paradigm. [FP specialist—E-16]
1c. Physician as an expert engaging in a paternalistic relationship with patients versus physician as patient advocate engaging in participatory models of care delivery.	Statements of perceived conflict on the role of the physician as an all-knowing medical expert, which was a core feature of the specialist logic, versus the idea that patients and informal caregivers have a role in deciding upon a particular course of treatment and the coordination of care, which was a core feature of the generalist logic.	The patient [in the old model] would not even think to question the doctor's decision. . .the role of the patient was to obey [the] doctor's advice. . .the family doctor must involve the patient in the care plan, and the patient needs to take responsibility [for] their own health, [he/she] has rights but also obligations. This is [a] core principle of family medicine but can be challenging for some doctors and patients. [Nonspecialist GP, retrained in FM—B-5] Patients under socialism were not actively involved in their treatment. There was a paternalistic relationship with the state, in [the] sense that the government and the ministry would take care of them, the state would educate them, give them jobs, houses and their health was the responsibility of the ministry and the doctors. . .in family medicine patients are expected to be active and many "old school" doctors' find it difficult to adjust. [FP & FM educator—S-6] In the system before the reforms the doctor was a small God, nobody would challenge their clinical decision. . .the more experienced doctors relied mainly on clinical experience, there were hardly any clinical guidelines available. [FM academic–S-14]
2a. Status of generalists versus narrow specialists.	Statements that revealed self-perceptions of unequal status between narrow specialist and generalist physicians.	People don't think of [the] family physician as an important person. They don't have their family physician in high esteem, but they do appreciate the expertise of specialists. [District physician—M-5] [As a narrow specialist in a polyclinic] you are an expert, you have specialized skills, you carry out complicated medical assessments. . .surgical specialists perform complex operations, they use the most complicated or high-end technology. . .family doctors, well, they may use the stethoscope, and especially the district [generalist] doctors in the past they commonly used just a pen to refer patients or write prescriptions, some called them "pen pushers" for this reason. [Internal Medicine Specialist Polyclinic—E-1] There are problems of status and career advancement for generalists as opposed to specialists, nobody can ignore that. [FP—B-16] If family physicians are poorly paid, or they commonly practice in poor work environments, and have limited possibilities of professional development, then the [status mismatch] will increase; how these physicians are regarded will depend on these factors. As a physician are you then attracted by this professional image? [FM academic—M-8]
2b. Status evaluation by medical peers and patients.	Statements that referred to status differentiators between narrow specialist and generalist physicians as evaluated by medical peers and patients.	The view of the population for GPs is that these are actually not real doctors; the real doctors are in the secondary and tertiary health care. This belief undermines the real value of family medicine doctors and reputation; it is an impediment to the spreading of the model. How can you persuade a narrow specialist in primary care to be retrained as generalist? [Experienced GP—B-15]

TABLE 4
(Continued)

Identity Threats	Description	Exemplary Quotations
		We have a saying: "the person who says 'I know everything' knows nothing;" this is a problem with FM. What are these doctors experts [in]? [Pediatrician—B-17]
		People often look at you differently if you work in a primary care center compared to when you are a doctor in a hospital irrespective of how good [a] clinician you are. Family doctors are down there in terms of prestige, specialists still earn more money and that is also a clear status indicator I think. [FP, former GP—B-19]
3a. Perceived incongruence between the new model and the national history and tradition.	Statements that dissociated the model of family medicine from the health tradition in the country in which the physicians practiced.	The concept of FM is if you like a Western construct, it is alien to the medical tradition in this country. [Nonspecialist GP—SR-1]
		The tradition here in Moldova has been that there were specialists to treat patients. These foreign consultants brought the idea of having a generalist doctor, which contradicts a well-established clinical norm in this country. [Pulmonologist in polyclinic—M-12]
3b. Perceived misalignment of the new model with personal ideology and values.	Statements indicating a contradiction between principles of the new model of family medicine and an internalized core belief or ideology of the physicians.	I don't like [the fact] that medicine is becoming more like corporate business. . .more emphasis is on revenues and profit and the patient is of less importance. . .the primary care practices becoming independent enterprises is just the beginning I am afraid. [FP- S-11]
		There is discussion about encouraging family physicians to become owners of the practices, which I do not personally agree with, in my view it commercializes the health service, but education and health care should always be public goods. [District physician—M-5]

TABLE 5
Forms of Identity Work Resolving Each of the Three Key Identity Threats

Form of Identity Work	Description	Exemplary Quotations
1a. Relating the new professional identity to **enduring medical values.**	Mindful efforts to relate the new professional identity to what our informants described as enduring values of the medical profession.	**Becoming a family doctor helped me rediscover the grassroots of medicin**e if you like. **Family medicine adheres to the basic, the core values of the medical profession**. . .medicine is science, but it is very different from other "hard-core" sciences such as physics or mathematics, it is **the most humanized of sciences**, it has elements of art in connecting with people because each human being is so very damn different. Seen one patient, you've seen one patient, you have dealt with a **unique person** and that's that and as a family doctor you live this unique experience everyday. [FP private surgery—S-3] FM is a biopsychosocial model; it is more family-oriented. . .[being an FP] I **care for the person, I am a friend, an advisor for my patients**. . .I am a complete doctor, "all-rounder," this is what medicine is about!. . .**Hippocrates if he was still alive would be a family doctor not a narrow specialist.** [FM educator—B-21] Family medicine **brings to the fore the human side of medicine**. . .It feels nice to **care about your patients** rather than just mechanically treat their ailments. . .**I feel [I am] a better doctor, a true doctor.** [FM specialist—E-3]
1b. Strengthening **physician–patient relationships.**	Statements referring to physician–patient relationships making claims regarding core aspects of the generalist logic.	[As an FP] you build a **trustful relationship with the patients**, you **respect your patients** and they trust you. This has been **the archetypal model of practicing medicine for centuries**. . .it is not only about competence but also about commitment, integrity, human relationships. . .**historically these have been central values of the medical profession.** [FP—B-29] The **essence of medicine**, at least how I personally see it, is about **commitment**. . .the **doctors will stay with a person whatever his problem** may be and this [is] a **core value of the clinical work of a family doctor.** [FP, former gynecologist—B-1]
2a. Identity **repudiation.**	Statements about identity content claiming *who family physicians are not.* Attempting to resolve conflicting elements of new professional *identity status* by emphasizing *who or what family physicians are not:* lesser versions of other specialists, subordinate in status and prestige or importance to narrow specialists.	. . .**We are not the low-status district physicians, we are not what people used to call "pen pushers."** [FP—E-7] You see young, ambitious family doctors saying **we are not narrow specialists with a limited clinical scope**. . .**we are not "second-class" doctors any more.** [FM academic—S-10] The way I work [as an FP] is very different from how the internists in primary care used to practice during the Soviet times. . .the patients understand that family doctors are not the same as Soviet time internists. . .**I am not a "prescription doctor," [which] was a nickname for the old style internist.** [FP—E-8] [FPs] **we are not down there as in the past** [when] nobody would look at us as equals; we are not the lowest-status doctors. [FP—B-29]
2b. Identity **affirmation.**	Statements about identity content claiming *who family physicians are and what they do.* Attempting to resolve conflicting elements of the new professional *identity status* by stating who FPs are and the importance of the work they do.	I was retrained as [a] family doctor in [the] 1990s. I **work as an independent practitioner, I manage my own practice** and I have a contract with the Sick Fund. As you probably know, primary care doctors in the past were often referring patients to narrow specialists but now this has changed. . .**my work is more clinical, more satisfying**. . . [being an FP], **I am [a] more complete doctor**, I have **expanded my competence** to cover many conditions and different patient groups. [FP, retrained district physician—E-13] [As an FP] I manage a broad variety of clinical cases every day. . .The family doctor is the doctor of first contact. . .[FPs] **safeguard the continuity and coordination** of care for our patients. **We are advocates for our patients**. . .**family doctors are the bedrock of the health system.** [FM educator—B-28]

