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Thomas Andersson

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Thomas Andersson , (2015),"The medical leadership challenge in healthcare is an identity challenge", Leadership in Health Services, Vol. 28 Iss 2 pp. 83 - 99
Permanent link to this document:
http://dx.doi.org/10.1108/LHS-04-2014-0032

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The medical leadership challenge in healthcare is an identity challenge

Thomas Andersson
School of Business, University of Skövde, Skövde, Sweden

Received 1 April 2014
Revised 4 September 2014
Accepted 3 November 2014

Abstract

Purpose – The purpose of this article is to describe and analyse the identity challenges that physicians with medical leadership positions face.

Design/methodology/approach – Four qualitative case studies were performed to address the fact that identity is processual, relational and situational. Physicians with managerial roles were interviewed, as well as their peers, supervisors and subordinates. Furthermore, observations were made to understand how different identities are displayed in action.

Findings – This study illustrates that medical leadership implies identity struggles when physicians have manager positions, because of the different characteristics of the social identities of managers and physicians. Major differences are related between physicians as autonomous individuals in a system and managers as subordinates to the organizational system. There are psychological mechanisms that evoke the physician identity more often than the managerial identity among physicians who are managers, which explains why physicians who are managers tend to remain foremost physicians.

Research limitations/implications – The implications of the findings, that there are major identity challenges by being both a physician and manager, suggest that managerial physicians might not be the best prerequisite for medical leadership, but instead, cooperative relationships between physicians and non-physician managers might be a less difficult way to support medical leadership.

Practical implications – Acknowledging and addressing identity challenges can be important both in creating structures in organizations and designing the training for managers in healthcare (both physicians and non-physicians) to support medical leadership.

Originality/value – Medical leadership is most often related to organizational structure and/or leadership skills, but this paper discusses identity requirements and challenges related to medical leadership.

Keywords Identity, Culture, Manager, Medical leadership, Physician, Profession

Paper type Research paper

Introduction

Who will lead and who will follow in healthcare? This was a non-issue for many years: physicians should of course lead. However, when administrative logic became more prominent, and especially when administrators renamed themselves managers (Glouberman and Mintzberg, 2001), this was no longer self-evident. New Public Management (NPM) implied further increased expectations in managers' capabilities to lead health-care organizations (Hood, 1995), but the difficulties to integrate health-care organizations remained (Scott *et al.*, 2000). Four worlds or logics of healthcare co-exist, but have been scarcely integrated (Glouberman and Mintzberg, 2001); there is a major

This research has been financed by AFA Försäkring research grant no. 110159.

Leadership in Health Services
Vol. 28 No. 2, 2015
pp. 83-99
© Emerald Group Publishing Limited
1751-1879
DOI 10.1108/LHS-04-2014-0032

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cleavage between the worlds of control (managers) and cure (physicians). As managerialism has, in many ways, colonized leadership (O'Reilly and Reed, 2011), there is more focus on managerial leadership than medical leadership.

One strategy to bridge the gap between managers and physicians, as well as to increase the focus on medical leadership, is to make structural changes, aiming at integrating physicians into administrative structures (Baker and Denis, 2011). To some extent, this has opened a "two-way window" between the two worlds and has started to create a new discourse of management/medicine, combined (Llewellyn, 2001). The two worlds are embodied in one person (Dawson *et al.*, 1995) and means that professionals lead in hospitals (Witman *et al.*, 2011). Many researchers claim that the only way to transform healthcare is to put physicians not only in informal leading positions but also in formal leading positions (Snell *et al.*, 2011). However, there is an imbalance in these hybrid forms, and physicians mostly remain foremost physicians (Llewellyn, 2001).

Physicians in leading positions have increased the interest in medical leadership (Chadi, 2009). The field has grown from almost a non-issue in medical research a few years ago (Dowton, 2004) to something that has created major ventures in policy and practice (McKimm and O'Sullivan, 2011). Several well-known competency frameworks for medical leadership have been developed such as the NHS Leadership Qualities Framework and the Medical Leadership Competency Framework (Clark and Armit, 2010) and the LEADS framework in Canada (Dickson, 2009).

Structural changes and competences are important prerequisites for medical leadership, but in this paper, the claim is that the medical leadership challenge is not only a structural and/or competence challenge, it is just as much an identity challenge. Many researchers have illustrated how becoming a manager is more a question of maturity in the managerial role (Watson, 2001) and of mastering a new identity (Hill, 1992) than learning (competence) or being appointed manager (structure). The purpose of this article is to describe and analyse the identity challenges that physicians with medical leadership positions face.

