INTERACTIVE IDENTITY WORK OF PROFESSIONALS IN MANAGEMENT: A HOSPITAL CASE STUDY

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ABSTRACT

Hybrid professional managers appear less effective in introducing management into public professional settings than policymakers hope. To date, research has offered little understanding of professionals' identity transition challenge and the role of social interactions underpinning this process. We studied the identity work of hybrid doctors inside a large public healthcare organization, finding that it takes place through processes of *familiarising* with management, *rationalising* being a hybrid, and *legitimising* the new role-identity. We contribute to the literature by showing that identity work is distributed and enabled by social interactions beyond the professional group. Implications for policymakers and executives are discussed.

KEYWORDS

Professionals, hybrids, identity work, health care, new professionalism

INTRODUCTION

Understanding the evolutions of professionalism is one of the challenges for public management research and practice. Traditionally professionalism values autonomy and self-regulation, as well as institutionalised work routines, norms and values which are necessary to apply to complex real problems a body of knowledge acquired through higher education (Abbott 1988; Freidson 2001). However, public sector reforms introducing managerial supervision and budgetary control in professional organizations, have put professionals under pressure calling for an evolution of the meaning of professionalism and the identity of individual professionals (Brock, Powell, and Hinings 1999; De Bruijn 2010; Noordegraaf and Steijn 2013; Noordegraaf 2015). This is especially true in the public sector of most Western countries, which on one hand underwent major budget cuts and cost containments, and on the other experienced an evolution of citizens' expectations in terms of quality and timing of services, accountability and performance disclosure, both requiring a change of professional work practices (Harrison and Pollit 1994). The development of hybrid roles is an important strategy that has been developed in these countries as a solution to 'bridge the gap' between professionalism and management (Kirkpatrick, Ackroyd and Walker

2005). Understanding the process of hybridisation is relevant as the involvement of professionals in management has not often yielded the expected results. Behaviours such as resistance towards, reluctance towards or circumvention of hybrid managerial roles are commonly reported, and effective professional-managerial hybridisation has not always been achieved (Numerato, Salvatore, and Fattore 2011; Waring and Currie 2009; Correia and Denis 2016). As recent scholarship has shown, the effective enactment of hybrid roles is not only an issue of performing managerial actions and behaviours, but rather an issue (or problem) of inner values and identity (e.g. Doolin 2002; McGivern et al. 2015; Croft, Currie and Lockett 2015; Reay et al. 2017). Therefore it is highly relevant, for both policymakers and executives in public organizations, to understand the process which underlies hybridisation, and the facilitators and constraints which may affect it, so that appropriate development and support can be provided for those individuals moving into managerial roles.

Existing research has greatly contributed to our knowledge of professional hybrids in the public sector (e.g. Byrkjeflot and Kragh Jespersen 2014; Kirkpatrick and Noordegraaf 2015; Schott, Van Kleef, and Noordegraaf 2016). Yet, we still characterise most of the literature examining hybrid professional managers as based on a dualistic view where managerialism and professionalism are in conflict, and as telling us much about the problems associated with the implementation of hybrid roles. Yet, it offers little understanding of how the *process* of role-identity transition takes place and how this is or might be supported in organizational contexts (McGivern et al., 2015). In particular, research has looked at the role of interdependencies of hybrids within the professional community, which is important because professional legitimacy is necessary for hybrids to lead colleagues as "primus inter pares" (Llewellyn 2001). However, we know relatively little about the interaction of professional hybrids with other key organizational actors, when identities are (re)construed.

We address these gaps by examining how hybrid medical managers construe their managerial/professional selves through identity work, which has been defined as that "process by which people strive to shape relatively coherent and distinctive notions of their selves" (Brown and Toyoki 2013, 876). Our central research question, thus, is: *How does hospital medical managers' hybridisation evolve and how are transitions enabled by social interactions in a wider organizational context?*

In this paper we use a case study as a basis for extending theory (Eisenhardt 1989). We focus on the role-identity transition of clinical directors, i.e. doctors in charge of multiple clinical specialties, who are given managerial responsibilities, in a large Dutch public university medical centre. The paper identifies the micro-processes which take place in the construction of identities of hybrids, which make possible the evolution and reconfiguration of professionalism. We show how interactions with social actors play out in these processes, so that professionals' identity work is not so much the result of individual efforts, but rather is distributed.

The paper is organized as follows. We firstly provide a brief overview of the literature of hybrid professional managers, and the present theory on identity work, which we draw upon to study the dynamics of hybridisation. Then we explain our focus on clinical directors and then describe the qualitative research methods used to collect and analyse empirical data. Next we illustrate our findings and discuss theoretical and practical implications for public management.

THE CHALLENGE OF BRINGING TOGETHER PROFESSIONALISM AND MANAGEMENT

The evolution of professionalism and the blurring of professional and managerial domains is a lively area of organizational research, especially within the public administration field. Public sector reforms are continuously challenging existing professional boundaries, work practices, hierarchies and coordination mechanisms, values and identities of professionals at the collective and individual level (Noordegraaf 2015). This was experienced in a number of public sector environments, including universities (Deem, Hillyardand, and Reed 2007; Telkeen 2015), education (Nordegraaf and De Wit 2012) and, especially, healthcare (e.g. Forbes, Hallier, and Kelly 2004; Witman et al. 2011; Schott, Van Kleef, and Noordegraaf 2016).

A first line of research has emphasised dualism and opposition between professionalism and management. With reference to healthcare, it has been shown how giving managerial responsibilities to medical professionals can increase their power, making it more difficult for government and executive management to challenge their work behaviours (Hunter 1992). In some cases, doctors appointed to a management role openly resisted their new role and its strategic expectations, as they saw management and professionalism as incompatible (Griffiths and Hughes 2000; Degeling et al. 2006).