TABLE 5
(Continued)

Form of Identity Work	Description	Exemplary Quotations
		[The FP] is the most inclusive type of doctor. The narrow specialists specialize in one area excluding all others but [as an FP] you cannot do that; you need to broaden your knowledge, constantly **develop new skills in different fields** of clinical practice. [FP, former GP—B-26]
		The family doctor **is the gatekeeper and coordinator** for patients. Specialists are the diagnostician or the therapist. [As FPs] **we guide the patient in the health system, we do the follow up, we work more on prevention.** [FM specialist—E-16]
		I trained as an FP because I want to **care for the "whole person"** rather than focusing on specific organs. . .[FPs] focus on the whole person, we **adhere to different values or principles in comparison to narrow specialists.** [FP– S-12]
		FPs treat patients, not diseases. **That's what distinguishes us** from internal medicine and other narrow specialties. . .[FPs'] expertise lies in our **capacity to coordinate [and] integrate** care for complex health problems. [FM academic—E-5]
2c. Relabeling.	Using labels in narrative statements to distance physicians' professional role and self-concept from the preexisting role of the GP or the unspecialized physician in primary care during the Communist era. Emphasizing one aspect of physicians' identity (e.g., academic) over another (e.g., practitioner) to compensate for a perceived loss in professional status.	. . .**even being called family doctor makes you automatically a different type of doctor**. It means that you are different from the district internists whose reputation as doctors was very low in comparison to specialists in polyclinics. [FP specialist—E-3]
		I think most of my younger colleagues share this feeling that we are different. . .**the name of family doctor helped us feel that we are different from the poor image of primary care doctor. As a family doctor I am respected** by my colleagues, the patients, I feel proud as a clinician. [FP—E-8]
		All doctors in Estonia used to be salaried employees. It's very different from the past, I don't know if you are familiar with the previous model, we used to have district internists. . .those doctors were nicknamed "pen pushers;" it was used as a derogatory term to indicate the limited clinical work these doctors were doing, they had much lower professional prestige relative to hospital specialists, and low pay. . .**we [FPs] are [a] very different type of doctor that did not exist in the country previously.** [FP—E-11]
		. . .family physicians have a **new role as integrators** across specialties. . .**coordinators** of care for our patients, their families, the community. [FP—S-11]
		The **academic reputation of family medicine is well established, there is no difference in prestige or**. . .**professional standing** compared to the other medical departments. . .we were the **first department that introduced innovative educational models** such as action learning, live case studies, videoing in the assessment that differed substantially from the traditional methods used in the medical faculty. . .**everyone from the other departments are now copying us.** [FM academic—S-14]
		Estonia was the first post-socialist country that created an independent family medicine department in 1992 and recognized FM as an independent medical specialty in 1993. . .it was not like a government-led reform but it started from the doctors' level and also academic professors. . .**our job as academics has been to create a new type of doctor [that is] more entrepreneurial, more confident in dealing with the uncertainty of unspecified illness**, this work has been recognized by our peers in the (medical) faculty and also by medical students who choose the new specialty. [FM academic—E-2]

TABLE 5
(Continued)

Form of Identity Work	Description	Exemplary Quotations
3a. Rediscovering own **national culture/history** through the new professional identity.	Statements incorporating political or social ideals to make the model of family medicine and the associated professional identity appealing.	Within. . .medical circles, and especially among the early proponents of FM in Tartu, the idea was discussed, as it was the norm for other Nordic countries. . .most Estonians feel they are Nordic people. . .**[FM] is closer to what the medical practice used to be here before the country was forced to adopt the Soviet system that was not part of our tradition and national history.** [FM specialist—E-16] There was a general attitude of people in Estonia after independence, not only in health care but in. . .society, to do everything differently than during. . .Soviet times. . .**family medicine is not Soviet or Russian as was the specialist model and polyclinics**. . .**[FM] fits very well with the entrepreneurial spirit and individualism of Estonians.** [FM academic—E-5] There has been a long history of general practice in all the countries of former Yugoslavia even before Communism. . .**the work of [the] family doctor continues [to have] a long history in community care and social medicine, [which] are the foundations of general practice**. . . the *Dom Zdravlje* [DZ: primary care centers] were **part of our national heritage in Bosnia**, but subspecialists dominated and transformed the DZ into polyclinics almost the same as hospitals. So, **the model of family medicine is not Canadian or foreign as many narrow specialists claim but it has been really part of our national culture**, it is based on the very same principles that initially created the DZ for which everyone was proud in former Yugoslavia. [FP—B-41] This model is not particularly new; the basic principles of FM doctors existed 100 years ago. But political and social systems change and so did the models of health care. In the prewar period our health system was definitely among the best in Europe and probably in the world. . .**in this country we have had links with general practice**. . .**through the role of family doctor we return to those foundational principles that had faded in the meantime.** [FP, experienced GP—B-44]
3b. Associating the new model and professional identity with a notion of **modernity**, as well as **historical and cultural ties with the West.**	Statements associating the new model with modernity and esteemed Western health systems that have a reputation for being effective and offering high-quality care.	**FM is widely viewed [as] a European model and this is in contrast to the previous Soviet model** we had in Estonia. . .[FM] is an effective system of health care. . .[the] polyclinics idea is old-fashioned, it is what remained from older times. [FP—E-11] FM is common practice in **many Western countries, for example our neighbors in Finland, Sweden.** [FM academic—E-5] **Slovenia has had historic and cultural ties with the West and other Central European nations**, which continued even during socialism. . .the transition has been seen as **the opportunity for the country to reestablish its position as a modern Western European nation**. . .some of us who trained as family doctors. . .developed very close professional relationship with WONCA Europe [the international FM association] and **colleagues in Austria, the Netherlands, which prepared us, I would say inspired us, to get family medicine running around the country, it has been working effectively for those countries, why not here?** [FP, experienced former GP—S-15] In Bosnia, simple procedures such as the insertion of an intrauterine device is done by gynecologists, another example is that only orthopedic or general surgeons normally put in place a plaster cast, but in Western European countries these interventions are carried out by family physicians. **Specialist family physicians can perform these interventions effectively, I [hope I will] see one day our health system [being] modernized and follow[ing] the example of effective systems in other European countries.** [FP specialist, former GP—B-6]

