

The nature and manifestation of identity tension in England's National Health Service

Abstract

This paper critically examines identity tension in the National Health Service (NHS) and the associated consequences of inauthenticity, lack of credibility, and low self-efficacy. Data from 60 interviews with staff from a large acute care hospital (hereafter, Large East Midlands Trust (LEMT)) within England's NHS was collected. Analysis revealed that inauthenticity, lack of credibility, and lower perceived self-efficacy are components of identity tension that staff experience as they face the bidirectional pressure exerted on their professional and NHS identities by the demand to engage in entrepreneurial activities. This research is the first to tease out the specific aspects of identity tension that individuals experience in their multiple social identities in response to change in their organisational context. In doing so we contribute to the conference sub-theme: identity and change- how 'who we are' influences how we drive or cope with the unexpected.

Introduction

The modern world presents conditions or precipitating event that cause disruptions to self-concept including, fragmented society, technological change or the competing professional and organisational demands of 'managerialst' structures such as New Public Management (NPM). Some scholars have recognised these conditions as contributory to the erosion of prototypical identities that have traditionally been clearly demarcated through one's profession or employer (Giddens 1991; Taylor 1991). This research examines the identity tension that is created in the NHS as it asks professional staff members to participate in various forms of entrepreneurship. Specifically this study explores corporate entrepreneurship (CE) where an individual or groups of individuals within an existing organisation, create a new organisation or instigate renewal or innovation on their organisation's behalf (Sharma & Chrisman, 1999).

Extant research into professional hybrids – individuals with professional backgrounds who take on managerial roles and are thus required to move between different

organisational groups – suggests there is identity conflict (Croft, Currie and Lockett, 2015; Ibarra and Barbulescu 2010). While hybrid roles have diffused across the medical profession (McGirven, Currie, Ferlie, Fitzgerald and Waring, 2015), the bulk of the research focuses on the managerial level, such as nurse managers and doctor managers and their experiences of identity transition as they take on hybrid roles (Ibarra & Barbulescu 2010; Ibarra 1999; Pratt, Rockmann and Kaufmann 2006). Increasingly however, NHS staff are being tasked to engage in entrepreneurial behaviour. Our research looks at identity tension that arises from taking on this task at all levels of the organisation.

Background

The social self is considered to be an all-encompassing concept consisting of many layers of identification that more or less overlap (Stets and Burke 2000). Organisational and professional identities constitute two of these layers within England's NHS. In another aspect of this research, Johnson and Hughes (forthcoming) identified two types of social identity in the NHS: NHS identity and professional identity. First, we found a lack of a specific LEMT identity as a form of organisational identity; instead an NHS identity was identified as being the dominant (only) form of organisational identity among respondents. Respondents used emotive and expressive language to convey their exceedingly strong positive feelings towards the NHS and the philosophical principles on which it was founded and remain at its core (1) that the NHS meets the needs of everyone (2) that the NHS be free at the point of delivery (3) that the NHS be based on clinical need and not the ability to pay (Klein, 2001; NHS, 2013)

While NHS identity does not relate to a specific organisation, it does conform to the idea of organisational identity, which broadly captures the commonly shared and collective understanding of the defining characteristics and values of an organisation that is held by its members (Brown and Starkey 2000). It is common in the identity literature to conceptualise organisational identity as stable and durable (Albert and Whetten 1985). Primarily due to the enduring meanings, significance and expressed values organisational members attach to what they believe an organisation to be which has implications for organisational change such as the introduction of CE. There has been growing support, however, for the proposition that this stability may

not be as steadfast as previously presented (Gioia, Schultz and Corley 2000; Pratt et al., 2006), especially, in the face of increasingly turbulent economic environments characterised by munificence, hostility and public perceptions of the organisation.