Such resistance has been open or, more often, subtle. And professionals selectively and externally conformed to managerial practices, but without doing so substantially (Kitchener 2002). Rather than co-opted into managerial practice, they have been characterised as co-opting management to pursue self-interest (Waring and Currie 2009). In these cases, doctors in management, meant to be a solution for effectively running healthcare in the New Public Management era (e.g. Ferlie et al. 1996), turned out to be a problem necessary of management, rather than a solution.

At the same time, research has increasingly reported multiple instances of professionals developing new and hybrid identities through the capacity to negotiate and merge professional and organizational/managerial cultures (e.g. Denis, Ferlie, and Van Gestel 2015; Kirkpatrick and Noordegraaf 2015; Schott, Van Kleef, and Noordegraaf 2016). In that way, they develop a dual commitment to both the profession and the organization (Hoff 2001). Hybrids have the capacity to overcome the clash between pure professionalism and market based principles by developing new blended roles, routines and ways of working.

However, although most literature tells us much about the responses associated with hybrid roles, it offers little understanding of the dynamics of identity transition and their determinants. As argued by Denis, Ferlie, and Van Gestel (2015, 285), research needs to look beyond hybrids' response strategies and study "the agency and social interaction processes that shape these responses and consequently explore the hybridisation *process* in various public sectors". With a few notable exceptions (e.g. Pratt, Rockmann, and Kaufmann 2006; Bevort and Suddaby 2016) most authors study hybridisation as one among professionals' responses to complex institutional environments, but do not open the box of hybrid identity construction (Numerato, Salvatore and Fattore 2009).

Further, authors like Llewellyn (2001) or Witman et al. (2011) looked at the social dynamics taking place in the professional community, showing that managerial role-taking is facilitated when the hybrid has, and maintains, legitimacy within their group of peers. However, in these studies, hybridisation has been intended relatively independently of the broader social organizational order, and in particular has overlooked the relations with other key organizational actors, such as other professions and non-medical managers. Authors like Pratt, Rockmann, and Kaufmann (2006) and McGivern et al. (2015) suggest antecedents of identity transition, but offer little evidence regarding this, relegating the importance of interaction between professionals and

others to the background (Reay et al. 2017). Therefore in-depth qualitative research, bridging policy, management and organization studies (Currie et al. 2012) is needed to provide insight into this transition.

We claim this is a promising area for public management theory and practice, and it is subject to continuous evolution. Research on new hybrid forms (Postma, Oldenhof, and Putters 2014; Martin et al. 2015; Noordegraaf 2015) has underlined how environmental pressures and the evolution of professional work practices are determining that organizing becomes embedded within professional action. However, there is seminal evidence that reconfiguration of professionalism requires the redefinition and re-working of professionals' identities (McGivern et al. 2015). Therefore, it is necessary to move from the macro to the individual level of analysis to fully understand the mechanisms through which macro changes unfold (Bevort and Suddaby 2016). And an identity perspective on hybridity is highly relevant to study how professionals in complex public organizations deal with managerial role-taking, as it provides a richer understanding of the consequences, for groups and individuals, of macro- and meso-level interventions in the public sector (Denis, Ferlie, and Van Gestel 2015). Building on this literature, within our work we study a situated account in which hybrids (re)work their identities while being exposed to a highly complex institutional environment, and surrounded by individuals that have potentially conflicting agendas and expectations. Previous research has reported on the role of individual agency and interaction in the construction of identities of professionals within a community of peers (e.g. Pratt, Rockmann, and Kaufmann 2006; Bevort and Suddaby 2016), we study if and how social actors beyond the professional group influence this process.

CONSTRUCTING HYBRID IDENTITIES THROUGH IDENTITY WORK

Institutional theory offers a powerful perspective to study the processes that take place in complex professional service organizations including modern hospitals (e.g. Greenwood et al. 2011; Lockett et al. 2012). Professionals have been described as powerful 'institutional agents' (Scott 2008), and hybrids, who are exposed to the contradictions of medicine and management, are in a social position to engage in the continuous reshaping of existing institutions and in the creation of new ones.

In particular, we examine hybrids' *identity work* as a form of institutional work. The notion of institutional work underlines the role of actors continuously engaged in creating, maintain and disrupting institutions (Lawrence, Zilber, and Leca 2013). Identity work is that form of institutional work which takes place through the creation or transformation of established identities (Lawrence and Suddaby 2006). Identity work is manifold as it involves the "forming, repairing, maintaining, strengthening or revising" of the components of the self (Sveningsson and Alvesson 2003, 1165), and has increasingly been considered an important form of institutional work (McGivern et al. 2015), as the taken-for-grantedness of values and practices is strongly affected by the construction of identities. Some authors view identity work as an inner struggle between alternative selves (Watson 2008), while others depict it as a more harmonious process (e.g. Leung, Zietsma, and Peredo 2014). Identity work has both an internal and external dimension, since often new identities are established when a socially prescribed role becomes internalised (Leung, Zietsma, and Peredo 2014). Although some studies have underlined how actors can be externally driven by processes of "identity regulation" (Alvesson and Willmott, 2002), another stream of literature (e.g. Lok, 2010; Reay et al, 2017) underlines agency and the capacity of individuals conduct their own identity work, eventually elaborating on external role identities.

The concept of identity work is useful in understanding professionals' identity transition as it emphasises the dynamics of identity construction and its intrinsically processual nature, as well as the fact that identity construction is "more interactive and more problematic than the relatively straightforward adoption of a role or category" (Pratt, Rockmann, and Kaufmann 2006, 237). By bridging institutional theory and identity theory it provides the theoretical tools to understand how social groups and other individuals actively interact with individual agency in shaping new identities (Bevort and Suddaby 2016). However, the latter remains a promising area for research, and Leung and colleagues (2014) have made a call for studies on *how* enabling collectives allow individuals to conduct identity work.