TABLE 6
Adoption of New Professional Identity

Identity Outcomes	Description	Exemplary Quotations
1a. Redefining the relationship with patients; patients viewed in the context of their family and community.	Statements indicative of physician's engagement with a new viewpoint on the relationship with patients that aligns with core principles of the logic of generalism.	The relationship with patients has changed dramatically. I know my patients much better, I know their family situation, I am aware of issues from their social surroundings that might affect how they feel, **my perspective on how I see them is different and you can now feel that the patients trust me more, they open up and discuss their problems, I feel great responsibility for them.** [FP—B-24] I think that with the new model [FM] it is the patients that get more and not us, the clinicians, because this system allows patients to have better service, to have better communication, better relations with the clinicians, the doctor knows all about [the] patient's family and all the burden factors. . .time is saved both for doctors and patients, because the patient knows exactly when to come, so we can plan. Before the war I used to work in Sarajevo for 10 years, during the war I went to Croatia, where I worked three years and then I moved here, and from all these years of experience **I can tell that the FM model is the most human friendly, the family doctor is a personal carer**. . .**we do care for the wellbeing of the person within the community they live [in]** and you can see this more in more rural areas like in this *ambulanta* [outpost surgery]. [FP—B-25] We [FPs] have enough time for our patients; there are no crowds in the corridors, no pressure on doctors. . .**We get an [insight] into the whole family,** [patients'] **health status, their social situation**. . .**Many people visit their doctors because of their social and not health problems**. We spend enough time on each patient, we get a good insight in their health condition, we follow up...**there is continuity of care, we see the patient holistically [and] we also understand their social environment.** [FP specialist—B-4]
1b. Perceiving the **philosophy, clinical tasks, and activities** associated with the new professional identity as **meaningful and valued.**	Statements indicating acceptance of values and meanings that align with the principles of the logic of generalism; the relative value and priority the physicians assign to the new clinical tasks and activities suggesting personal commitment to the new role.	The way of thinking and the style of practice have changed for the better...**I feel much more satisfied professionally when I practice medicine in a comprehensive way**, I can spend more quality time with my patients because I know their background . . .we routinely practice **preventive care** and that helps shift your attention more to

TABLE 6
(Continued)

Identity Outcomes	Description	Exemplary Quotations
		health promotion. [FP working as independent practitioner—S-3] If you perform clinical tasks that only specialists used to do in the past and you do them well that makes you feel confident. . .the patients recognize your competence and skills and they prefer you over the narrow specialists even though they have the possibility of going there; this is very empowering. . .we [FPs] **coordinate care for patients**. . .**we are the point of first call**. . .**over time I have built a trustful relationship with my patients, they are my friends**. . .**my work has scope and meaning, it is like fulfilling your calling for being a doctor.** [FM specialist—M-1] I used to work with the previous model as a GP and I simply could not monitor what was going on with my patients. Patients on the other hand had to tell their clinical history over and over again each time they visited a GP, as he was usually a different person. . .with FM, primary care has found its proper position. . .**the whole family visits just one doctor, we have an appointments system, you can now follow your patients, you feel more responsible for their overall well-being, not just the medical condition.** [FP, former GP—B-26] **I'm very keen to help keep my patients healthy**. . .**I want to get to know my patients over time**. . .Specialist care doesn't necessarily mean better care for patients. Specialists can arguably provide better care for rare diseases or complicated illness, but it is not very effective for disease prevention, keeping people healthy, or caring for chronic illness and multiple diseases. [FP—E-8] There is now the **element of human contact**. . .**better relationships between doctors and patients.** [FP, former GP—B-44]

> mainly trained to diagnose and cure disease. . .in my day-to-day work I was not practicing prevention;. . . [being retrained as a family physician] required me to work with a different set of principles, and somehow change the way of my thinking about health, about medicine. For the first time I have been responsible for health promotion and disease prevention. . .I realized that I needed to develop some expertise and skills in this area. . .completely change my orientation and what I do as a clinician. . . It is still quite unsettling. . . in theory it [retraining] may sound reasonable or straightforward, however applying it in practice is a different story. [FP, former internal medicine specialist—B-8]

Second, there was conflict between the idea that physicians were experts in particular diseases, ailments or organs, which is a core value of the specialist logic, versus the idea that physicians should look at the "whole person" when diagnosing, treating, and caring for patients. For example, a particular drug might help cure a particular physical ailment, but cause depression or another psychological disorder, which may lead physicians to consider less orthodox treatments that do not cause such side effects; this requires a different mindset so that the physicians think in terms of the whole person, both body and mind.

Many physicians highlighted that becoming a family physician required the adoption of a broader perspective (bio-socio-psychological), according to which not only biological, but also psychological and social factors all play a significant role in shaping disease and illness. Consistent with such a perspective, understanding the patient's subjective experience becomes an essential contributor to accurate diagnosis, and the provision of more effective and humane care that also takes into account the patients' preferences, the social support available to them, and their economic situation. This is in sharp contrast to the reductionist biomedical approach that characterizes the narrow specialist logic. The dilemma expressed by a pediatrician who retrained in family medicine highlights this tension:

> We had the Canadian doctors and professors lecturing us about the value of the family medicine approach, how important it is to treat and care for the whole person, to follow a bio-psychosocial model in medicine in contrast to a focus on disease or body parts. . .then the dilemma comes, who am I? What doctor am I? Before I was a pediatrician for school-aged children I specialized in diagnosing and treating diseases for this specific population group. I knew what I was expected to do, it was clear to explain to someone what I am doing. But now I am an expert in what? The whole person's health? The family and the community? This doesn't makes much sense to me, at least the way I have been thinking so far as a doctor. . .it is hard to explain what I do to my mother who is quite old or explain what type of doctor I am to a lay person. [FP, former pediatrician—B-7]

A third conflict concerned the role of the physician as an all-knowing medical expert, which was a core feature of the specialist logic, versus the idea that patients and informal caregivers have a role in deciding on a particular course or treatment and the coordination of care, which was a core feature of the generalist logic. For many physicians, the idea that they might be challenged about their approach towards treating a particular patient was an extremely disconcerting experience. According to one family physician who owned a private practice:

> There has definitely been a change in expectations. . . In the past, the physician–patient relationship was more paternalistic. Patients accepted all decisions. . .made by the doctor, while with family medicine this is not the case. More and more patients get involved in decision making, and sometimes, patients know more than the physician. This was unthinkable in the past because the patient was aware of his ignorance, and used to say to the doctor "Whatever you will decide". . .this makes my everyday clinical work far more challenging and demanding, quite often can be very stressful. [FP—S-6]

In sum, a series of conflicts were felt by many physicians with respect to their core values that shaped how they practiced medicine, their expectations about how they should interact with patients, their understanding of what constitutes quality care and effective clinical service, and how they viewed themselves as physicians. The differing values that underpinned the two logics left many physicians with a sense of unease and sometimes confusion about their professional identity. In other words, they threatened how physicians felt about their professional roles and selves.

