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Abstract

Purpose – The purpose of this paper is to uncover paradoxes emerging from physicians' experiences of a patient-centered and team-based ward round, in an internal medicine department.

Design/methodology/approach – Abductive reasoning relates empirical material to complex responsive processes theory in a dialectical process to further understandings.

Findings – This paper found the response from physicians, to a patient-centered and team-based ward round, related to whether the new demands challenged or confirmed individual physician's professional identity. Two empirically divergent perspectives on enacting the role of physician during ward round emerged: We-perspective and I-perspective, based on where the physician's professional identity was centered. Physicians with more of an I-perspective experienced challenges with the new round, while physicians with more of a We-perspective experienced alignment with their professional identity and embraced the new round. When identity is challenged, anxiety is aroused, and if anxiety is not catered to, then resistance is likely to follow and changes are likely to be hampered.

Practical implications – For change processes affecting physicians' professional identity, it is important for managers and change leaders to acknowledge paradox and find a balance between new knowledge that needs to be learnt and who the physician is becoming in this new procedure.

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Originality/value – This paper provides increased understanding about how physicians' professional identity is interacting with a patient-centered ward round. It adds to the knowledge about developing health care in line with recent societal requests and with sustainable physician engagement.

Keywords Change, Complexity, Physicians, Professional identity, Patient-centered, Ward-round, Team-based, Bio-medical, Paradox, Complex responsive processes

Paper type Research paper

Introduction

Meeting the needs and preferences of patients has increasingly become an explicit aspect of health system policy and performance. The World Health Organization (WHO) has patient-centeredness as an aim for high-performing health systems (World Health Organization, 2000). The US Institute of Medicine (IOM) included patient-centeredness as one of the six core aims for future health-care systems (Institute of Medicine Committee on Quality of Health Care, 2001). The Organization for Economic Cooperation and Development (OECD) stated that quality health care should produce outcomes that patients' desire and individuals will vary in their preference for different treatment options (Hurst and Kelley, 2006). Sweden has had patient-centeredness as a policy aim for many years; however, research addressing patient-centeredness and patient-involvement comparing 11 countries indicated that there is potential for progress in this area (Schoen *et al.*, 2011, Osborn *et al.*, 2014).

There is no global consensus definition, but to act in a patient-centered way, health professionals need to have more focus on "life over disease", compared to a more traditional bio-medical focus of "disease over life" (Zoffmann and Kirkevold, 2005). The concept of patient-centeredness may also be understood by underlining that it is not physician-centered, hospital-centered, technology-centered or disease-centered (Stewart, 2001). The essence is about changing the physician's question to the patient from "What is the matter with you?" to "What matters to you?" (Bisognango, 2012).

The University of Gothenburg Centre for Person-Centered care asserts that patients are persons who should not be reduced to their disease alone (Ekman *et al.*, 2011), instead their experiences, goals, desires and life-situations should be taken into account, and health care should shift away from models where patients are passive targets of bio-medical interventions toward a model where patients are involved as active partners in the care and cure process. This article considers both terms' valuable but will use patient-centeredness going forward.

With the specialization of skills and increasing complexity of care, smoothly functioning multi-disciplinary teams are needed to reliably deliver the best possible patient care (Institute of Medicine Committee on Quality of Health Care, 2001, Weller *et al.*, 2014). Weller *et al.* (2014) stated that team orientation is the willingness to also take others' ideas and perspectives into account and a shared belief that the team's goals (centered on what is best for the patient) are more important than any individual's goals.

Focusing on the basic mechanism of disease and pathophysiological principles is part of a long and successful bio-medical orientation (Institute of Medicine Committee on Quality of Health Care, 2001). However, a global independent commission reviewing the status of post-secondary professional education in health (medicine, public health and nursing) concluded that there is a mismatch between professionals' competences, patient and population priorities and twenty-first-century needs (Frenk *et al.*, 2010). Patient-centeredness and working in teams were stated as central capacities to

complement traditional health professional identities (Horton, 2010, Royal College of Physicians, 2012).

Team-based care and patient-centered care are aspects of twenty-first-century health care as outlined by the world federation of medical education (Gordon and Karle, 2012), as well as the Lancet global review of medical education (Frenk *et al.*, 2010). Kirkpatrick and colleagues suggest that many agree to this in theory, while there is limited knowledge about actually applying these principles to central care processes, like the ward round. Ward rounds are said to deserve the same focused attention as the most expensive technology or complex drug treatment (Caldwell, 2013).