The paper is structured as follows: first, previous research on medical leadership is described. It is followed by the overall frame of theoretical assumptions, describing how different social identities are important in identity processes. Then, previous, relevant research on social identities – manager and physician identities – is described, emphasizing the struggle encountered by these multifaceted identities. In the following part, a theoretical framework for understanding multifaceted identities in action is presented. In the method section, information on the execution of the study is provided. The empirical results are described under the common theme: "Identity struggles of physicians who are managers". This is divided in three subsections: their relationship to the organizational system, balancing acts between different identities and manager as an anti-identity to being a physician. The analytical section begins with an analysis, where the theoretical framework on multifaceted identities in action is used to understand physician/manager identities in action. The paper ends with a discussion, where the most important contributions are described, both in relation to research and practice.

Medical leadership: physicians in leading positions

Health-care organizations have always been described as difficult to manage and control, mainly based on a conflict between professional logic and administrative/

managerial logic (Scott *et al.*, 2000). Many researchers claim that the only way to transform healthcare is to put physicians in formal leading positions (Snell *et al.*, 2011). One reason is that physicians can inhabit the managerial world, whereas non-physician managers can hardly inhabit the medical world (Llewellyn, 2001). Consequently, physicians have the best possibilities to integrate the different worlds of healthcare, but in that case, there is a need for medical leadership that goes beyond the traditional physician identity, which is clearly an identity challenge. And not just for physicians, but for everyone involved with physicians.

There is a growing body of research on physicians as managers, and in many ways, this research confirms difficulties related to physicians in leading positions, as well as on nurses as managers (Bondas, 2006). Nurses have in general found it easier to adapt to administrative positions (Blomgren, 2003), but then, without influencing the physicians and, thereby, medical leadership is outside their scope. When studying physicians as managers (Llewellyn, 2001; Baker and Denis, 2011; Witman *et al.*, 2011; Berg and Byrkjeflot, 2014; Byrkjeflot and Jespersen, 2014), the most intriguing dilemma has been how they combine medical and managerial leadership in different hybrid forms. Most efforts in developing medical leadership have been based on structural changes aiming at integrating physicians in administrative structures, with limited impact (Baker and Denis, 2011). The result of these hybrid forms is generally that physicians co-opt managerial positions and continuously steer mainly medical issues, as physicians who are managers tend to see management values as conflicting with their professional and personal values (Llewellyn, 2001). Physicians who are managers have more influence on clinical activities than non-medical managers, but the basis of their leadership is the fact that they are physicians rather than managers (Witman *et al.*, 2011).

These hybrid forms have effected an evolving new discourse on management/medicine, even though its managerial content is modest (Llewellyn, 2001) and managers who are physicians may take a modest mediatory stance towards managerial ideas and political reforms (Wallace *et al.*, 2011). The common denominator of these studies is the limited identity change among physicians. Physicians continued to be physicians but in new positions. However, there are also studies showing that physicians can creatively reconstruct managerial discourses and technologies in ways that benefit medicine, management and patients (Levay and Waks, 2009), but it is done by affirming the physicians' primary identity while incorporating management as a trivial subset of skills that physicians already possess (Hotho, 2008; Spyridonidis *et al.*, 2014). However, any reconstruction of identity is a two-way flow involving both changing discourses and physicians adaptive to identity change (Kreindler *et al.*, 2014).

Culture and discourse as identity resources and constraints

Identity is defined here as an ongoing, social construction of the self (Andersson, 2012). Thus, although identity is fluid and temporal, it is not directionless (Watson and Harris, 1999). This emphasizes self-awareness in the identity processes (Alvesson and Willmott, 2002), which originates in Giddens' (1991) concept of self-identity. The construction of identities is a continuous process of referring to different social systems of meaning (cultures) that we relate to (identify with) or that we de-identify from (Czarniawska, 2002). The process of establishing identities is an ongoing process of defining who we are similar to and not. That is, different cultures are either brought to us as something we relate to (identity), or something we *de*-identify *from* (alterity).

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Consequently, cultures we do not relate to ("I am not like that") are just as important as cultures we relate to when constructing our identities. Identity work thereby constitutes ongoing implicit dialogues on whether "Who am I?" "Who do I want to be?" "Who am I like?" and "Who am I not like?" are related to each other (Andersson, 2010).