Identity work 1: Authenticating. Our analysis revealed that in order to address the identity threat posed by the professional values conflicts outlined above, physicians engaged in identity work that involved making authenticity claims about the profession of general (family) medicine. Such authenticity claims were underpinned by three narrative strategies. First, physicians engaged in conscious efforts to discursively relate the new logic of generalism with what our informants described as the enduring values of the

medical profession. Indeed, informants claimed that their new roles were about "returning to the basic values of the medical profession" and "rediscovering the Hippocratic medical tradition." One physician made this point in the following way:

> Family medicine is the closest you can get to the core principles of what medical practice is about, what true medicine is, and has always been, about. . .becoming a family doctor gave me the opportunity to care for a person, not just treat a disease, and this is the essence of medical practice, not only now but since ancient times. [FP—S-4]

Second, many physicians emphasized that general medicine gave them the opportunity to strengthen their relationships with their patients, which they argued is at the core of medical practice. For these physicians, an emphasis on nurturing human relationships, a strong commitment to patients, and the prevention of illness—all of which are consistent with the generalist logic—were essential elements of medicine that needed to be nurtured and promoted. Crucially, these aspects allowed for the construction of authentic physician–patient relationships. According to one of our informants:

> The first family doctor was arguably Hippocrates, he lived in the community and cared for the community, his teachings stressed the importance of developing strong relationships with patients, he was seeing patients of all ages, he was treating all kinds of illnesses, he recognized the links between, not only the physical but also the mental or psychological, and social influences on his patients' health. This is what general practice is in essence really. [FP—E-7]

Similarly, another physician noted,

> Of course we need specialists. But we also need doctors who know their patients long enough and well enough to truly care for their needs, to manage the health of the whole person. We need to provide not only treatment but also care for the patients with respect. . .[it] is [a] core principle of good medical practice. If patients are able to talk openly to a doctor and trust their doctor this has immense therapeutic value in itself. It is a ritual that was lost in the specialized, depersonalized medical care that was provided in the polyclinics. [FP—S-11]

Third, physicians in our study engaged in arguments that suggested that delegation of responsibility to patients—a key element of the logic of generalism—enhanced joint decision making and facilitated patient empowerment. This further helped to overcome the often distant and hierarchical relationships between patients and clinicians that characterized the provision of care under the logic of narrow specialism. Consider, for example, the comments of an experienced family physician in Estonia:

> In the Semashko system before the reforms the doctor was "God". . .the patient must simply follow instruction. . .Family medicine has introduced a very different perspective. . .. we the doctors are experts about the disease and know how to fight it but patients know more about their real needs. . .I know my patients as persons, who they are, what is going on in their lives, they trust me. This is key in how we practice [as FPs]. [FP—E-3]

Thus, a number of physicians in our study sought to resolve the threat posed by professional values conflicts through identity work that appealed to various claims for professional authenticity. Such identity work likened core elements of the new logic and the professional identity associated with it to a return to a "true" form of medical practice and patient–clinician relationship. The aim was both to create a sense of *continuity* with the past, as well as *congruence* between medical ideals and clinical practice to unearth a professional value system that had been eroded.

Identity Threat 2: Status Loss

The second identity threat widely reported in physicians' accounts was the perceived risk of a loss of professional status. For the physicians in our study, to be told—after years of developing their careers based on specialist sets of skills and knowledge—that their services were no longer valued was extremely upsetting. This was particularly the case for the most senior professionals in the highest-status medical specialisms, who had often been in the system for a considerable length of time. It was also a particular challenge for those physicians in our study who had to abandon their medical subspecialty and consider practicing generalist medicine, which for many was an unfamiliar concept: these narrow specialists were told that they needed to retrain to keep their jobs in the health system. The following excerpt is indicative of the trauma and turmoil experienced by many of the specialists we interviewed:

> I was working as a school pediatrician for over a decade, I was told I had to retrain as generalist doctor in primary care, which meant taking care of a large number of elderly people with chronic conditions, or pregnant women, something I hadn't done since my

> years [at] medical school. They were only looking for family doctors in primary care, not pediatricians, not school doctors, not gynecologists, that was made quite clear. But my alternative option was to be left without a job, so I accepted a job as a family doctor. The most frustrating thing was that I had to start almost at the bottom of the professional hierarchy as a medical clinician; you know family doctors were widely seen as the lowest-status doctors. I also had to go through a resident-like training, which if I am honest with you I found it initially rather humiliating. But I had no option, I had a family to support, I could not leave the country for a number of reasons so I had no other option really. [FP, former pediatrician—E-12]

Professional frustration focused in particular on concerns about perceived status loss among both *patients* and *peers* as compared with narrow specialists. This was widely reported by family physicians in our study. According to one family physician:

> Doctors view family medicine as less prestigious than other specialties, and surgery is at the top. There is a very clear hierarchy in medicine among doctors but also in the public, and family medicine is close to the bottom. [FP—M-2]

The perceived lower status of generalists was reported to be associated with lower remuneration, the use of less sophisticated technology, more basic working facilities, and the application in practice of what was often perceived as a less valuable type of medical knowledge. The following claim by a physician highlights elements of this threat:

> A specialist doctor masters [skillful clinical] techniques, and has expert knowledge. The tools that family physicians use, are, well, the stethoscope, and lots of pens. It is not a very prestigious or intellectually challenging discipline, is it? [Pediatrician—M-9]

Our respondents spoke of their frustration with the fact that there was a limited understanding of family medicine, which was equated to a "basic" set of services and thought of as "intellectually nonchallenging." For specialist physicians, this dampened even further their enthusiasm for entering residency programs that provided training in family medicine. A quote from one physician in primary care highlights these concerns:

> [Family medicine] is very devalued, family doctors are only seen as those who write prescriptions and fill in forms... You think I have undertaken 10 years of hard training [to end] up writing prescriptions—is this who I really want to become? [Internal medicine specialist—SR-2]

The low professional prestige of family medicine practice appeared to be concomitant with the lack of a clear medical identity from a biomedical or organ-centered point of view:

> A lay person asks you "What type of doctor are you? A family doctor? What is that, what do you cure?" Then what can you answer? A cardiologist treats heart diseases or a nephrologist treats kidney diseases. As a family doctor, what do you treat? [Pediatrician—M-4]

Identity work 2: Reframing. The second form of identity work, which we term "reframing," was undertaken by physicians who aimed to resolve the threat associated with a perceived loss in status as a result of the new professional logic. Unlike authenticating, which focused on a comparison between the new logic and an idealized conception of the nature and purpose of medicine, reframing involved making direct comparisons between the incoming and outgoing professional logics that positioned the new logic of generalism in a favorable light. Specifically, our analysis suggests that this form of identity work comprises three discrete narrative strategies.