Existing research on individual professionals' identity development has largely focused on the process of construction of professional selves as part of natural career transitions, and if it has analysed the role of interactions in this process has done so by looking at those taking place within the professional group. Ibarra (1999) studies how

professionals evolve to more senior roles by observing role models and experimenting provisional selves. Pratt, Rockmann, and Kaufmann (2006) study how young professionals in training take on their professional group identity, showing how this is a dynamic process encompassing identity customization and social validation within the professional group supported by interactions with senior colleagues and peers. Similar findings regarding how interaction enables professionals' role change through social validation of the new identity are reported by Chreim, Williams, and Hinings (2007). Creed, Dejordy and Lok (2010) provide a rich analysis of the processes through which professional actors trigger institutional change through identity work. However, they study the heroic agency of marginalized professionals acting individually against the professional group and its institutions.

Therefore, in most cases scholarship has studied the role of professional peers as enabling collectives in the identity development process. However, the relations of professionals with diverse social actors in the development of hybrid individual identities has remained vastly on the background. In particular, we lack a clear understanding of how professionals working in complex institutional environments - where they interact with actors embodying apparently conflicting logics - perform identity work and develop hybrid identities. McGivern et al. (2015) do explore the processes of hybrid identity construction in this kind of settings, i.e. medical managers in modern healthcare organizations. They show that while "incidental hybrids" maintain and protect their traditional identity, professionals willing to take up hybrid roles are capable to reconstruct their professional identity. However, although acknowledging the formative work related to action of mentors or role models, their analysis provides limited evidence regarding the relational dimensions of identity processes, and does not explore the social contexts where the processes of identity change take place. The study by Reay and colleagues (2017) has tackled the topic showing how relational spaces facilitate social interaction across the stages of hybrids' identity construction. This work is particularly interesting as it shows the potential for identity change to be orchestrated by others, i.e. business managers, who supported doctors in incorporating managerial values. However, it studied the process of hybrids' *collective* identity construction, and did it by analysing general practitioners, frontline professionals working in individual or small practices. Within our work we study a situated account in which professional-managerial hybrids dynamically construct their *individual* identity through identity

work. We do this by studying hybrids working in hospitals, complex institutional environments where traditional professionalism is challenged by new managerial values and practices embodied by a number of diverse organizational actors.

CLINICAL DIRECTORS

We focus on clinical directors as a relevant example of hybrid professional managers. Pioneered at John Hopkins Hospital in the 1970s, these roles dispersed in North America and then in the National Health Service of the United Kingdom (Chantler 1993; Kitchener 2000). The UK example was followed by Australia and multiple countries in continental Europe, including: The Netherlands, Norway, Denmark, Italy and France (Neogy and Kirkpatrick 2009), where clinical directorates (labelled divisions, departments, *poles de gestion*, etc.) were introduced. In hospitals organized according to the clinical directorate model, homogeneous clinical units are grouped in directorates led by a doctor (clinical director) who is in charge of managing human, financial and physical resources and supports the hospital top management in decision-making (Forbes, Hallier, and Kelly 2004).

Clinical directors' hybrid role should give them the opportunity to effectively perform activities in between management and professionalism, such as the promotion of clinical governance, the development of multi-disciplinary and inter-professional collaboration, the achievement of cost savings, but without compromising the quality of care (Braithwaite et al. 2005). Furthermore, clinical directors are also in between hospital top management and front line managers, and they can contribute to the implementation of organizational policies and to the reduction of the disciplinary fragmentation typical of professional organizations. As a consequence clinical directors, as professionals engaged in managing colleagues and resources while at the same tome retaining professional legitimacy within the group of peers (and, often, their clinical practice), have been studied as a paradigmatic example of hybrids in public professional organizations (Llewellyn, 2001; Witman et al. 2011,; McGivern et al. 2015).

However, while these results were achieved in a number of instances, in many other cases clinical directors were unwilling or incapable to take up managerial roles (Waring and Currie 2009; Croft, Currie and Lockett 2015; Correia and Denis 2016). Other times they were not supported by non-medical managers or by pre-existing medical manager

roles (Sartirana, Prenestini, and Lega 2014). The identity transition of clinical directors is therefore a challenge for professionals, but also for policymakers and executives. It is important to have a deep understanding of process of managerial role-taking, and the *conditions* which underpin it, in particular the role played by social interactions, especially between clinical directors and other organizational actors. In the following paragraphs, after illustrating our research approach and methods, we present the three micro-processes of identity construction we found in clinical directors' hybridisation, and how interactions with managers, nurses and external staff supported it.

RESEARCH DESIGN AND METHODS

We conducted a case study in a large university public hospital with the aim to extend theory (Eisenhardt 1989; Yin 2009). The use of a multiple sources of evidence, and in depth analysis of our case, was suitable for the goal of understanding the organizational interactions and the complex dynamics taking place in a hospital. Furthermore, the same methodology had been successfully used by previous studies on hybrid roles of professionals in management in healthcare (e.g. Kitchener 2000; Forbes, Hallier, and Kelly 2004; Witman et al. 2011). We gathered our data through the selection of doctors in management and respondents of different professional groups, namely administrators and nurses, and at different management levels. We based our understanding and interpretation of identity work around interactive processes. Employing abductive reasoning (Locke, Golden-Biddle, and Feldman 2008; Mantere and Ketokivi 2013) we were driven by constant focusing on the theoretical question in conjunction with providing an explanation (Alvesson and Kärreman 2007). Our approach promoted constant dialogue between theory and empirical findings, which underpinned an analytical strategy based on continuous formulation and iteration of questions and answers from literature to both focus and explain emerging findings (Alvesson and Kärreman 2007; Locke, Golden-Biddle and Feldman 2008; Mantere and Ketokivi 2013). In line with this, we were guided by literature that a priori drew attention to the importance of identity transition towards hybrid managerial roles, which was underpinned by identity work, but induced dynamics and categories of identity work from our empirical analysis.