Baathe *et al.* (2014) reported physicians' experiences from patient-centered and team-based rounding. They concluded that patient-centered and team-based ward rounding appeared to be a fertile development journey. However, they also reported paradoxical findings and stated more contextual research was needed. The need for contextuality was also emphasized by Snell *et al.* (2011), who argued for more research with a clinical focus to better understand the needs and wants of physicians. A Cochrane review, including two round studies, concluded that studies with qualitative methods were recommended to provide further insights (Zwarenstein *et al.*, 2009).

As described previously, many institutions seem to be in consensus about the need to evolve healthcare toward increased patient-centeredness and teamwork. There is, however, limited understanding of how patient-centered care models interact with physicians' professional identity. This study will respond to this gap by taking its point of departure in physicians' experiences of a patient-centered and team-based ward round.

The aim of this study was to uncover paradoxes emerging from physicians' experiences of a patient-centered and team-based ward round and relate empirical findings to the theory of *complex responsive processes* to further understandings.

Methods

Setting

The setting for this study was an internal medicine department at a mid-size emergency hospital in west Sweden. The hospital provided specialist care in general and orthopedic surgery, internal medicine, geriatrics and psychiatric care, with a total of 200 beds, 1,500 employees and care responsibility for an area with 118,000 citizens. The department had about 140 employees, about 4,000 inpatients a year, whereof about 85 per cent were admitted via the emergency. The internal medicine department catered for both emergency and chronic patients with a spectrum of diseases related to hormone-based, intestinal, hematology, cardiac and pulmonary disorders. The department was divided into two wards with 25 beds each, with an average length of stay around four days. Each ward had three single rooms available for the most critically ill patients and three rooms with double occupancy. The remaining beds were available in four-bed ward rooms. The ward patients were equally divided between men and women with an average age of 67 years old.

This study was based on empirical data from interviews with physicians experiencing working in a new patient-centered and team-based ward round. The new round originated from conversations among the professional groups at the internal medicine department. The initiative was supported by the head of the department and handled by internal staff without extra resources. The new round had three principles:

(1) increasing patient integrity;
(2) minimizing information-handovers; and
(3) finalizing all possible tasks related to each patient.

Rounding went from loosely structured, where traditionally each individual physician decided how to round, to a defined team-based work plan. Table I (below) outlines key differences comparing the new round with the previous, more traditional, ward round. Physician experiences from the new ward round is reported in a previous article (Baathe *et al.*, 2014).

Data collection

Interviews were used to understand the world as experienced by the physicians (Kvale and Brinkmann, 2009). A purposeful heterogeneity sampling (Patton, 2002) was used to find information richness and diversity in physician voices. Selection criteria were physician seniority, gender and both positive and negative attitude toward the new round. Interviewees were organized in cooperation with an administrator at the medical department. The interview guide was semi-structured and had open-ended questions to allow probing into aspects that emerged during the interview (DiCicco-Bloom and Crabtree, 2006). The translated interview guide is available as an Appendix to this paper. All interviews were conducted face-to-face using local conference room facilities on the hospital site and were digitally recorded. In all, 13 physicians from the internal medicine department were interviewed (average time span about 80 min). Six were experienced physicians (three male and three female consultants), three were physicians in specialist training (three female residents) and four were junior physicians (two male and two female interns).

Analysis

The analytical process followed principles for qualitative analysis as outlined by Miles and Huberman (1994). The interview material was transcribed verbatim, and each interview was read with a focus on physician experiences when working according to the new round. Empirical dimensions where formed within each interview transcript and each interview was condensed. Thereafter, similarities across different interviews

	New round	Previous round
Structure	Pre-defined work plan, same structure for all	Undefined, senior physicians had individual structure and style
Team	Senior physician, physician, nurse, assistant nurse	Senior physician, alone or together with other staff
Round frequency	Need-based, for a special cause	Everyday
Location	Room reserved for rounding	Four-bedded ward room
Patient position	Sitting in a chair (80 % of patients)	Lying in bed
Physician position	Sitting in a chair	Standing next to bed
Documentation	Team documentation, physician was responsible	Each health professional was responsible for own documentation
Office space	Team was sharing one office	Separate offices; physicians in one, nurses + ass-nurses in another