First, some physicians defined the new logic and the professional identity associated with it by contrasting generalism with other biomedical professions. Specifically, these physicians refuted the aspects of generalism that had been designated as low status when the field of health care was dominated by the logic of narrow specialism. They attempted to resolve contradictions that stemmed from the identity status threats they experienced by emphasizing *what or who family doctors are not.* In other words, they used statements to suggest that family physicians are not unimportant, that they are not easily ignored professionally and politically, that they are not "lesser versions" of other medical specialists, or are not the remnants of other specialties in terms of what they do as professionals. This differentiation tactic is illustrated in the following quote:

> We're not just a little bit of pediatricians, a bit of gynecologists, a little bit of cardiologists or internists...We are not second-rate doctors as the general practitioners used to be considered. We're the real doctors; we are the most complete ["*sveobuhvatna;"* also translated as "comprehensive"] type of doctor...we have our own specialty, our own clinical perspective, now we have a [medical] discipline. [FP specialist—B-4]

A second narrative strategy often used in conjunction with repudiation—see, for example, the quote above—involved physicians affirming their new role by stressing their belief in their abilities as physicians, highlighting their professional "worth," and claiming

status parity with the narrow specialists. In other words, they sought to affirm their new identity. In doing so, physicians attempted to resolve the status issues that they experienced by emphasizing *what or who family physicians are*. In other words, they used statements designed to convey the message that family physicians are as important as any other physician. Consider the following quotation from a family physician we interviewed:

> This was the feeling [as a family physician] I am very important and I have my own patients and money to manage and, you know, these kinds of thoughts. [FP—E-3]

Another physician sought to affirm his role as a family physician and his enhanced status by highlighting his work as a patient advocate:

> [The] family physician has now become an important person because he sees the patient, he makes decisions with the patient; in the past nobody had the responsibility in the end for patients and patients were on their own. Now [the] family physician is patient's advocate. In the past, [the] patient was seeing many doctors of different profiles and everyone was carrying out their part and [no one] was seeing the patient as a whole. Or things in the past could have been even worse when individual patients decided by themselves that they needed to be seen by a particular specialist. [FM specialist—M-1]

A third narrative strategy that formed part of identity reframing involved relabeling; i.e., using new labels to highlight how the physicians saw themselves as professionals. Individual physicians employed this strategy in their narrative efforts to resolve the identity threat associated with the lower perceived status of physicians in primary health care prior to the reforms. For example:

> ...there has always been an image issue for GPs...but [as] GPs under the new name of family physicians we are getting the role we deserve, not so much as gatekeepers, but as care coordinators, we are not the low-status professionals anymore. [Private FP—S-6]

The terms "general practitioner" in the former Yugoslavia and "district physician" in the former Soviet Union were synonyms for a physician who had no specialty training. Many of the physicians in our study were careful to refer to themselves as "family physicians" or "family doctors" not only to distance their new role from the low-status image of "old-style" primary care physicians, but also to reflect their elevated status as "specialists."

In addition, a subgroup of our informants engaged in a variation of the relabeling strategy. While practitioner specialists in internal medicine were among those who had particular difficulties adjusting to what they perceived as a profound drop in status, academics of the same specialty engaged in extensive relabeling work in order to try to address this threat. These physicians emphasized the academic, rather than the practitioner, aspect of their new professional identity, as the following quote indicates:

> When we created the department in the university, Estonia was the first former Communist country that opened a department in family medicine, this was very important because it signified acceptance of family medicine, it gave legitimacy to the new specialty. For us who took up the lead, and the professional risk, and became academics in family medicine, we are at the same level with all other academics [in medicine], there is no difference in legal status, level of education or professional prestige. In some countries, even today there are no academics in family medicine and therefore family medicine in these countries faces many difficulties. . .our department [FM] has been the most international, we have had strong links with other faculties abroad and we are amongst the most innovative in the medical school in training and academic practice. [FM academic—E-5]

In doing so, these informants were able to emphasize other aspects of their identity—in the above case their academic role—that compensated for the perceived status loss that internal medicine practitioners experienced.

In sum, by engaging in reframing, physicians sought to highlight that they are independent professionals with their own academic knowledge and clinical practices. Crucially, they claimed specialist status, likening their new role to other, more traditional, biomedical specialties in order to negate the idea that they are subservient to narrow specialists. Specifically, through the use of specific narrative strategies, they sought to persuade themselves and significant others of who they were and who they were not.

Identity Threat 3: Social Identity Conflict.

A third type of identity threat was connected to influences on physicians' professional identity beyond the settings in which they worked. Unlike professional values conflict (threat 1), which is rooted in tensions about the nature of professional

work and what it means to be a physician, social identity conflict is concerned with tensions between physicians' sense of self outside of work and the ideas and practices that underpinned the new logic.

Specifically, physicians' attitudes toward the logic of generalism were linked in part to the degree of its perceived congruence with their broader social identities. Thus, the physicians were inhabitants of countries in transition—their entire economies and societies were experiencing a dramatic shift from Soviet or Communist to Western ideas and practices. As a consequence, many of our informants struggled to make sense of their national identities—while some believed the "Westernization" of their countries was positive, others were deeply concerned and wished for a return to Communism, while still others felt caught between these two positions.

However, even for some pro-European, pro-Western physicians, feelings of nostalgia for Communism and strong attachment to the values of collectivism and egalitarianism often emerged in our interviews. While many acknowledged its shortcomings, for older informants in particular the Communist period was often associated with times when there was "social solidarity," while "education, housing, and health care were readily available to everyone." Thus, the new logic of generalism was seen as a break with social tradition and as violating important aspects of the preexisting value system. The following excerpt from a therapist in Moldova represents a good illustration of this type of identity threat:

> I was much happier in the old days when I was working as a therapist in a polyclinic in Chisinau. The patients, everyone was happier. I am not saying that things were ideal under Communism but at least people were more or less equal, everyone had a job, there were no people sleeping on the streets. . .When they introduced family medicine some years ago they were saying that it is an effective model, but what we had here before was superior, there were specialists and health care was free for all. . .they are introducing health insurance and many people are not covered, I am afraid that they will eventually make the family doctors only treat patients who are insured. . .Most [physicians] in primary care will have to retrain but I cannot see myself becoming such a doctor, [it] is against. . .what I believe, I do not think this is the best for our patients. [Therapist, rural practice—M-14]

This group of physicians said that they felt that the new logic of generalism was in some sense "foreign" and unfamiliar, and thus inconsistent with how they had been brought up and with their broader national identity, as the following quote by a physician in Serbia indicates:

> Under Communism the state took care of the people's health, jobs, housing, education. Many, especially older people feel nostalgia for those days. . . doctors—myself including—we are very proud of our health system. We do not support radical changes... I am a specialist doctor, to be specialist for a doctor is something that you should be proud [of]. . .the family medicine doctor that they try to introduce is foreign to our history and tradition. [Pediatrician—SR-3]

In particular, the opportunity for family physicians to become "entrepreneurs," owners of their surgery, and work as independent private practitioners—an aspect of the new logic of *generalism*—generated ideological threats that were evident in many respondents' accounts: some informants viewed privatization as aligned with the wider political project of "de-Sovietizing" and "de-Socializing" the country with a view to becoming "modern," "Western," and "European." But at the same time, it was also widely seen as an attempt by the government to withdraw from its longstanding commitment to provide free health care to all and a violation of the deep-rooted principle that access to health care is a fundamental civil right. Physicians reported that the generalist logic entailed not only elements of "patient advocacy" but also a "pro-business" approach to clinical practice, which were often seen as being in conflict with their professional identities. This threat was evident even among physicians who were supportive of the logic of generalism:

> I like being a family doctor; I like what I do. We are advocates for our patients. . .we have the full picture about [patients'] needs [and] we fulfill a social duty. . .we coordinate patients' care; we help guide them through the health system. I would not feel right having my own private practice. . .on ideological ground[s] because I believe that health care should not be provided privately. . .I still prefer to work as a salaried employee for the primary care center. [FP—S-7]

In sum, the intensity of the final threat varied between informants. Specifically, physicians that self-identified as pro-Russian, Serbian nationals, or pro-Communist reported higher levels of perceived conflict between the logic of generalism and their professional identities on the basis of their national identities as citizens of particular countries or adherents to particular political ideologies. By contrast, pro-European and pro-Western informants felt

this threat less acutely, but nonetheless were required to make sense of the relationship between their broader social identities and their professional identities, which was often highly challenging.