Different cultures are concerned with systems of meaning and taken-for-granted assumptions (Alvesson, 2004). Any groups in society with a shared history that spend enough time interacting can share cultural values (Schein, 1990). The most used term is organizational culture, but because health-care organizations are characterized by professionals who tend to identify more with their profession than their organization (Wallace, 1995), organizational cultures within healthcare tend to be rather undeveloped. In other words, as professional cultures create shared values, it also implies that health-care organizations tend to be different worlds/cultures (Glouberman and Mintzberg, 2001).

Cultures provide social identities, which can be seen as templates for whom to be or to become (Watson, 2001). Different cultures might be related to different professions, and each of these cultures provides images on how to be. Furthermore, discourse can be seen as a cultural resource, as it consists of a set of statements, concepts, terms and expressions, which constitutes a way of talking and writing about a particular issue (Watson, 2001). Different discourses then frame people's understanding and action related to the certain discourse. However, there are also interactive effects between culture and discourse, which means that discourse, on the one hand, can be seen as "culture-in-action", but, on the other hand, as the main medium where cultures are constructed, reproduced and changed (Alvesson, 2004).

Managers/physicians are no different from anyone else in that they use different discourses to make sense of themselves (Alvesson and Sveningsson, 2003; Sveningsson and Alvesson, 2003). These different discourses become discursive resources in identity formations, but at the same time, the discourses constrain what managers/physicians can "be" – there is a mixture of choice and constraint (Watson, 2001). In this consideration of discourse, I take both interpretative and critical approaches to identity formation (Alvesson *et al.*, 2008). The interpretative approach highlights the agency in the identity process, whereas the critical approach recognizes that the essential power of discourse is its frequent "taken-for-granted-ness", providing us with model selves, such as the "good manager" or the "good physician". These model selves may appear at both the macro and micro levels of discourse (Watson, 2008): at the macro level, for example, more generic role categories are connected to a profession, but at the micro level, there might also be more local organizational expectations within the same profession. Agency/choice and constraint are manifested in processes of identity work and identity regulation, which represent two different roles discourses can have in the identity processes (Kuhn, 2006). Sveningsson and Alvesson (2003, p. 1,165) describe identity work as "forming, repairing, maintaining, strengthening or revising the constructions that are productive of a sense of coherence and distinctiveness". People frequently find themselves in complex and multifaceted situations that challenge their sense of a coherent identity (Collinson, 2003) and provoke identity work. Identity regulation, according to Alvesson and Willmott (2002), consists of the discursive practices that set the conditions of the identity processes. In short, while identity work means interpretative actions implying some form of agency, identity regulation means discourse which ties people to certain social structures using roles, scripts, etc. In

practice, these processes of identity work and identity regulation are intertwined and might be impossible to separate. Identity work means integration processes between self-identity and social identities, in which inward/internal self-reflection and outward/external engagement are joined (Watson, 2008).

In their many and varied discourses, people receive messages with conflicting ideals, norms and images of the world (Gergen, 1991). Physicians who are managers, typically participate in different "levels" of management discourses and different levels of professional discourses (Doolin, 2002; Pratt *et al.*, 2006), etc. Some professional discourses co-exist harmoniously with management discourses, while others directly conflict (Andersson, 2005). In their identity processes, therefore, physicians who are managers must adjust to shifting contexts even as they try to maintain different – and occasionally conflicting – commitments (Andersson, 2012). Managers/physicians struggle with these processes as they try to harmonize the different discourses and their conflicting demands and align them with their self-view (Alvesson, 2010).

Manager/physician identity

Physicians' discourse and managerial discourse imply very different model selves/social identities, which means that physicians who are managers might struggle to make internal peace with the multiple components of their selves and the claims of the different cultures to which they are connected (Andersson, 2012). This might also explain why previous research illustrates how physicians in leading positions tend to remain mainly physicians (Llewellyn, 2001; Baker and Denis, 2011; Witman *et al.*, 2011). It might simply be too hard to integrate or relate to the many different, and sometimes conflicting, demands.