Additionally, the organisational identity to which employees adhere, healthcare organisations are considered to be quintessentially professionalised as they provide an environment where the socialisation processes necessary to transform individuals into professionals readily occur (Cohen and Musson, 2000; Doolin 2002; Pratt et al. 2006). In line with this, our research showed that NHS employees who identify strongly with a professional employee group, emphasised the prescriptiveness of their professional identities by conveying the importance of adhering to their professional behaviours as well as the proscriptive nature of professional identity that led to intolerance for non-professional work content (Johnson and Hughes, forthcoming). Their professional identities such as nurse and doctor contain a constellation of beliefs, values and behaviours people use to define themselves in specialised, skill-based, and education-based occupations or vocations (Ibarra 1999; Schein 1978). This identity influences self-definition as it positions an individual in society via the relationships formed with others and how others view professionals. This is traditionally reflected in the higher levels of prestige, privilege, and autonomy that society affords professionals with unique knowledge and skills (Gecas and Burke 1995).

Some scholars have described professional identity as highly robust and resistant and therefore does not change or subsume new behaviours quickly or easily (Chreim, Williams and Hinings 2007). This resilience can be attributed in part to the legitimacy one finds in being a professional. Legitimacy provides the foundation for what Abbott (1988) calls professional jurisdiction, which captures both the authority that goes with having command of specialist knowledge and the importance of complying with the recognised rules, standards, traditions and behaviours of a chosen profession (Goodrick and Raey 2010). Professional legitimacy is further reinforced in the organisational context as it establishes the interactions that are the basis of the organisation's structure thereby framing the occupational hierarchy within (Abbott 1988). However, alternative perspectives on the nature of professional identity suggest it is more malleable or adaptable (Ibarra and Barbulescu 2010; Pratt et al. 2006). The general consensus in the socialisation literature indicates that professionals

will adapt their work content, or more simply ‘what you do’ as a professional, over time as their career progresses (Ibarra 1999; Pratt et al. 2006).

One line of enquiry into the resistant and yet changing nature of professional identity has led to an increased focus on the emergence of professional hybrids in professionalised organisations such as the NHS (Hartley and Allison 2000; O’Reilly & Reed 2010). Professional hybrids move between different organisational groups where they take on managerial roles that still require them to retain influence in and operate as legitimate members their professional group (McGirven et al., 2015; O’Reilly and Reed 2010; Tummers, Steijn and Bekkers, 2012). The ability of hybrids to alternate between these two distinct functions and align professional and organisational demands is indicative of how valuable hybrids can be to these organisations (Ferlie, Fitzgerald, Wood and Hawkins 2005; Noordegraaf and Van Der Meulen 2008). Existing research on professional hybrids seeks to understand how their emergence is facilitated or hindered. For instance, there has been significant research on how professionals attempt to reduce both the resistance to change and the conflict created between their commitment to prototypical professional identities and the uptake of managerial duties (Ibarra and Barbulescu 2010; O’Reilly & Reed 2010). What remains vague in the extant literature, however, is how hybridity-associated conflicts are managed so that professional identity can be changed and new identities can emerge (Croft et al., 2015).

Michlewski (2008) suggests that the conditions of modernity or precipitating events can cause identity tension as an individual is confronted with and struggles to balance multiple identity demands. For instance, an individual who is committed to an over-idealised nurse archetype may take issue with what are perceived as incompatible NPM objectives like profit maximisation and can experience identity tension (Currie, Koteyko and Nerlich, 2009). Portrayals of identity tension in the literature indicate that identity demands can be experienced as contradictory or incompatible creating ambiguity and paradox for the individual (Knights and Willmott, 1999; Kreiner et al. 2006). This research is guided by the question: *How is this this ambiguity and paradox manifested in individuals as their identification with multiple groups are eroded by change?*

Research setting

LEMT is a useful and unique case to explore how identity tension is manifested as NPM reforms have attempted to move organisations like the NHS towards more managerialist structures that utilise techniques such as entrepreneurial governance (Exworthy, Macfarlane, and Willmott 2015). However, in the NHS, professionals have established multiple identities over time (Chreim et al., 2007; Gougoumanova and Guven-Uslu 2014), which are potentially quite far removed from any notion of CE.

Public sector organisations like LEMT-NHS are especially notorious in the management and entrepreneurship-CE literatures as being invariably hostile to entrepreneurial activity (Morris, Kuratko, & Covin, 2011). This is chiefly because public sector organisations develop complex systems of bureaucracy that limit managerial autonomy. Further, the NHS is a not-for-profit organisation driven by a social mission versus wealth creation, which is still seen as the main objective of CE (Wennberg, Wiklund, Detienne and Cardon, 2010). Lastly, the heavily professionalised and institutionalised NHS context involves high levels of task specialisation, adherence to formal rules and procedures and an expectation of a lifetime career. Combined, these issues can foster an aversion to the risk-taking and proactiveness processes suggested by Lumpkin and Dess (1996) as individuals may be inclined to place more value on the job security associated with public sector employment than risk entrepreneurial activity (Currie et al. 2010).