Table I. The new ward round compared to the previous round

were considered and similarities were combined into empirical themes. In our previously published paper, these empirical themes were presented, and we suggested future research to further explore surprising findings with very different responses from equally experienced senior physicians to the new ward round (Baathe *et al.*, 2014). This paper investigates those empirical findings further by the use of abductive analysis. Coffey and Atkinson (1996, p. 156) suggest:

> We identify a particular phenomenon – a surprising or anomalous finding, perhaps. We then try to account for that phenomenon by relating it to broader concepts/[…]/In other words, abductive inferences seek to go beyond the data themselves, to locate them in explanatory or interpretative frameworks.

Abductive analysis creates an interactive dynamics between empirical material and theory, striving for increased understanding (Coffey and Atkinson, 1996, Alvesson and Sköldberg, 2008). While many management theories consider paradox as an anomaly that managers should strive to eradicate, the theory used, complex responsive processes (Stacey, 2011), consider paradox a natural dimension of any organization. This specific theory will be introduced more in detail below.

To cater to a multi-faceted interpretation of the empirical data, the analytical process involved a transdisciplinary team of four senior researchers, in addition to the first author. Each of them read selected interviews and participated in face-to-face meetings in the above-described iterative process. Emerging dimensions and themes were presented and challenged until a negotiated consensus was reached about the interpretation of empirical material. The group of researchers had complementary experiences. One experienced physician who was also associate professor in medicine, one experienced nurse who was also professor in health-care pedagogics, one PhD and senior lecturer in health-care pedagogics and one professor in business administration with experience from health-care research. The first author was a doctoral candidate in medicine with management experience from health care and high-tech industry, trained in group relations theory and educational background from industrial engineering and management. Members of the research team had extensive experience of qualitative analysis.

Ethics

In this study, health-care professionals were interviewed. The risk for harm to participating physicians was low, and thus, the project did not meet the criteria justifying an application to the ethical board, according to the Swedish law concerning ethical application for research relating to humans (Act 2003, p. 460). Ethical demands for qualitative research, informed consent, confidentiality, the consequences of the study and role of the researchers, have been considered and followed.

Complex responsive processes – a recent theoretical construct

Many traditional managerial models and theories are based on reductionistic and mechanistic theories, where planning, control, certainty and predictability have been the central aspects (Sandberg and Targama, 2007; Burnes, 2009; Capra and Luigi Luisi, 2014). Complexity science has introduced the science of uncertainty, where the unpredictable nature of human organizations has been a definitional prerequisite (Capra and Luigi Luisi, 2014). Complexity science has attracted health-care practitioners and researchers (Institute of Medicine Committee on Quality of Health Care, 2001; Plsek and

Greenhalgh, 2001; Glouberman and Zimmerman, 2002; Crabtree *et al.*, 2011; Sturmberg, 2014). The theory of complex responsive processes (Stacey, 2011) explores the ways of understanding actions by human beings in organizations. Stacey (2011) has in his theory interpreted findings from complexity science with the help of pragmatic philosophy, social psychology and process psychology. In particular, he is drawing on George Herbert Mead and Norbert Elias. It can be noted that identity is a foundational aspect in the theory of complex responsive processes. Dickson (2012, p. 7) working to form a research-based framework about physician engagement considered an organic complex system perspective most relevant. He suggested that the theory of complex responsive processes could be "an appropriate lens to apply".

Conversations paradoxically being the foundation for organizational continuity and change

Complex responsive processes regard organizations as patterns of conversation between interdependent individuals and place much emphasis on paradox as something normal and inevitable. The individual and the group are paradoxically formed by and forming each other, at the same time. Organizational members have the possibility to include their own intentionality when responding to a proposed change. Attention is focused on the interplay between individual intentions and organizational intentions and the often complex and unexpected patterning from such responses, sometimes called the interplay of intentions. Small adjustments in conversation patterns can escalate and produce astonishing and unpredicted results, also affecting power relationships, individual and collective identities.

The paradox of simultaneous predictability and unpredictability

Particularly important for the study of life in organizations is the paradox of simultaneous predictability and unpredictability. Stacey (2011) states that contradictions, tensions and dilemmas are recognized by many management theories but that they are mostly seen as resolvable. Many management theories see the resolving of paradoxes as the purpose of management. This is a major difference compared to the theory of complex responsive processes, where paradox is seen as a part of life in organizations and, as such, needs to be coped with. Paradox according to complex responsive processes cannot be resolved or harmonized, only endlessly transformed.