Thunborg (1999) describes physician identity is set at three different levels. The first is the occupation-related level, implying that the basis of physicians' work is medical science which they should use to make competent medical decisions. Their decisions are made using their judgment, implying a high level of autonomy and individual responsibility. The second level is the activity-related level, which, on the one hand, focuses on differences in physicians' identities because of division into subspecialties, meaning variations in activities. However, similarities between subspecialties mean that physicians' activities are self-governed to a higher extent than in other professions. The third level is individual-related and concerns how far the physician has come in his/her career. The more experienced tend to be more involved in research, education and clinical development. Common to all three levels is the endeavour for professional fulfilment, which motivates physicians' engagement in both short- and long-term activities (Lindgren *et al.*, 2013).

An important trigger for identity reflection and struggle is mismatches between work and identity (Pratt *et al.*, 2006), that is, between what they do and who they are. "Cure" is the main logic in terms of what physicians do (Glouberman and Mintzberg, 2001). In other words, to improve the conditions of patients based on interventions, and ultimately to cure them. These medical interventions can be placed into four different groups: incursion, ingestion, manipulation and mediation (Glouberman and Mintzberg, 2001). They should be seen as a continuum from intrusive to interpretative. Incursion (e.g. cutting) is the most intrusive, but also best defined, whereas mediation (talking to the patient) is the most interpretative, but also the least defined. In between these two, there is ingestion (e.g. giving medicine) and manipulation (touching). Physicians

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themselves tend to regard the more interpretative interventions as unscientific, so there is a preference and status related to the more intrusive medical interventions, as science is the basis for the cure logic. This means an obvious identity conflict, physician vs manager identity, as the latter is often perceived as unscientific and political; the more intrusive the physician work, the more probable the identity conflict in relation to a manager identity.

The social identities of managers and physicians differ in many ways, but also a manager identity can be described with the previous described three levels. Regarding the occupational-related level, a manager is not a profession when it comes to certain educational requirements, license, etc. This makes managers' backgrounds and also identities less homogeneous. Regarding the activity level, managerial occupational identity (Sveningsson and Alvesson, 2003) often differs a lot from managerial work (Tengblad, 2012); that is, while the social identity is about rationality, strategy, analytical thinking, etc., the practices/activities of managerial work are often characterized by brevity, fragmentation and action. A managerial career often means "climbing the ladder" in the organizational structure. The basic logic of managers' work ethics is bureaucratic order, and this has successively emerged as the new power in healthcare, especially when administrators renamed themselves managers (Glouberman and Mintzberg, 2001). Managers should use the limited resources as effectively as possible to achieve the goals set by politicians for the hospital. The logic of control is based on an administrative hierarchy and containment. Managers can, on the whole, intervene by putting restrictions on (professional) activities, such as budget restrictions, number of beds, re-organizations etc.

The medical autonomy of physicians, which is one of the major characteristics of physicians as a profession (Abbott, 1988; Freidson, 2001), creates another difference in thinking. The physician professional culture is characterized by a belief in personal responsibility for decisions, which means that physicians think in terms of individuals (Bååthe and Norbäck, 2013), meaning that what happens in a health-care organization can be related to what specific individuals (physicians) have done. This can be contrasted with a manager, which is a position in a hierarchical, administrative system. The position does not exist without the organization as a system.

Physicians are known to resist threats to their identities, especially in relation to other professions (Abbott, 1988). However, identity threats can originate from anywhere, and the identity that physicians evoke to combat these threats can differ between different threats (Kreindler *et al.*, 2012). Even though medicine is normally heavily related to science, medicine can be claimed to be an art in relation to managerial pressure to comply with clinical practice guidelines and other rational measures (McDonald *et al.*, 2006). One reason why physicians so persistently resist threats to their identities is that being a physician is inevitably an elite identity. Elite identities create identity regulation processes, in which status anxiety creates reluctance to diverge to the ideal (Gill, 2015). Becoming a manager might be perceived as a threat to or a diversion from this elite identity. Taking a life cycle perspective, a lot has been invested in a physician's career, and because a manager's career is perceived as "another" career rather than a further career, it is a major step to take. On the other hand, in later years of practice, physicians become more involved in education and often support younger colleagues; thus, the interest in organizational development and leadership might arise (Clark *et al.*, 2008).

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The difference in social identities between manager and physician means identity struggles for a person occupying both, and it probably involves formation of multiple or multifaceted identities. The next section will deal with multifaceted identities and their connection to actions.