Nonetheless, developing and inculcating entrepreneurial behaviours in the existing workforce has become even more salient as the UK government mandates the creation of “the largest social enterprise sector in the world by... giving NHS staff the opportunity to have a greater say in the future of their organisations, including employee-led social enterprises” (DoH 2010, p. 5). This calls on NHS staff to develop an entrepreneurial mindset in keeping with du Gay (2004) who argues the control exerted by NPM tenets subverts the orientation and ethics of the collective or individual so they become complicit in adopting an identity that can be characterised as entrepreneurial in nature. Descriptively, the beliefs, values and behaviours attributed to such an identity include being less risk-averse, innovative, responsive, and creative (Osborne & Gaebler, 1992).

Much research has sought to capture the manifestation of the ambiguity and paradox in individuals as their identification with multiple groups are eroded by change (Ellemers, Spears, and Doosje 2002; Roberts 2005; Tedeschi and Melburg 1984). However these studies largely neglect to identify *how* identity tension is manifested and where these studies have been conducted within healthcare organisations, medical doctors have been the focus (Croft et al. 2015). Beyond this group there has been little research that has investigated the way other healthcare professionals experience identity tension when faced with these disruptions. To redress this exclusive focus on doctors, we examine how doctors, nurses, allied health professionals (AHPs), healthcare scientists, and managers experience identity tension in the NHS and how it is manifested.

Data & Methods

This research was part of a larger study of the formation of CE intentions in the NHS where a single in-depth case study using qualitative methods was employed. 60 semi-structured interviews were the main data source and were triangulated using (participant) observations and archival analysis (Yin, 2009). Specific effort was made to interview, observe and collect documentation on each of the 5 major professions commonly found in the NHS Agenda for Change policy: nurse, doctor, AHP, healthcare scientist, and manager (DH, 2004). Three embedded units were selected within the single case at various levels in the organisation – corporate (macro), clinical business unit (meso), and service (micro) – since the use of sub-units allows for a better understanding across the organisation while preventing ‘slippage’ from the phenomenon under study (Yin, 2009) as shown in Figure 1.

<<Insert Figure 1 here>>

The main analytic techniques employed were within-case analysis and cross-case patterns analysis (Eisenhardt, 1989), both of which are suitable for the single embedded case. Both these techniques aided in identifying key themes and patterns to create first and second order codes to link the data with theoretical explanations based in the CE, entrepreneurial intentions and social identity theory (SIT) literatures and the research question (Coffey and Atkinson 1996). To aid the coding process we used the software programme NVivo 10 guided by qualitative data analysis procedures

established by Cresswell (2009) and Tesch (1990). By travelling back and forth between the literature and data, a master list of first order codes was generated and subsequently grouped to produce second order codes by considering what fit with our theoretical framework and whether new codes or categories had emerged (Miles & Huberman, 1994).

In total, three reactions to identity tension were identified in the analysis: feelings of inauthenticity, reduced credibility, and low perceived self-efficacy. Specifically, we found that the nature and complexity of identity tension for each of the social identities that respondents proffered as central and salient in this context differed from each other. The coding tree is presented in Table 1 and the findings are briefly discussed below.

<<Insert Table 1 here>>

Findings

Bidirectional Pressure

First, respondents described the disruptions to their multiple social identities as being pulled in two separate directions by two sets of identity demands. We summarised all of these accounts with the first order code *bi-directional pressure* (Table 1). The first of these demands that case informants described was the pull of an existing social identity, whereas the second set of demands originates from the new circumstances created by NPM-related precipitating events in the LEMT context. These new circumstances advocate that respondents should ultimately adopt some new set of beliefs, values and behaviours that differ from those originally held by the social group. Returning to the identity literature, I was able to link the bi-directional pressure first order code to the existing identity tension construct as a second order code (Table 1). Respondents generally associated identity tension with great uncertainty in keeping with portrayals in the literature, which indicate that shifting identities can be experienced as contradictory or incompatible. As such, identity tension is often characterised by ambiguity and paradox (Kreiner et al., 2006; Knights & Willmott, 1999).