Study context

The hospital is located in the Netherlands, thus empirically extending geographical coverage of studies of hybrid medical management roles, mostly developed in Anglo-American contexts (Numerato et al. 2011). It has an integrated structure, bringing together service delivery through a teaching hospital, and research and education, through a medical faculty, both governed by one board of directors. It is organized in eleven clinical divisions, headed by a clinical director, who is a professor of a specialty and was selected among department heads. Each clinical director is part of a division management team, composed of a medical manager (the clinical director), a care manager (most often a nurse), a financial manager and a research manager, which together report to one of the hospital board members. Management team members are formally on the same hierarchical level, with the medical manager acting as the chair of the team.

The hospital introduced the clinical directorate (division) organizational structure in the early '90s. Divisions were delegated decision making over strategy, organization and human resource management, and the formerly unified corporate staff body was largely decentralised. This push toward divisions' autonomy, together with their size both in terms of turnover and personnel, required significant involvement of clinical directors' in management, and it is what makes the hospital a representative case (Yin 2009) suitable to study the processes of hybridisation of (medical) professionals in managerialised public service organizations.

Data collection, analysis and interpretation

We obtained access to the site thanks to a research partnership established between the hospital and the university employing two of the authors. Data was collected in 2012 through semi-structured interviews and document analysis. The first interviewees were clinical directors identified by the partnership contact point, a clinical director herself, with the aim to let us interview both successful and less successful hybrids. Subsequently the selection of respondents took place through purposeful sampling based on the progressive analysis of data. For instance we interviewed respondents that were openly referred to as relevant actors, as in the case of the former hospital CEO or the former director of one of the divisions.

Overall we conducted 29 interviews (Table 1). They included seven representatives from the executive management team and the hospital central HR staff, including two former clinical directors who moved to full time management jobs; 15 members of the division management teams, among which were 7 clinical directors, with an average of 4.5 years in the position; and seven frontline managers. About one third of interviewees were women, and respondents represented 9 out 11 divisions (the two missing divisions were non clinical ones, providing diagnostic services or research). Interviews were conducted with guarantees of anonymity, they lasted 40-70 minutes, were recorded and transcribed, accounting for about 500 pages of transcripts. They were complemented by notes taken during the interviews, and at the end of each of them, in order to capture the interviewer's feelings and impressions. Interviews were conducted on site and by a single researcher, which reduced variability in data collection.

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Insert Table 1 here

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One interview protocol was used for clinical directors, which was structured in three parts: (a) content of clinical directors' work; (b) how they experienced being a professional in management; (c) which factors affected the managerial role-taking. For the other respondents, a different and more open protocol was used, as they were asked to report (a) their experience with clinical directors, (b) the nature of the interactions they had with them, and (c) the evolution of both. The interviewees told us about the different occasions, including formal and informal meetings and interactions, in which discussions took place regarding clinical directors' bridging of professionalism and management. To increase credibility of data, we encouraged interviewees to provide illustrations and concrete examples, and this also contributed to our confidence in understanding the trustworthiness of respondents' statements (Weiss, 1994). As data gathering and analysis were intertwined, the emerging themes served as the basis for focusing and fine-tuning the questions. The interviews were complemented by the analysis of divisional organizational charts and respondents' resumes.

Data were first analysed through close reading of the transcripts. Coding was then performed by one of the authors in multiple waves. With the support of Atlas.ti software we developed a first order analysis of all transcripts, using in vivo coding (Strauss and Corbin 1998) whenever possible to give voice to informants' own words and to the concepts they used to describe and make sense of personal experiences. We then went back and forth from data, emerging theory and literature, as we looked for patterns and idiosyncrasies across respondents, in particular comparing the answers provided by clinical directors with those given by other informants. Through this process we identified our emerging themes and tested their appropriateness (Braun and Clarke 2006; Saldana 2012). We then collapsed related themes into broader explanatory categories, which allowed us to make sense of the data and achieve increasing levels of theoretical abstraction. On the basis of our empirical data, we eventually found that identity construction takes place through three micro-processes, i.e. processes that occur at a micro level (see also Creed, Dejordy and Lok 2010 and Reay, Golden-Biddle and Germann 2006). We refer to them as: *familiarising oneself with management*; *rationalising being a hybrid;* and *legitimising the new role-identity.* For instance narratives related to professionals' attempts at seeing the division wellbeing as a whole were associated the theme "bringing the focus away from one's own specialty". This theme, together with "experiencing issues at a higher level" were consolidated in the category "familiarising with management". While passages in which interviewees referred to the discovery and development of new competencies were associated with "elaborating a new self-description". This theme, with "giving meaning to management" was condensed in the category "rationalising being a hybrid". At the same time, we identified the interaction mechanisms which accompanied each of the three micro-processes, enabling and supporting identity change through: *developing managerial capacity*; *role modelling and coaching*; *increasing space for action*. This process of analytic generalisation (Yin 2009) led to the conceptual framework presented in this paper.

FINDINGS

In the following paragraph we illustrate our findings on hybrids' identity change, presenting the three micro-processes of identity construction and how social interactions with key organizational actors like managers, nurses and external staff

were associated with them. Of course professionals varied in their degree of hybridisation and some social actors were more engaged than others in supporting professionals' identity transition. However, except for the one case described below, all clinical directors reported significant changes in their professional identities.