Multifaceted identities in action

Multifaceted identities do not pose a problem as long as they are separated, but what happens when multiple and perhaps contradictory identities are evoked at the same time? Multiple identities, of which some are contradictory, create ambiguity. Ambiguous situations are dealt with following a logic of appropriateness rather than a logic of rationality, according to March (1994). The logic of appropriateness is based upon the idea that the people in question are deemed to ask three implicit questions:

1. *The question of* recognition: What kind of situation is this?
2. *The question of* identity: What kind of person am I?
3. *The question of* rules: What does a person such as me do in a situation like this?

The process is not random, arbitrary or trivial, but systematic, reasoning and often complex. The first question describes a problem setting: trying to define a situation. Trying to define a situation is one of the basic aims of communication, so this definition is foremost done through communicating with oneself. The second and the third questions are both related to identity work. The second question could be interpreted as: which identit-*ies* have I established? The third question opens the way for dealing with multiple/multifaceted identities, as it implies defining oneself to different situations, that is, "choosing the appropriate identity for the situation". Consequently, the logic of appropriateness is based upon defining situations, defining oneself in relation to the situation and defining the rules in this identity – situation relation. The process is not sequential, but the questions are related to each other and are defined and re-defined in a complicated, intertwined and simultaneous process.

This logic of appropriateness (March, 1994) illustrates how processes of identity work, and identity regulation is happening all the time, while we are acting. It illustrates how identities influence action, but also how action forms, repairs, maintains and strengthens identities. It also illustrates how we allow external expectations (from professional, managerial and other discourses) to influence action. We define the boundaries of what is appropriate. We create rules and adopt rules, from our organizations, from our profession, etc. Rule-following might sound deterministic, but considering the complex processes by which both identities and rules are created, maintained, interpreted, changed, but also ignored, rule-following is far from deterministic or static; it is rather ambiguous and filled with uncertainty.

Not all parts of an individual's identities are available at the same time. Managers or physicians do not act like managers or physicians in all situations. Aspects of the self that are seen as central are more fully elaborated, whereas more peripheral aspects of the self are less elaborated, less frequently evoked and less burdened with requirements of consistency than the more central aspects. The pursuit of appropriateness involves experimentation with new identities, inconsistency and "self-discovery" (March, 1994).

March (1994) describes the interaction of four psychological mechanisms in noticing the relevance of identities or rules in situations. First, there is *experiential learning*. Individuals learn to evoke (or not to evoke) an identity in a situation by positive or

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negative experiences from the past. Identities connected with positive experiences are more likely to be evoked. Second, there is *categorization*. There are parts of the self that are more central and parts that are more peripheral. Identities that constitute conceptualizations of the more central parts of the self are likely to be evoked more frequently. The third is *recency*. Identities that have recently been evoked are likely to be evoked again. Finally, there is the *social context of others*. The real or "imagined" (through generalized others) presence of others highlights social definitions of identities.

The logic of appropriateness evokes different identities and different rules to different situations. However, identities are rarely precise; the same identity may evoke inconsistent rules as well. Consequently, there is an ambiguity *between* identities as well as *within* identities. To say that a physician/manager constitutes one identity would, therefore, be an over-simplification. The logic of appropriateness influences action, as it means that the manager/physician defines what actions are appropriate, in relation to identity, rules/roles and situation. Such coordinated behaviour emerged from subjective perceptions and preferences and is "negotiated" with explicit and implicit others, constituting social identities (Watson, 2008).

Method

This paper is based on data from four different qualitative case studies of healthcare performed in four different hospitals. All selected units were actively busy with organizational improvements, implying that both managerial and professional logics were in play, which was of importance to the study. Here, identity is defined as processual, relational and situational, which has implications for the choice of method. First, the processual aspect is emphasized through the longitudinal aspect of all the case studies, whereby different processes were followed for 1-3 years. Second, to consider the relational aspect of identity, interviews were not only performed with physicians who were managers but also with different health-care personnel (different professions, functions, peers, supervisors and subordinates) who worked together with these physicians/managers. Third, regarding the situational aspect, the goal was to collect in-depth, context-sensitive and rich stories. The interviews were also complemented with 11 observations during different types of meetings involving both managers and physicians. The observations were primarily used as the sources of input for the interviews. This was another strategy when considering the situational character of identity, as the interviews could concern issues from the observations. Furthermore, it kept the interviewees focused on their own experiences, without digressing into their "theories" on how things "should" be. A total of 52 interviews were held, of which, 20 were with physicians and 18 were with managers. Ten of them were physician managers. The interviews were semi-structured with open-ended questions. The aim of the interviews with managers and physicians was to collect narratives on "who they were", "who they wanted to be" and "the expectations of whom they should be", as well as how they related this to their work and their relationships to others. All interviews were recorded and transcribed. They varied in length from 30 minutes to 1.5 hours.