Authenticity, credibility & self-efficacy

Seven first order codes emerged that spoke to the nature of identity tension: two for the NHS identity and five for professional identity. Analysis revealed that the possibility of shifting from their NHS identity to some new version of their NHS self, raised concerns about *incompatibility* of the old and new. For instance, having a commercial mind-set in a publically funded institution. They also considered the possibility of a *NHS identity cost*. That is, the future version of their NHS identity would require they compromise or give up the NHS founding principles upon which their NHS identity is predicated. Similarly, respondents were concerned about a *professional identity cost* where their new professional self may take them away from the frontlines of practice. Case informants also refer to the perceived *incompatibility* of new work content with their existing work content. We linked the two NHS identity first order codes and two professional identity first order codes to the *inauthenticity* construct.

Data analysis revealed three additional first order codes (later mapped onto 2 second order codes) that characterised professional identity tension. The possibility of a shifting professional identity raised issues surrounding an individual's competency in the eyes of others. We summarised these issues in the two first order codes *other's perception* and *in-group relationships* and linked them to the second order code *credibility* from the identity literature. The final first order code, *adopting new work content*, emerged as respondents conveyed concerns about their own competency. This aligned with the concept of *self-efficacy*.

Discussion & Conclusion

Our findings corroborate the extant research suggesting that identity tension manifests as the pressure exerted on individuals when identity demands pull them in two or more directions (Beech 2011; Beech, Gilmore, Cochrane and Greig 2012; Ellis and Ybema 2010; McGirven et al. 2015). Identity tension was characterised by respondents as a bi-directional pressure where they were pulled toward some new set of values, beliefs or behaviours stipulated by precipitating events that differed from their prototypical social identities. Specifically, NHS identity tension manifested when NPM-related precipitating events required respondents to move away from the founding principles of the NHS. Whereas professional identity tension materialised as

respondents were faced with altering their professional work content and adopting the largely foreign CE based work content and responsibilities dictated by NPM-related precipitating events.

This research presents identity tension can be multifaceted as respondents' were focused on scrutinising the implications of becoming some future version of themselves. This is indicative of the destabilisation of respondent's multiple social identities (Ibarra, 1999) with each of these social identities exhibiting its own defining amalgam of identity tension reactions in response to NPM-related precipitating events. For NHS identity tension, case informants cited perceptions of inauthenticity of their possible future self as their main concern. Whereas professional identity tension concerns included perceptions of inauthenticity as well as reduced credibility (among their peers) and lower levels of self-efficacy of their possible future self.

The variation in the nature of identity tension in the NHS identity versus the professional identity also suggests that identity tension is can also be multi-layered based on the number of salient and central identities in a given context. While respondent's NHS identity tension was characterised by inauthenticity where they perceived their existing social identity as incongruent with their possible identity, professional identity tension proved more complex as multiple professions exist in the LEMT context. Thus, in addition to inauthenticity, the credibility of the new CE-related identity in the eyes of others and respondents perceived self-efficacy to fully behave in accordance with a more CE-related identity emerged as important manifestations of professional identity tension. Combined, these multiple layers identity tension may amplify the destabilisation effect experienced in existing multiple social identities in response to change.

References

- ABBOTT, A. (1988). *The system of professions: An essay on the division of expert labor*, Chicago, University of Chicago Press.
- ALBERT, S. & WHETTEN, D. A. (1985). Organizational identity. *Research in organizational behavior*.
- BEECH, N. (2011). Liminality and the practices of identity reconstruction. *Human Relations*, 64, 285-302.

BEECH, N., GILMORE, C., COCHRANE, E. & GREIG, G. (2012). Identity work as a response to tensions: A re-narration in opera rehearsals. *Scandinavian Journal of Management*, 28, 39-47.

BROWN, A. D. & STARKEY, K. (2000). Organizational identity and learning: A psychodynamic perspective. *Academy of Management Review*, 25, 102-120.