Familiarising oneself with management

A first way in which doctors worked on their identity was through the connection and reconciliation of medical and managerial activities. This happened when clinical directors, some months after their appointment, started changing the daily way of working and experiencing issues at a higher level:

> "There is much more pressure, because you have always to be sharp, you have always to be there, you have always to read everything […] it is a big big difference, it is much broader, it is much more interconnected. And I have direct contact with the board of directors, almost every day" (#26, Clinical Director).

Clinical directors enjoyed increased acquaintance and confidence from practicing managerial tasks, and this reduced their resistance apparent when first appointed. Becoming aware of the nature of managerial responsibilities allowed the building of local bridges between the worlds of medicine and management in areas like inter-professional collaboration and division-wide strategy making.

This process occurred through the continuous interactions with the members of the division management team, and we found that these exchanges helped professionals in understanding management and in seeing the complementarities between their clinical and the managerial work. For instance, care managers (nurses) helped doctors to better understand how to deal with patient centred pathways and to work together with non-medical professionals. Meanwhile, discussions with the finance managers represented occasions for hybrid medical managers to gain a deeper awareness of the purpose of reporting instruments and reimbursement mechanisms. Therefore, interactions represented an occasion for developing managerial capacity with doctors learning the "what" and "how" of managerial practices. Both formal team meetings, and informal interactions, such as morning conversations around the coffee machine, represented other arenas through which hybrid medical managers familiarised themselves with the new management role:

"You get a lot of input. Basically I can tell you that 90 per cent of what I learned from managing the department I learned from the other managers. I just ask a lot and I basically copy-paste what I like from others [...] Also when, for instance, I have a very complicated discussion [...] I ask one of the other managers to join me in that discussion, and then after that I ask feedback: what would you say, how would you do that?". (#17, Clinical Director)

The provision of this type of feedback was key for hybrid medical managers to reflectively identify effective (and ineffective) managerial practices and styles. During the management team meetings, clinical directors were commonly asked to address managerial issues, whose scope was far beyond the level of their expertise gleaned from longstanding clinical activity. As a consequence they gained an opportunity to derive a broader strategic picture of the organization. So they progressively abandoned short term, tactical and specialty oriented approaches to management, which might have come from a position as heads of one of the clinical units. This was helped significantly by the open climate in which strategic choices were discussed within the divisional management team, with specific reference to investments, resource allocation and business development opportunities. The practice of disclosing these decisions transparently within and across the organization not only prevented the emergence of opportunistic behaviours around self-interest, but also forced a progressive shift in the mindset and behaviours of many medical managers:

"Being very transparent, sharing all information related to budgets, changes in budgets, deficits, problems with budgets, everything was shared in the division [...] there was no secrecy" (#16, Executive Manager, former Clinical Director)

Feedback provision supported the strategic enactment of the managerial role for clinical directors and the progressive reconciliation of medicine and management. Sometimes the process was rather smooth, in other cases it involved open discussions:

"We had some very big discussions [...] he also had some serious talks with the chief of our board of directors [...] and that helped [...]. So now a year passed by, and we are happily surprised, my colleague and I, about the way he developed himself" (#24, Nurse Manager).

Rationalising being a hybrid

A further component of the process of hybridisation was doctors' internalisation and self-reflection over the evolution of their professional identity. This allowed them to progressively elaborate new convincing self-descriptions, and to avoid seeing the internal divide between medicine and management as an insuperable obstacle.

> "I think my strengths are inspiration and motivation [...] I can inspire and motivate people to do it like that and I'm very result-driven [...] a lot of people are good doctors and in my opinion there were a lot of people who were as good as researchers as I was. I am especially good in the things I told you [listening to people and reorganizing things] [...] and if you do that well, it's fun and you get recognition for it." (#20, Clinical Director)

Such rationalisation of potential conflicting identities helped in assimilating what medical management was, and what was not, and which were its immediate and ultimate goals. Those doctors who had performed a deeper reconstruction of their professional self were those who referred prospectively at their managerial and professional career, locating their efforts in changing their identity within a longer term frame of personal development.

> "The question is, why do you want to be a manager, because you want to have more power, or [...][because] you are looking for an answer to the question 'how can I improve patient care'?" (#22, Frontline medical manager)

Medical managers started understanding management as "being in a position where we connect things" or "combining the interests of people and bringing that together", or:

> "Keeping everybody on board, because [...] everybody has his own way of thinking about things and you all have to bring that together. So mainly it's doing that, working on strategic issues, trying to get everybody on board." (#26, Clinical Director)

This was helped by a growing shared understanding that the way professional their work was carried out needed to change because society outside was calling for that:

> "This is not changing the culture because I want to, but because we have to, society is changing, the chances are changing, our hospital nowadays is not the same as 10 or 20 years ago [...] what we regard a top professional these days is not the same as what one regarded a top professional 20 years ago". (#17, Clinical Director)

We heard about different types of interactions associated with this evolution, always in one-on-one settings. Most medical managers reported the importance of having other people who helped to deal with the identity struggles of the new situation they faced in their managerial role. For instance some mentioned conversations with executive managers, especially those who had been practicing doctors and had experienced similar challenges in the course of their career. One doctor found it particularly useful to have periodical talks with the former head of the division, who was a respected clinician:

> "What worked well for me, is to get feedback from people I respect [...] I have some people who either had my position before and are now retired - one of the divisional heads is a personal friend - and now I ask him sometimes: what would you do?" (#26, Clinical Director)

Interactions also provided the space and time for deepening the reflection on professional/managerial values and identity transition. For instance, some clinical directors benefited from discussions with external professional coaches to reflect upon enactment of the hybrid managerial role:

> "I had this coach and this coach told me, after half a year, I should go away for a week. Stop working, go home, think [laughs], and that's what I did [...] Because before that time you just work, work, work and run around like an idiot, and you don't see anything anymore. That was very helpful." (#6, Clinical Director)

Legitimising the role-identity

From previous research we already know that, in order to become a hybrid in a professional organization like a hospital, it is necessary to be recognised by peers, to have and maintain a high level of professional legitimacy (Llewellyn, 2001), and this was the case also in the hospital we studied. One of the clinical directors, due to a physical problem, had to significantly reduce the clinical activity and therefore devoted more time to management, but given this specific situation former colleagues did not view this transformation as a betrayal of the professional values. Other clinical directors who were prestigious scientists or doctors decided to maintain part of their medical practice or research activity, and therefore they retained the legitimacy in the professional domain:

> "[The clinical director] makes clear that he knows what goes on, so he is a professional, [although] not involved in actual patient care. It's just the fact that he is

known to be interested and involved in the way people deliver the care […] that gives him an enormous credit." (#10, Frontline medical manager)

Yet, within our study, another key element in the construction of the new identity turned out to be the progressive development of *organizational* legitimacy, or social acceptability outside the clinical domain. This involved making the new managerial side of these professionals visible and acknowledgeable, openly showing the sensibility and the added value of the new hybrid profile across the organization, providing and reinforcing the status of medical managers, as key for hybridisation. This activity consisted in the effort to obtain the respect and the resources associated to the clinical director role. As a position not yet fully recognised within the professional community, it was not endowed with social and cultural capital, and therefore doctors in management strived to accumulate these resources.

This process occurred through the interaction with actors others than specialist professional peers, in particular executive managers, who supported and enabled the legitimisation process. Openly backing clinical directors' most delicate decisions, which might, for example, adversely impact their specialist clinical peers, proved crucial to legitimise their role.

"If then the Board doesn't support you for 100 per cent you're not going to be successful. They have to back you up with the difficult decisions and they have to go all the way in supporting you with these difficult decisions. And in the implementation of the decisions." (#14, Clinical Director).

On the contrary, when support and "space" for action was not guaranteed – as it had happened in the past, with executive managers bypassing clinical directors in order to solve problems - hybrids' capacity to enact their role was deeply compromised.

"From the old days and from the old professors, there was still a way, a bypass, I mean: the chief of [surgical specialty x], if he had a complaint about not getting enough theatre time, he just went straight ahead to the chairman of the Board and said: listen guys, I am a famous professor and I want this and that." (#2, Executive Manager)

The situation was different for those clinical directors who were not famous researchers or practitioners and were not the "obvious" candidates with high seniority;

i.e. not necessarily "first amongst equals". They faced the greatest challenges, as shown in these instances:

> "You have to be respected and people have to recognise that you have influence [...] A lot of people are very much respected, because they are the top in research, or the top clinical doctor [...] I'm top in fixing things and innovating the whole process of doing our job here [...]: that's respected. I don't say I'm the best specialist or the best researcher here. I don't seek for respect on that". (#20, Clinical Director)

> "In my age - but I am not so old - you were regarded a top doctor if you published in a huge impact journal [...] Basically what I am trying to do is getting some of the respect that people gave to top scientists [...] distributing the admiration a little bit better". (#17, Clinical Director)

Their efforts in service improvement initiatives, training of residents' organizational competencies, development of care pathways or collaboration mechanism across disciplines, represented strategies to build professional legitimacy. Furthermore, their legitimacy was buttressed by executives through appointment to positions which provided high professional visibility within the hospital and outside, e.g. appointment as director of medical students' training or as member of an important national committee.

In-between identity transformation and maintenance

The familiarisation with management tasks, the personal rationalisation upon enacting the new role and the development of organizational legitimacy represented three micro-processes for construction of the new hybrid identity, which moved hybrid medical managers beyond a reluctant stance. These individuals experienced an evolution of the self towards a hybrid professional-managerial identity that, although at different degrees, had become stable and meaningful.

However, we should not assume this was always the case. For one doctor we interviewed, the work of maintenance of the pre-existing identity clearly prevailed. He entered the role reluctantly and was not able to reconcile the two identities, always referring to his identity retrospectively, talking about his original professional blueprint. Even after years of involvement in management, he had not internalised the strategic demands of the hybrid medical manager role: the mismatch between the managerial

role and the personal identity remained. Since he had been offered the same type of support provided to other doctors in management, this different outcome was arguably due to rooted personal traits and values. He was incapable to deeply engage in management, irrespectively to the influences of the social environment. And he had firmly decided that he would have stepped back to the profession after a limited number of years as clinical director.

> "I am a little bit different than most of the other clinical directors, in the sense that I have always retained a lot of clinical activity [...] My inspiration is taking care of patients and doing good patient care, my inspiration is not being a manager or being an administrator [...]. I don't think you should do that your whole life [...] then you become an administrator, but you're not truly a doctor anymore". (#4, Clinical Director)

Although this was the only reluctant clinical director we interviewed, this attitude was not considered not an isolated case within the group of unit chiefs at the hospital. Many professionals were indeed not motivated to take up a relevant management role.