The first step in the analysis was to select all the different expressions of physician and manager identities, which were then applied to the more overall framework of cultures and discourses as providers of social identities that people relate to. With these two descriptions of social identities in hand, special attention was given to situations and narratives where the two social identities met in different ways, mainly through the

physician managers' own struggles to make sense of their two identities and their work, as well as through both the physicians and managers relating to other people. This second step in the analysis resulted in three main categories that best described and explained the struggles between the two identities. These were called "Being part of the organizational system or a free agent within it", "Balancing incompatible identities" and "Manager as anti-identity to physician". This second stage of analysis was more of an interplay between the empirical material and the overall theoretical framework, whereupon these were gradually refined. In the third part of the analysis, the more specific theoretical framework on multifaceted identities in action was used to analyse actions, either described in interviews or observed in observations, to understand how these identities influenced actions.

Results: identity struggles of physicians who are managers

In this part, identity challenges relevant to medical leadership are described. The material illustrates identity struggles of physicians who are managers, constituted by the two different social identities. Furthermore, it shows how these identity processes influence action and, thereby, constitute prerequisites for medical leadership.

Being part of the organizational system or a free agent within it. It is not at all a self-evident career step for a physician to go into a leading administrative position. Compared to a traditional managerial career, which means increased influence, increase power, etc., a physician following a managerial career does not necessarily experience an increase in influence. Some physicians described how they have focused on development issues since their first day as a physician and have always initiated and been involved in different development projects. Not only medical and technical development projects but also organizational development project. However, becoming a manager did not always mean a better chance to work with these issues:

> Then [when becoming manager] I got assignments […] I should do that and that, and then report. I was clearly a subordinate even though I was then head of development. As a physician I could initiate any development project I thought was urgent and important, so my opportunities to influence were better as a physician than as a manager (Pulmonary medicine physician/manager).

The physician identity is very much about autonomy, which is almost opposite to the managerial identity. A manager is a position in an administrative system that is built upon top-down hierarchies. You are very clearly part of a system, or even a subordinate in a system, while as a physician you are more of a free agent within the system. Those physicians who want to influence, a managerial career is not necessarily the best way.

The administrative logic can be seen as a managerial logic and will, thus, be part of the culture and discourse connected to manager identity. There are other more important cultures that physicians can to relate to:

> Well, normally I present myself as a physician, but I only mention where I work [hospital X] […] if someone asks. The important thing is that I am a physician. That means comradeship and loyalty. I can use my free time to help a colleague at another hospital. We physicians do that. We can go through a lot of inconvenience to help a colleague with a patient (Paediatrician A/non-manager).

All physicians in the main, independently of being managers or not, seem to be more strongly related to the professional culture of being a physician than to any form of

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organizational culture. Identity templates of being a physician are consequently more natural to elaborate and are more deeply rooted in the identity process. The quotation above illustrates identification with a system that goes beyond the organization; a system that is held together by comradeship and loyalty (and probably by shared values, experiences, knowledge base, practice and education). Independently of whether the above is "true" or not, it is a part of the professional discourse and, thereby, influences social identities.

Balancing incompatible identities. Identities do not only influence how people do things, they also create boundaries for what people "should" do or not do:

> I have worked here as a physician for almost 30 years, and I didn't have a clue that we had people employed for organizational improvement. Seriously! And I think I am a rather typical physician. It is simply not something that we [physicians] see as part of our job. It's now, on becoming a manager, that I have noticed there are improvement projects going on at the hospital that are not directly medically related (Surgeon/manager).

There do not seem to be many areas where the two identities, i.e. manager and physician, intertwine. Physicians tend to define non-physician responsibilities as manager responsibilities:

> Organizational improvements? Of course not, those are not my responsibilities. They can't steal time from patients. Let managers do that (Paediatrician B/non-manager).

This is not something unique to physicians. Different health-care professions in the study seem to explicitly or implicitly define "organizational issues" as beyond their scope of work and, thereby, a managerial responsibility. However, it is most obvious among physicians.