Identity work 3: Cultural repositioning. To counter the threat rooted in *social identity conflict,* physicians engaged in what we identified as a third form of identity work—cultural repositioning. Specifically, we found that some physicians incorporated social or political ideals to make their new role more appealing in their own eyes and to improve their chances of being positively validated by significant others. Through this form of work, they aimed to narratively connect the logic of general medicine and the enactment of the respective professional identity to particular historical and cultural claims. We identified two types of narrative strategies associated with cultural repositioning.

In the first narrative strategy, physicians engaged with the new professional identity by appealing for a symbolic return to a long established national "social tradition," and the rediscovery of a lost "national character." For some of our interviewees, being a family physician meant reconnecting with elements of their national identity that had been lost when their country had subsumed within the Soviet Bloc. These physicians used the changing expectations placed on them as professionals as an opportunity to strengthen their identity as citizens of newly liberated countries. In the following excerpt, a family physician from Estonia reflects on the broader social meaning that the new professional logic entailed for him:

> I remember when I was young we lived in Tallinn and we could watch Finnish television; during the Soviet occupation, this was our window to the outside world, we could see how was life in a Western country. . .when Estonia became independent, especially in the early days, there was a sense of superiority over everything that was Soviet. . .Estonia is like Finland, a Nordic country, we have similar language, culture, mentality. . .I went to be trained in family medicine in Finland. . .during the training [in family medicine] I was working with my Finnish colleagues in the community clinic, at that time it was for me like I was discovering part [of] our lost national character, if it hadn't been for the Soviet occupation we would be in a situation similar to Finland and other Nordic countries and our health system would have been not the Soviet polyclinics model but a system similar to the family medicine model in Finland. . .the old system was Russian, Soviet but the family doctors we feel part of a new system which is Estonian, our own national health system. [FP—E-8]

A physician in Bosnia and Herzegovina who self-identified as Croat–Bosnian highlighted the symbolic return to what she described as a long-established national tradition that the new professional logic allowed. This tradition was classified as neither European nor Soviet, but rather as distinctly Croat:

> Primary care has a long history in Yugoslavia, especially in Croatia, at least since [the] 1920s when Andrija Stampar introduced social medicine and community primary care. The first specialist training in general practice in the world started in Croatia in former Yugoslavia in the 1960s. . .family medicine continues the tradition in general practice that has had deep roots in this country. . .I feel proud that I am a family doctor. . .with our work we [family physicians] help bring back to life this old tradition. [FP specialist—B-34]

As part of this narrative strategy, some physicians also sought to endorse general medicine by delegitimizing the preexisting logic and the professional identity associated with it. They did so by disconnecting the logic of narrow specialism from the tradition of medicine in the country in which they worked. By contextualizing in their narratives narrow specialism as "socialist" or "Soviet," these physicians presented the notion of the narrow specialist physician as outdated, and as being in sharp contrast with the progressive aspects of the new generalist logic. Consider the following quotation from a family physician:

> During the Soviet period we didn't have primary health care similar to other Western countries in Europe, although there was strong outpatient care before [the] 1940s, which was provided mainly by private doctors. During the Soviet era, there were no private doctors. As the country was reestablishing its European heritage in [the] 1990s we also reformed the health system and family medicine was seen by many of the younger doctors as part of this, so we had to create everything and we started from the education and training of health professionals and we saw ourselves being part of this national reformation. [FP—E-4]

In the second narrative strategy, physicians associated general medicine with health care in affluent Western countries characterized by highly effective medical systems, while the new identity of family physician was presented as "modern," "progressive" and "innovative." Here, the aim was to align the new logic with the broader social changes occurring in

our focal countries, as illustrated in the quote by a physician in Estonia:

> . . .[FM] is common practice in many Western countries. . .There are [FPs] for example in our neighbors Finland, Sweden. . .if you look at what Estonia has achieved, we are innovative and ready to accept new ideas more easily than other countries. . .the entrepreneurial aspect of family medicine attracted me to the specialty because it has been innovative and different, more modern if you like, you don't have a boss above your head so you can organize your work independently. . .[FPs are] the most progressive, innovative type of doctor. [FP—E-11]

Another family physician in Bosnia and Herzegovina highlighted linkages between the logic of generalism and the Western medical tradition in this way:

> . . .for most people, FM was perceived as a Western notion, most of the countries in Western Europe or Canada for example have established a similar system [a] long time ago, after the Second World War. [FM academic—B-10]

In sum, the use of cultural repositioning needs to be seen in the broader context of the de-Sovietization and de-Communization that was taking place in our study countries, and as part of the process of accession to Western politico-economic structures such as the EU and NATO. This transition intensified the social identity conflict faced by physicians: while many of those who engaged in it were sympathetic to the "European project," others were forced to abandon claims about the "superiority" of the Soviet era, which many found extremely difficult.

An Emerging Model of Professional Identity Change During Logic Shift

As our findings show, the physicians who adopted the new identity did so by engaging in forms of identity work that allowed them to resolve the identity threats they had experienced following the shift in logics. These physicians engaged deeply with the principles of the new logic and there was evidence that they fundamentally changed how they viewed themselves as professionals and how they viewed the appropriate organization of health care. In other words, they reconstructed their professional identity to align it with principles of the new logic of generalism.