> "[In] management I tried to my best, but it's not my talent, it will not give me energy and it will never be my attitude […] I think there's quite a reluctance to go into management despite the fact that there are financial gains. There's more reluctance than a trend to do it." (#10, Frontline medical manager)

> "It's not a job many people would like to have, so there's not much about a fight. Because for many people it's not what they choose for when they started to be a doctor." (#22, Frontline medical manager)

Accordingly, training opportunities and careful selection processes – comprising interviews and assessment sessions – had been put in place at the hospital in order to identify those candidates with the willingness and potential to become medical managers:

> "This is a difficult model. How do you find them? I said: we have about 130 professors here, we have about 600 medical professionals, the country has 6000 academic medical professionals, I only have to find 11, that must be possible". (#2, Executive Manager)

DISCUSSION

Our aim was to understand how hospital medical managers' hybridisation evolves and how transitions are enabled by social interactions in a wider organizational context. Drawing from a healthcare context we investigated the interactive construction of identities of professionals in management in an organizational environment. We found that hybrids' identity construction is a dynamic process, which takes place in different ways and does not stand in isolation but rather is institutionally sensitive and is made possible by social interactions. The three micro-processes through which hybrid identity is shaped are:

(1) Familiarising: acquiring awareness and practical knowledge to fill the (apparent) gap between professional and managerial practices;

(2) Rationalising: increasing the understanding of the hybrid identity, elaborating new meanings given to the professional self;

 (3) Legitimising: developing social and cultural capital enabling hybrids to be authoritative and credible in the role.

Medical professionals we interviewed changed their way of daily working by bringing focus away from their own specialty and experiencing an interconnected activity and decision making at a higher level. Then they made sense of managerial practices in a way compatible with patients' demands and other traditional professional motivations, such as visibility, innovation and research, therefore "storying" their identity transition in a personally meaningful and convincing way. Further, they obtained validation within the organizational context thanks to work of legitimisation, encompassing the achievement of influence, credibility and respect within the professional group. The hybridisation process was not intended as the unnatural juxtaposition of two clashing sets of practices and values, but rather as a sensible – although not always easy – evolution of professionalism. When such work is performed these professionals can learn to *be* hybrids rather than just *do* management reluctantly (McGivern et al. 2015).

The three micro-processes have a strong relational dimension, and they were associated with different dynamics of interaction with key organizational actors. We found that familiarisation with management was especially accompanied by learning through feedback exchange and observation of co-workers, while the rationalisation of the new

identity was supported by private interactions with role models and mentors, capable to touch the most inner dimensions of self. Finally, the legitimising process was enabled by the back up and support provided within the organization. Interaction therefore favours professionals' identity work by supporting their capacity and willingness, as well as by providing sources of legitimacy. In our hospital case the actors that played a key role in these processes were non-medical managers with different professional backgrounds, senior medical management or external coaches, and hospital executives. Therefore, it emerged that the construction of new identities is affected not only by individual traits, but it is more fundamentally influenced by relations and surroundings. In Table 2 we summarize the three identity process, the specific social interactions that facilitated these processes, and the mechanisms that affected identity formation and change.

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Insert Table 2 here

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Such approach allowed us to turn the attention from the outcomes of identity transition to the mechanisms which underlie them, and contribute to answer the call by Sveningsson and Alvesson (2003, 1190) for the development of research giving a "better feeling for the contexts, complexities and processes of identity construction", overcoming the limits of a literature which "emphasised the individual level of analysis and perhaps included organizational context as a constraint" (Chreim, Williams, and Hinings 2007, 1516). And our in depth qualitative methodology proved appropriate to grasp an understanding of individual responses to the role taking and the complex system of interactions occurring in a professional organization.

These findings contribute to our knowledge of professional hybrids' identity work in multiple ways. In organizations where a context for interaction and effective support is provided, hybrids' identity work can be something different from juxtaposing incompatible logics, or incorporating managerial values and practices in the professional world. Rather, it can be a process where professionals partially reframe the very notion of professionalism, broadening the scope for professional action and redefining patients' interests from individual to collective (McGivern et al. 2015). Most of the hybrids we studied understood new societal demands and in order to maintain credibility in front of

society they accepted the challenge to co-evolve and reconfigure traditional identities (Martin et al. 2015). In our case, professionals reframed their value sets and started seeing management as a way to take care of patients at a higher level, and therefore envisioned the managerial identity not as alien, but as in line with professional tradition (Noordegraaf et al. 2015). However, this is not a straightforward process. Medical professionalism can indeed be redefined and reconfigured, but only if individual professionals are provided the support to engage in processes of identity work. The purposeful action of others – in our case managers, nurses and external professionals – facilitate identity change.

Accordingly, as far as the debate on the role of agency/structure on the identity construction of professionals is concerned, we claim that professional hybrids in complex institutional environments do not act as heroic individuals who are called to reconcile autonomously alternative logics (Bevort and Suddaby 2016). Nor they are necessarily passively subject to the influence of the dominant professional mindset or the pressures of imposed organizational/managerial logics "regulating" their identity (Alvesson and Willmott 2002). Rather there is space for a constructive interplay between individual action and the complex network of relationships in which the professionals participate. Therefore, identity work through which professional identities can be reconfigured is not concentrated to the individual professional, but rather is *distributed*, as it arises through the interaction with other relevant actors.

Our findings support what found by Pratt, Rockmann, and Kaufmann (2006) and McGivern et al. (2015) on the role of interactions in identity construction. However, in our case of hybrids exposed to institutional contradictions, we found first of all that relevant interactions involve actors that lie beyond the limited and homogenous boundaries of the profession, in particular nonmedical managers and other professions. By embodying different logics and sets of values these actors allow the springboard of novel identities, and through this interaction individual agency is supported and fostered. The frequency and quality of forms of interaction we found in our analysis probably explains the high number of professionals who reconfigured their professional identity. Secondly, interactions play a role not only in the ex post social validation of identity (e.g. Pratt, Rockmann and Kaufmann 2006) but in the entire process of the identity shaping. This is in line with the work by Reay et al. (2017) showing that professional role identities can change thanks to the collective efforts of others.