For physicians who are managers, this means a careful balancing of the two discourses and the two identities. Physicians need to navigate very carefully, not to lose credibility as physicians if they act "too managerial":

> I think I provoked people more during the first years I was manager. I thought I had "seen the light" through improvement science and I wanted to implement my ideas, I directed people too much. Especially my physician colleagues reacted in a sour manner. Several times I heard "I don't have time for this crap, I need to take care of my patients". Now I have taken a few steps back and talk to my physicianal colleagues as colleagues. I think I have re-gained some of my influence, a strategy of "help it happen" has worked better than one of "make it happen" (Pulmonary medicine physician, development manager).

Manager as anti-identity to physician. For physicians, it is not only that physician and manager identities seldom intertwine, they are almost opposite to each other. When describing what a physician "should do", physicians often describe it in conflict with managerial intentions; that is, a manager's identity is a sort of anti-identity to a physician's identity:

> Managers sometimes present directives on how we [physicians] should do things. Most often their directions don't agree with how patient work should be done. So we just don't do it then, we don't argue about it, it's easier just to ignore it. The important thing is our responsibility to the patient (Physician internal medicine/non-manager).

Furthermore, considering that physicians' professional discourse has, to some extent, made a manager appear as an anti-identity to physician, it seems also important as a physician not to strive for a manager position. Common for most physician managers in

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the study is that they never present a will to become appointed manager. Instead, they describe it either as a coincidence or as "sacrificing" themselves because "others" wanted them to do it. Independent of whether this is "true" in an objective sense or not, it illustrates how important it is for a physician not to appear to aspire for a managerial position. Otherwise, they probably risk their credibility as a physician.

A thought-provoking indication in the material is that when physicians describe situations with well-functioning medical leadership, the situations often mean that physicians have influence, but are not managers. Medical leadership most often implies that physicians take leading positions, but considering that leadership is a process of influence in a relationship, the physician does perhaps not need to be a manager to ensure medical leadership. A physician collaborating closely with a non-physician manager might be a solution that evokes less identity conflicts.

Analysis: physician/manager identities in action

March's (1994) four psychological mechanisms (experiential learning, categorization, recency and social context of others) interrelate and influence people's perception of relevant identities/rules in situations of ambiguity and conflicting demands. In this section, these are used to illustrate how physicians in leading positions tend to act in different situations.

Experiential learning. Individuals learn to evoke (or not to evoke) an identity in a situation by positive or negative experiences from the past. Physicians who are managers tend to have more positive experiences related to the physician identity, also when acting as managers:

> I have learnt that the other physicians listen to me because I am a physician, not because I am a manager. Or rather, they might listen to me despite the fact that I am manager, since I am a physician. Being a physician is my source of influence and it puzzles me how nurses who are managers can influence physicians, but perhaps they simply can't (Surgeon/manager).

To further my point: it is never wrong to be a physician in a health-care organization, independent of situation, but it is often wrong to be a manager. It is easy to understand why physicians who are managers frequently evoke the physician identity also when performing management tasks, as it is their main source of influence.

Categorization. Identities that constitute conceptualizations of the more central parts of the self are likely to be evoked more frequently than parts that are more peripheral. Physicians who are managers have been physicians longer than they have been managers, their education is to be physicians and being a physician is often a very important part of their self-description:

> I trained to become a physician. Manager […] I was appointed manager, and I still don't know what it means (laughter). I love being a physician, so I want to have autonomous subordinates who enable me to be a physician as much time as possible (Neurologist, manager).

This confirms a general theme among studies of professionals: the more dearly you hold an identity, the more likely it is to be evoked. One reason is that physicians have invested much more in their physician identity than in their manager identity, so a life cycle perspective tends to explain the path-dependency (McSherry, 1981).

Recency. Identities that have recently been evoked are likely to be evoked again. Physicians never stop being physicians, and they tend to be approached as physicians also when being managers:

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> We have many different relationships, but I mostly seek him as a physician. I need his clinical advice more often than his managerial advice (Nurse/non-manager about her manager/physician).

To be approached as a physician frequently means that it is more likely to evoke a physician identity.

The social context of others. The social context of others influences our identity, directly and indirectly. We are sensitive to other people's expectations of who we should be and how we should act. We also tend to take in imagined reactions of others, also when they are not present. Identity is inevitably relational, as our identities are constructed in negotiating with others' direct or indirect expectations. This is exemplified by a nurse who talks about which managers she trusts:

> Well, he's a manager, but foremost he is a neurologist, so he understands what this is about (Nurse/non-manager).