Consider, for example, how one physician described the independent nature of her clinical work as a family physician and the change she experienced in her professional identity through redefining her professional relationship with patients. It is interesting to note how nuanced her understanding of her new role is, reflecting core principles of the logic of generalism:

> [As family physician] I work more independently. . .I care for the whole person, and much of my work is about fostering rapport with the patients. . .[I] maintain relationships with all my patients as persons, I do not see them as malfunctioning organs, I know their family situation, I see them in the community, how they live, what they do. . .I see myself as a physician that cares for the people and all their needs; not simply treat the [clinical] condition. . .I consider myself more of a healer, an advocate for my patients. [Former GP who had completed FM residency—S-9]

The physicians adopting the new identity perceived the new clinical activities and tasks associated with the logic of generalism as meaningful and valued, suggesting personal commitment to the new role. The following quotation is indicative of this group of physicians' engagement with the core principles of the new logic, and shows how it changed their understanding of their clinical work:

> I care deeply for my patients. . .Family doctors care better for comorbidities, it is not a matter of preference but it is due to clinical need in everyday practice that you have to care for patients beyond the narrow disease silos. . .I work from children to their grandmothers, I know the entire family, so we are working better and the communication is better. . .with getting to know people individually we [FPs] know what the problems of the members of one family are, so we can work to promote good health at individual and family level. . .[being an FP] helped me change my way of thinking about the disease and how to practice medicine, I look at my practice as a doctor more holistically now. [FP—B-27]

This group of informants spoke in very positive terms about the new model. They were particularly keen to contrast what they saw as the strengths of the generalist model with the apparent weaknesses of the specialist one:

> There is [a] misconception that family medicine mostly involves the clinical distinction between serious and mild diseases, to decide whether or not it is necessary to urgently refer a patient to subspecialists or the hospital, but the essence of family medicine is much broader. The main feature of the practice of family medicine is not just first-contact care but also continuity, coordination, comprehensiveness of care, and above all it includes also nonmedical aspects of

> care, the human relationship, treating a person rather than a clinical case. And that is what I feel my work is all about. [FM specialist—E-16]

In order to explain this professional identity shift, and to help make sense of the various concepts and their relationships in our data, we developed the model illustrated in Figure 2. The model summarizes the outcome of our empirical analysis and presents our response to the question of how individual professionals manage their professional identity following pressure for change stemming from a shift in the logic of the field in which they practice.

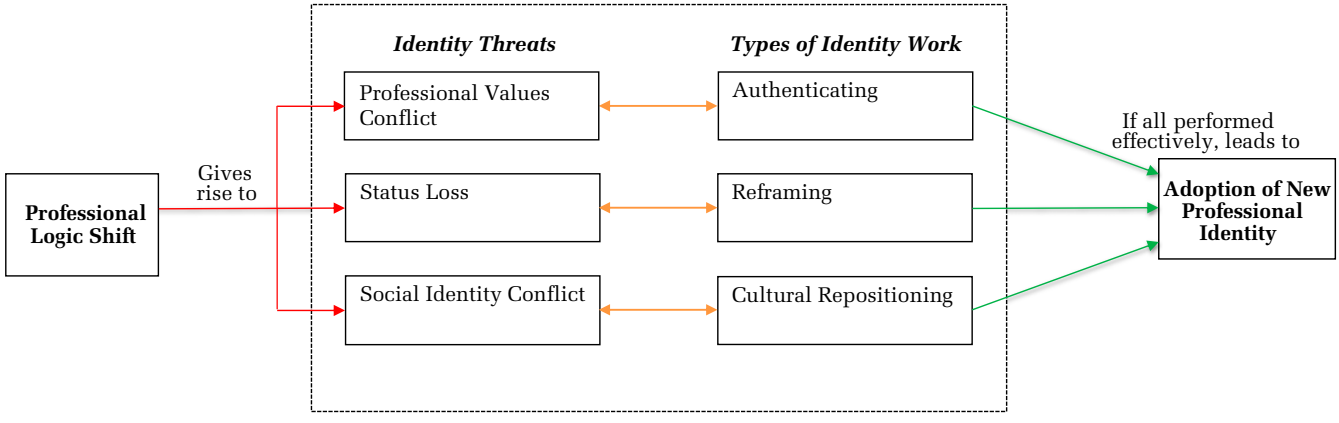
The model suggests that the identity pressures that emanate from a shift in professional logics threaten professionals' identity and give rise to feelings of psychological threat as they encounter conflicting beliefs associated with the contradictory principles of the old and new logics. We propose three specific identity threats, two of which are related to the individuals' professional identity (which we term "professional values conflict" and "status loss"), while the other is linked to identity issues beyond the workplace (which we term "social identity conflict").

The feelings of cognitive and emotional discomfort engendered by these threats lead some individual professionals to engage in three discrete forms of identity work: authenticating (which corresponds to the threat of professional values conflict), reframing (which corresponds to the threat of status loss), and cultural repositioning (which corresponds to the threat of social identity conflict). The purpose of these forms of identity work is to restore a sense of cognitive consistency and psychological balance by reconstructing their professional identity. Some professionals may decide not to engage in these forms of work, or may enact them ineffectively, the result being that their identity remains rooted in the old professional logic. However, this is not the focus of our analysis: our model focuses on those professionals who successfully enact various forms of identity work that allows them to: (a) make sense of the threats that they face and (b) align their identities with the new logic so that they minimize the cognitive distress and function effectively within their new "reality." In other words, they adopt a new identity that embodies the new logic. This leads to resolution of the identity threats experienced.

DISCUSSION AND CONCLUSIONS

In an important study of professional identity formation among physicians, Pratt et al. (2006: 259) ended their discussion with a call for studies of professionals "at various stages in their career processes." More recently, Barbour and Lammers (2015: 2) pointed to another important gap when they argued that "the connections between the identities of those holding professional positions and macro organizational and extra-organizational phenomena have not been worked out." Our findings are an answer to these calls and provide additional insight into how established professionals facing pressure to adopt a new professional identity "worked things out" (Reay & Hinings, 2005: 352) following a change in professional logics. In this section, we will discuss three areas in which we believe these findings have particularly important implications for existing research on professional identity, and institutional theory more generally. We will end the section with a discussion of the limitations of the study.

FIGURE 2
A Model of Professional Identity Change When Institutional Logics Shift



Changing Professional Logics and Professional Identity

Previous research has provided deep insight into topics such as the formation of professional identity among new professionals (Pratt et al., 2006), the influence of institutional and organizational contexts on professional identity (Chreim et al., 2007), how professional identities can be used as a marker of a change in logics (Meyer & Hammerschmid, 2006), and how professional identity can be measured (Barbour & Lammers, 2015). It has also examined the political processes that unfold when professional fields move from one dominant logic to another, and the influence of field structure on these processes (Reay & Hinings, 2005). However, it has not provided a well-theorized account of how established professionals manage their professional identities in the face of a contested and incomplete shift in the professional logic that characterizes their field. Yet this is a relatively common occurrence anecdotally, an important event in the lives of professionals when it happens, and has important practical implications for society (Dunn & Jones, 2010). Our findings therefore contribute to current knowledge by beginning to uncover the complex processes at work in this situation.

It is particularly interesting to contrast our findings about identity change in the context of established medical professionals with Pratt et al.'s (2006) findings about identity formation in the context of new medical professionals. In Pratt et al.'s study, the main identity threat faced by trainee physicians was a conflict between "who they were" as high-status professionals and the nature of the (often menial) work that they were required to do. This identity threat overlaps to an extent with the notion of status loss that we identified. However, we also found evidence of two other identity threats—professional values conflict and social identity conflict—that appear specific to established professionals facing challenges to an existing identity that is deeply entrenched.

With regard to the forms of identity work deployed by professionals in response to identity threats, Pratt et al. (2006) highlighted that trainee physicians engaged in enriching (developing a deeper understanding of their professional identity), patching (drawing on one aspect of their professional identity to fill "holes" in their understanding of who they were), and splinting (building a temporary identity based on past student experiences until a fuller professional identity emerged). The forms of identity work that we found in the context of logic change among established professionals were quite different. Specifically, we found that established physicians facing identity threats engaged in authenticating (connecting the new identity to "true" medical values), reframing (articulating how they understand what their new professional identity is and is not), and cultural repositioning (using aspects of national or wider social culture to justify the new identity).