We were intrigued by strong evidence of successful identity transitions that we found during our data collection, therefore in this work a mostly harmonious view of identity work prevails, whereas previous research tend to describe identity work as struggles (e.g. Sveningsson and Alvesson 2003). At the same time, like most of the literature on hybrids our study shows some, albeit limited, variation, with at least one of our role holders remaining aligned to his traditional clinical self, being incapable to hybridize and thinking and talking about his identity retrospectively (Bevort and Suddaby 2016). And a number of doctors working as unit chiefs seemed unwilling to take up managerial roles. Therefore, we cannot expect all doctors to engage in identity work to support their transition into a hybrid medical management role, even if requisite support is provided. Individual willingness, values and capacities do maintain a significant role in explaining doctors' hybrid identity construction. As shown by Sartirana (2015) in his study of Italian professional hybrids, although the opportunity to perform in the role provided by the organization is a key element for effective hybridisation, individual ability and motivation do maintain high relevance in the process. At the same time recent scholarship (Andersson and Liff 2018) has shown that also professionals unwilling to hybridize and coopting management just in an attempt to purse self interest, ultimately get unconsciously changed by the management logics to which they are exposed: this is a promising avenue for further research on a possible convergence between willing and unwilling hybrids.

Coming to the implications for policy and management, we acknowledge that hybridisation does indeed imply a challenge not only for hybrids but for policy makers and executives. It implies the risk of losing the leadership in the organization, of fuelling opportunistic behaviours, of empowering organizational antagonists (Sartirana, Prenestini, and Lega 2014). However, through examining interactions associated with identity work in taking up and enacting (medical) manager roles, we provided insight into how the transition might be supported. The study by McGivern et al. (2015) hints at antecedents of effective identity transition, but provide little information regarding this. Our study highlights the importance of those around hybrid managers, beyond their peer group, for providing support to the familiarisation, rationalisation and legitimisation processes. Even though clinical directors are less likely to hybridise compared to other executive medical management roles (McGivern et al. 2015) we

found that such process can take place, at least when clinical directors are properly selected, when the role is provided with autonomy, status and effective support.

This direction of change towards a reconfigured form of medical management looks promising for the numerous hospitals that have been struggling with the introduction of hybrid roles and are currently undergoing policy-driven organizational reconfigurations. This is why studying a Dutch hospital is interesting and the findings from this experience can find theoretical generalization, especially in European countries experiencing professional resistance to the introduction of managerial values and structures in healthcare (Kuhlmann et al. 2013)

Practices that can be explicitly or implicitly enacted by organizational actors include, first of all, solutions to develop hybrids' managerial capacity, through the presence of trained and empowered non-medical managers and support staff capable to provide applied managerial knowledge, and an organizational culture - supported by the purposeful actions of key organizational players – valuing transparency and feedback provision. Secondly, the adoption of formal (or informal) coaching and mentoring programmes, favouring role modelling and discussions over the evolution of the professional self, necessary to accompany uneasy identity changes. Training activities, such as MBAs or formal management programmes, outdoor directorate strategy making session, team building initiatives, can represent fruitful occasions for self reflection and growth. Finally, the capacity of executives to delegate and back hybrid managers, providing resources, autonomy, decision making power, overcoming the fear of a loss of power and control. And this set of organizational practices should be tailored to match the different needs of professionals, targeted at their primary gaps in terms of either bridging of management and professionalism, personal reflection or legitimacy in the new role. As a consequence, policymakers and executive managers pursuing implementation of hybrid roles, should understand that the process of becoming a hybrid is by and large shaped by the organization. These findings can provide relevant insights for public executives and policymakers dealing with professionals other than doctors, such as nurses, teachers, professors and researchers in different public professional organizations. Hybrid professionalism is not only about hybrids, rather it is about how hybrids are managed.

CONCLUSIONS

Professionals in management have become a common phenomenon, but this does not mean that taking up managerial roles has become common. Professionals, specifically those with a medical background, have often been seen to buffer their professional peers from managerial intrusion, rather than enact a strategic organizational role. This has been characterised as an identity transition challenge, but extant research has offered little understanding of how hybridisation takes place, and how it is influenced by the relations outside the professional group.

As a single case study of professional managerial hybrids in a Dutch hospital, our study may have limited empirical generalisability. Furthermore, our methods included document analysis and interviews with actors in managerial roles, while it would have been interesting to perform observations, in order to further explore interactions, and to interview frontline professionals, in order to understand how management logics was seen by doctors not (yet) involved in managerial roles. However, this paper offers theoretical and practical insights for understanding how the combination of professionalism and management generates hybrid situations, not only in terms of principles and structures, but also in terms of identity. This takes much effort, and our case shows that performing professional manager roles calls for relational and organizational support. Many others are important for becoming a hybrid. In that sense, identity work is primarily interactive, and hybridisation is not so much concentrated work, but distributed.

Accordingly, our research brings new perspectives from professionals in management in continental Europe, showed that public managers should invest in consciously organizing managerial role-taking, which they can shape by supporting the hybridisation processes we traced: familiarising, rationalising and legitimising. Instead of stressing classic managerial/professional dichotomies, this fits a more contemporary focus on organizational practices in which managerial-professional connections are reconfigured.

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1   *Table 1: Profile of the respondents by role and professional background*

	Doctors	Nurses	Administrators
Executive management and HR	2		5
Division management team	7	3	5
Frontline management	5	2	
	14	5	10

2

1   *Table 2: Hybrids' identity processes and social interactions*

Identity process	Social interaction	Mechanism
Familiarizing	• Receiving feedback in one-by-one and group discussions • Observing co-workers' managerial practices	• Developing managerial capacity
Rationalizing	• Discussing about self with senior hybrids and external professionals	• Role modelling/coaching
Legitimizing	• Receiving back up and opportunity to perform from executive managers	• Increasing space for action

2