It is obviously easier to trust a good physician than a good manager, which a physician who is a manager probably experiences in relationships with peers and subordinates. We also tend to perceive some contexts as more important than others, so which people constitute an important social context is essential as well:

> What really counts is acknowledgement from the physician community. To be noticed as a physician is something that goes beyond the hospital. That other physicians are impressed by something you have accomplished, that is as good as it gets (Paediatrician A/non-manager).

It does matter that physicians are more strongly related to their profession than their organization, particularly because manager is an organizational position, whereas physician goes beyond the organization. Or put differently, for physicians who are managers, manager is a nested identity and physician is a cross-cutting identity (Spyridonidis *et al.*, 2014).

Discussion

This study illustrates that medical leadership, implying physicians in leading positions, means several identity challenges. Culture and discourse put different pressures on physicians and managers, which means that the social identities of managers and physicians have very different characteristics. A further challenge is to align the work with the identities (Pratt *et al.*, 2006). Being both manager and physician implies identity struggles, and a lot of ambiguity is set by the different external demands. In this study, these struggles are described in terms of how physician managers balance these often incompatible identities. Major differences are related to physicians as autonomous individuals within a system and managers as subordinates of the same organizational system, as well as to differences in status and educational background. The study shows that even though physician managers might succeed in balancing their identities, the two identities are never equal; physician is a cross-cutting identity that goes beyond the organization (Spyridonidis *et al.*, 2014), and manager is a nested identity in the organization, which physicians can "try on" to see whether it fits (Ferlie *et al.*, 2012). An important contribution of this study is that it illustrates how psychological mechanisms (March, 1994) evoke physician identities more often than manager identities among physician managers, which explains why physicians who are managers tend to remain foremost physicians (Llewellyn, 2001; Baker and Denis, 2011; Witman *et al.*, 2011).

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Managers even seem to be somewhat of an anti-identity or alterity (Czarniawska, 2002) to physicians, which means that physicians who are managers must balance carefully the two discourses and two identities not to lose credibility as physicians. This pressure from the professional discourse of physicians (Pratt *et al.*, 2006) is manifested in a strategy among physicians not to appear to strive for managerial positions. Regarding those who have been appointed managers, they emphasize that it was a coincidence that they became a manager or that "others" convinced them to take the position (despite their unwillingness). This illustrates the relational aspect of identity (Gergen, 1991), in how other people influence individuals' identity processes, not only in terms of individual–individual relationships but also in relation to discourses/cultures. There are both choices and constraints related to identity processes (Watson, 2001). The "taken-for-granted-ness" of discourse and culture tends to make social identities of physicians so self-evident that physicians are unaware of their influence on them and how it makes it harder to elaborate a manager identity.

There are important practical implications of this study. First, considering the major identity challenges that physicians in leading positions imply, there might be reasons to doubt whether medical leadership is best performed by physicians in manager positions. Most obviously physicians must be involved in the way things are run in hospitals, but to reduce identity challenges, this involvement could take place through cooperative relationships between physicians and non-physician managers (mainly nurses). Nurses especially tend to see a managerial career as an alternative career (Berg and Byrkjeflot, 2014), and a nurse identity is more compatible with a manager identity (Blomgren, 2003). However, other challenges are evoked by the complexity of healthcare, manifested in the different worlds/cultures of healthcare (Glouberman and Mintzberg, 2001), as well as differences in power that might make it hard to develop reciprocal relationships. Second, independent of physicians or non-physicians as managers, medical leadership is not only a question of structure (appointing physicians into formal positions in the administrative hierarchy) or skills (training programmes for health-care professionals as managers). Attaining medical leadership inevitably means addressing identity issues. This could be a theme in training programmes. For example, the self-awareness tool in LEADS is a promising initiative. Medical leadership is dependent on identities that allow both claiming and granting influence (DeRue and Ashford, 2010). In other words, the major challenge for physicians might be identities that allow them to claim influence in managerial issues, as well as to grant others to have influence on them. Constructing identities that support medical leadership requires efforts by both physicians and people around them (Spyridonidis *et al.*, 2014).

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Corresponding author
Thomas Andersson can be contacted at: thomas.andersson@his.se

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