More broadly, our study confirms and augments the finding that the local effects of change in an institutional logic are shaped in important ways by the micro-level identity work of actors. As Lok (2010: 1330) discussed, "even highly legitimated logics advocated by powerful change agents are subject to subtle challenges based on the mutability of the identities and practices that underpin them, even when they appear broadly supported and diffused." Our study extends Lok's analysis to professionals, providing important insight into their responses to shifting institutional logics. Interestingly, we do so by focusing on a context in which the shift in logics is not broadly supported, but rather is a source of intense conflict despite powerful change agents championing the change. We found that some of the professionals worked to change their identities, while others actively worked to maintain all or part of their original identities. This had important consequences: the reaction of professionals, and the degree to which they adopted the new professional identities associated with the new logics, affected the degree to which they engaged in new work practices (e.g., "disease prevention" and being responsible for the "whole person"), took up new vocabularies (e.g., "family medicine" and "continuous care"), and adopted new professional titles (e.g., "general practitioner" and "family medicine specialist"). Changes in professional identity therefore have important implications for how logics are enacted at a local level.

Social Identity and Professional Identity

While we have focused primarily on professional identity, our study sheds light on the complex relationship between social and professional identity. The management literature has tended to assume that the construction of professional identities occurs in isolation and free from the influence of other aspects of social identity (Barbour & Lammers, 2015). However, a small number of studies have pointed to how professional identity dynamics may be shaped in part by broader social identities. For example, in her influential study of how professionals adjust to new roles, Ibarra (1999: 764) noted that factors such

as age, personality type, and gender influence professionals' experimentation with "provisional selves that serve as trials for possible but not yet fully elaborated professional identities." In addition, Creed, DeJordy, and Lok (2010) illustrated how gay, lesbian, bisexual, and transgender (GLBT) ministers experienced profound tensions between their professional identities as church leaders and their GLBT identities.

Our study shows that when professional logics shift, social identity can play a key role in enabling the ability and willingness of professionals to construct a new professional identity that is aligned with the new dominant logic. Specifically, our study indicates that when the new professional identity linked to the new logic is broadly consistent with salient aspects of professionals' social identities, it can provide an important resource that helps professionals to reconstruct their professional identities so that they are aligned with the new logic; where a new professional identity linked to a new logic is in conflict with salient aspects of professionals' social identities, it can form an important barrier to change.

In our study, this could be seen in the national and ethnic identities of the physicians, as well as their political ideology. For those physicians who had grown up in a former Communist Eastern European country under what they considered as Soviet "occupation," and who self-identified as European, it was easier to construct a new professional identity. By contrast, a number of the physicians in our study were ethnic Russians or Serbs (also Bosnian Serbs), the largest national group in former Yugoslavia. The social identity of these physicians was often tied up with ideas about what it means to be Russian or Serbian and an associated set of anxieties about the country's declining influence. In other words, the social identities of these physicians were in conflict with ideas from "the West," and they were more likely to resist the new professional identity that was being imposed on them. Theoretically, this finding resonates with the notion of "social identity complexity" (Roccas & Brewer, 2002) that has become prominent in social identity theory. This concept is concerned with how actors respond to the interrelationships between multiple group identities. Moving forward, work at the intersection of institutional complexity and social identity complexity has the potential to extend and refine our analysis.

Managing Large Scale Change in Health Systems

Our study also has important ramifications for practice. Given the interest around the world in carrying out large-scale change to improve health systems (e.g., Best et al., 2012; Harrison, 2004; Lukas et al., 2007), as well as the importance of these systems and their impact on health and well-being (e.g., Arah, Klazinga, Delnoij, Ten Asbroek, & Custers, 2003; Murray & Frenk, 2000), it is critical that change agents have an understanding of the professional identity dynamics that characterize these systems and their relationship to broader professional logics. While the existing literature has explained the importance of professional associations in field-level change (Greenwood, Suddaby, & Hinings, 2002) and discussed the significance of individual identity in logic change more generally (Lok, 2010), we add to this work by explaining the role that professional identities play in professional logic change.

More specifically, our work highlights the importance of considering processes of identity change among professionals when planning large-scale health system reform. This means that change agents should do everything they can to provide resources for professionals as they work to reconstruct their identities. This might include supplying identity narratives (Ibarra & Barbulescu, 2010), rhetorical strategies (Goodrick & Reay, 2010), role models (Ibarra, 1999), and other resources that professionals can use to fashion their new identities. Change agents should also be prepared to deal with any perceived loss of status and feelings of technical incompetence associated with the reorganization of professional work. While the specific nature of the support that professionals require will vary by context, our study provides important pointers for what change agents can do to facilitate the adoption of new professional identities.

Limitations and Boundary Conditions

While we believe our research makes an important contribution, it also has some limitations. First, it is a qualitative study and as such is intended to elaborate, rather than test theory. In other words, its purpose is to "expand and generalize theories... not to enumerate frequencies" (Yin, 2003: 10). Thus, the theoretical observations we have posited would benefit from testing in larger-scale, quantitative studies. It may be possible to conduct this sort of work in conjunction with a professional association that is interested in understanding the reactions of professionals to large-scale changes in their professional environments and the role of identity in these processes.

Second, although we believe our empirical context provides an excellent setting in which to examine

questions about professional identity and logic shifts, our case is also quite unusual. More specifically, the professionals we studied experienced a major change not only in their professional logic, but also across multiple fields as their entire societies and economies transitioned from Communism. The profound nature of the changes that these professionals experienced offers a "transparent example" for studying shifts in professional logics, but the extreme nature of the changes may also limit the applicability of the findings. It will therefore be important to examine other cases in which the change in question is limited to the professional logic and where the broader societal context is relatively stable.

Third, our study only examines one type of professional. While the study of physicians is common in the identity literature (e.g., Chreim et al., 2007; Pratt et al., 2006; Reay & Hinings, 2005), and while arguments have been made that physicians are a "prototypical profession" (Pratt et al., 2006: 259), this is an important limitation as physicians have some distinctive features in terms of their professional status. In particular, they are especially visible because of medicine's prestige and perceived social importance. More broadly, health systems are very politicized environments. It would therefore be useful to examine other professions and explore the degree to which the dynamics that we uncovered in our setting occur elsewhere.

Finally, we have focused on physicians who successfully reconfigured their professional identities in the face of logic change at the field level—constraints of space prevented us from considering in detail the experiences of those who did not manage this transition effectively and who clung to their existing professional identity rooted in the "old" logic. It would be interesting to examine these dynamics in more detail. Moreover, the literature has highlighted the role of hybrid identities that can span multiple logics (Jain, George, & Maltarich, 2009). It would be interesting to explore the experiences of professionals who adopt aspects of a new professional identity rooted in a new institutional logic, but who also retain aspects of their old professional identity rooted in an old logic.

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