CHREIM, S., WILLIAMS, B. E. & HININGS, C. R. (2007). Interlevel influences on the reconstruction of professional role identity. *Academy of Management Journal*, 50, 1515-1539.

COFFEY, A. & ATKINSON, P. (1996). *Making Sense of Qualitative Data*, London, Sage.

COHEN, L. & MUSSON, G. (2000). Entrepreneurial identities: reflections from two case studies. *Organization*, 7, 31-48.

CRESWELL, J. (2009). *Research design: qualitative, quantitative, and mixed methods approaches*, Thousand Oaks, California, SAGE Publishing.

CROFT, C., CURRIE, G. & LOCKETT, A. (2015). Broken Two-way Windows? An Exploration of Professional Hybrids. *Public administration*, 93, 380-394.

CURRIE, G., KOTEYKO, N. & NERLICH, B. (2009). The dynamics of professions and development of new roles in public services organizations: the case of modern matrons in the English NHS. *Public administration*, 87, 295-311.

CURRIE, G., FINN, R. & MARTIN, G. (2010). Role transition and the interaction of relational and social identity: new nursing roles in the English NHS. *Organization Studies*, 31, 941-961.

DH. (2010). *Equity and Excellence: Liberating the NHS* [Online]. Department of Health. Available: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353 [Accessed December 2010].

DH. (2004). *Agenda for Change* [Online]. London: Department of Health. Available: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825 [Accessed May 2012].

DOOLIN, B. (2002). Enterprise discourse, professional identity and the organizational control of hospital clinicians. *Organization Studies*, 23, 369-390.

DU GAY, P. (2004). Against 'Enterprise' (but not against 'enterprise' for that would make no sense). *Organization*, 11, 37-57.

EISENHARDT, K. M. (1989). Building Theory from Case Study Research. *Academy of Management Review*, 14, 532-550.

- ELLEMERS, N., SPEARS, R. & DOOSJE, B. (2002). Self and social identity*. *Annual review of psychology*, 53, 161-186.
- ELLIS, N. & YBEMA, S. (2010). Marketing identities: Shifting circles of identification in inter-organizational relationships. *Organization Studies*, 31, 279-305.
- EXWORTHY, M., MACFARLANE, F., & WILLMOTT, M. (2015). NHS Managers: From Administrators to Entrepreneurs?. In *Managing Change* (pp. 139-154). Palgrave Macmillan UK.
- FERLIE, E., FITZGERALD, L., WOOD, M. & HAWKINS, C. (2005). The nonspread of innovations: the mediating role of professionals. *Academy of management journal*, 48, 117-134.
- GECAS, V. & BURKE, P. J. (1995). Self and identity. *Sociological perspectives on social psychology*, 41-67.
- GIDDENS, A. (1990). *The Consequences of Modernity* (Cambridge. Polity, 53, 245-260.
- GIOIA, D. A., SCHULTZ, M. & CORLEY, K. G. (2000). Organizational identity, image, and adaptive instability. *Academy of Management Review*, 25, 63-81.
- GOODRICK, E. & RAEY, T. (2010). Florence Nightingale endures: Legitimizing a new professional role identity. *Journal of Management Studies*, 47, 55-84.
- GOUGOUMANOVA, Z., & GUVEN-USLU, P. (2014) Changing Professional Identities in the English National Health Service Acute Care: Institutional Logics and Healthcare Commissioning. In *2014 Asia Conference on Economics & Business Research (ACEB 2014) CONFERENCE PROCEEDINGS* (p. 204).
- HARTLEY, J. & ALLISON, M. (2000). The modernization and improvement of government and public services: The role of leadership in the modernization and improvement of public services. *Public money and management*, 20, 35-40.
- IBARRA, H. (1999). Provisional selves: Experimenting with image and identity in professional adaptation. *Administrative Science Quarterly*, 44, 764-791.
- IBARRA, H. & BARBULESCU, R. (2010). Identity as narrative: Prevalence, effectiveness, and consequences of narrative identity work in macro work role transitions. *Academy of Management Review*, 35, 135-154.
- JOHNSON, D. & HUGHES, M. (forthcoming). The role of social identity in the formation of corporate entrepreneurial intentions in the English National Health Service. Leicester Castle Business School Working Paper. Leicester Castle Business School: De Montfort University.
- KLEIN, R. 2001. *The new politics of the NHS*, Harlow, Prentice Hall.

KNIGHTS, D. & WILLMOTT, H. 1999. *Management Lives: Power and Identity in Work Organizations*, Thousand Oaks, CA, Sage.

KREINER, G. E., HOLLENSBE, E. C. & SHEEP, M. L. 2006. Where is the "me" among the "we". *Identity work and the search for optimal balance*. *Academy of Management Journal*, 49, 1031-1057.

LUMPKIN, G. T. & DESS, G. G. 1996. Clarifying the entrepreneurial orientation construct and linking it to performance. *Academy of Management Review*, 21, 135-172.

MCGIVERN, G., CURRIE, G., FERLIE, E., FITZGERALD, L. & WARING, J. 2015. Hybrid Manager-Professional's Identity Work: The Maintenance and Hybridization of Medical Professionalism in Managerial Contexts. *Public administration*, 93, 412-432.

MILES, M. B. & HUBERMAN, A. M. 1984. *Qualitative Analysis: A Sourcebook of New Methods*, Beverly Hills, CA, Sage Publications. .

MICHLEWSKI, K. 2008. Uncovering design attitude: Inside the culture of designers. *Organization Studies*, 29, 373-392.

MORRIS, M. H., KURATKO, D. F. & COVIN, J. G. 2011. *Corporate Entrepreneurship and Innovation*, Mason, OH, Cengage/Thomson South-Western.

NHS. 2013. About the NHS: Principles and Values that Guide the NHS [Online]. National Health Service Available: <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx> [Accessed May 2013].

NOORDEGRAAF, M. & VAN DER MEULEN, M. 2008. Professional power play: Organizing management in health care. *Public administration*, 86, 1055-1069.

O'REILLY, D. & REED, M. 2010. Leaderism: an evolution of managerialism in UK public service reform. *Public administration*, 88, 960-978.

OSBORNE, D. & GAEBLER, T. 1992. *Reinventing government: How the entrepreneurial spirit is transforming government*. Reading Mass. Adison Wesley Public Comp.

PRATT, M. G., ROCKMANN, K. W. & KAUFMANN, J. B. 2006. Constructing professional identity: The role of work and identity learning cycles in the customization of identity among medical residents. *Academy of Management Journal*, 49, 235-262.

ROBERTS, L. M. 2005. Changing faces: Professional image construction in diverse organizational settings. *Academy of Management Review*, 30, 685-711.

SCHEIN, E. H. 1978. *Career Dynamics*, Reading, MA, Addison-Wesley.

SHARMA, P. & CHRISMAN, J. J. 1999. Toward a Reconciliation of the Definitional Issues in the Field of Corporate Entrepreneurship. *Entrepreneurship Theory and Practice*, 23, 11–27.

STETS, J. E. & BURKE, P. J. 2000. Identity theory and social identity theory. *Social Psychology Quarterly*, 63, 224-237.

TAYLOR, C. 1991. *The ethics of authenticity*, Cambridge Univ Press.

TEDESCHI, J. T., & MELBURG, V. (1984). Impression management and influence in the organization. *Research in the sociology of organizations*, 3(31-58).

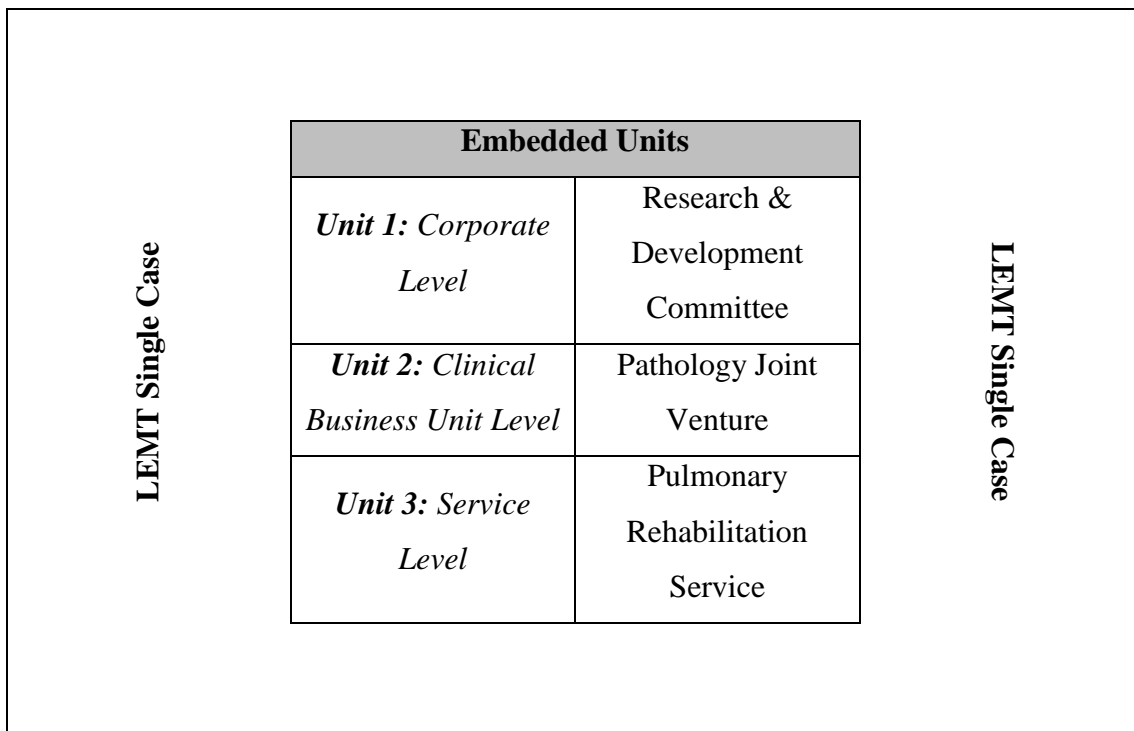
TESCH, R. 1990. *Qualitative research: Analysis types and software tools*, Psychology Press.

TUMMERS, L., STEIJN, B. & BEKKERS, V. 2012. Explaining the willingness of public professionals to implement public policies: Content, context, and personality characteristics. *Public administration*, 90, 716-736.

WENNBERG, K., WIKLUND, J., DETIENNE, D. R. & CARDON, M. S. 2010. Reconceptualizing entrepreneurial exit: Divergent exit routes and their drivers. *Journal of Business Venturing*, 25, 361-375.

YIN, R. K. 2009. *Case Study Research: Design & Methods*, California, Sage Publications.

Tables and Figures



*Figure 1: Embedded Units within the Single LEMT Case
(Adapted from Yin 2009)*

	Multiple Social Identities	First Order Codes <i>Statements about:</i>	Second Order Codes	Depictions of Identity Tension <i>Statements about:</i>	Second Order Codes	Findings Derived From
Precipitating Events Interrupt Multiple Social Identities	NHS Identity	<p>'Bi-directional pressure': being pulled in two directions</p> <ul style="list-style-type: none"> • Pull of prototypical social identity • Pull towards a re-constructed version of the self 	Identity Tension	<p>'Incompatibility' e.g.</p> <ul style="list-style-type: none"> • Business mentality versus NHS founding principles • Private versus public sector • Profit generation versus taxation funding 	Inauthenticity	Across the LEMT Case
				<p>'NHS Identity cost' e.g.</p> <ul style="list-style-type: none"> • Threat of losing NHS founding principles 		
	Professional Identity			<p>'Incompatibility' e.g.</p> <ul style="list-style-type: none"> • Changing professional expectations • Less time for practice 	Inauthenticity	
				<p>'Professional Identity cost' e.g.</p> <ul style="list-style-type: none"> • No longer on the frontlines • Forced to change work content 		
				<p>'Others perception' e.g.</p> <ul style="list-style-type: none"> • Is 'X' competent? • Working with other professions 	Credibility	
				<p>'In-group relationship'</p> <ul style="list-style-type: none"> • People challenge my new work content 		
				<p>'Adopting new work content' e.g.</p> <ul style="list-style-type: none"> • Am I capable? • Do I have the right skill sets? • What I do know versus what I do not know • Learning 	Self-efficacy	

Table 1 Data Analysis Table Showing the Outcomes of Precipitating Events that Interrupt the Normal Progression of Social Identity