Organizations are fundamentally about the identities of people

Stacey (2011) asserts that organizations and their strategies are fundamentally about the identities of people and that identities are shaped and reshaped through everyday human interaction. Stacey argues that the "dominant discourse", where people claim to be independent autonomous individuals, is a fiction because human beings are always fundamentally and inescapably interdependent. Through this change, he claims that complex responsive processes leads away from all individual-centered theories and, instead, understands individual selves as being thoroughly social, formed by social interaction, which they themselves form at the same time. In the theory of complex responsive processes, human interaction is perpetually constructing the future as the known-unknown, that is, as continuity and potential transformation at the same time. This is defined as a paradoxical theory of causality, and what is being perpetually constructed as continuity and potential transformation is human identity (Stacey, 2011).

Change impacts identities which may cause anxiety

Stacey (2011) stresses that an organization is about evolving identities and that the theory of complex responsive processes sees human identity as having two inseparably interwoven aspects: the individual and the collective identity. Change in organizations involves deeply personal change for individual members. In any change process, new ways of talking publicly are reflected in new ways of individuals making sense of themselves, and such shifts unsettle the way in which people experience themselves.

The experience of relating not only is expressed in vocal public conversations between people but also resonates with, and affects, the silent, private conversations that are thoughts or individual minds (Stacey, 2011). During periods of change, anxiety is seen as an inevitable companion, as uncertainty is created, in particular uncertainty about individual and collective identities. It is important to understand what enables persons to live with that anxiety, so that they can experience excitement and get energy from the new structures. This energy is essential to facilitate the struggle with the search for new meaning and revised identity.

The theory of complex responsive processes focuses attention on the importance of fluid conversations to enable people to search for new meaning (Stacey, 2011). Without these shifting patterns of conversation which give rise to anxiety, there would be no change, no emergence of innovation and new ways of relating. Trust between those engaged in difficult conversations is central to handling the anxiety that change generates.

The radical difference compared to other theories of organization

Stacey (2011) argues that perhaps the biggest and most radical difference to most other theories of organization is the major limit to certainty and predictability of the long-term evolution of organization that the complex responsive processes theory points to. Surprise is inevitable no matter how well-informed, competent and well-behaved people are, as surprise is part of the internal dynamics of complex responsive processes themselves. It is thus quite natural for a person to not always know in advance what result a decision will lead to. The resulting potential feelings of incompetence and shame that this might arouse do not have to incapacitate one.

Findings

Two empirically divergent physician perspectives emerged when analyzing the interviews. The naming of each perspective was derived from where the physician's role was centered during ward rounding. One perspective was called the *We-perspective* and the other the *I-perspective*. These two perspectives are outlined in Table II.

Reality is of course much more intertwined, complex and multi-faceted than these two perspectives can do justice to, and it was clear that the *We-perspective* and the *I-perspective* were not dichotomous phenomena but opposing perspectives on a continuum. Some of the physicians interviewed were in a dialectic motion seeming to alternate between the two perspectives, and others were more firmly rooted in one perspective. However, for the benefit of a temporal theoretical clarity, we concluded on the dichotomous presentation format in Table II.

The paradoxical findings with two different understandings of the professional role as physician present at the same medical ward by physicians from the same medical specialty was further understood by the abductive analysis using complex response

We-perspective	I-perspective
The nucleus of this perspective was the personal experience that working closely with other care professionals reduced the risk of errors for the individual physician in charge. Teamwork was experienced as contributing to increased care quality. "We" was central in this perspective When doing the ward round, the importance of gathering knowledge about the patient by conversing with the patient was emphasized. The anamnesis was central, and pre-understandings gained from reading available medical records were seen as potentially distracting, preventing full attention during the conversation with the patient. The presence of nurses and assistant nurses during the patient conversation enabling them to also contribute their knowledge about the patient, facilitated for the physician to make accurate diagnosis and treatment decisions. Complementary knowledge from other care professionals was seen as most beneficial when the patient was a complexly fragile multi-sick person The care plan strove toward balancing optimization and satisfaction. Optimization was based on objective evidence-based guidelines and best practice. Satisfaction was based on the more subjective goals as expressed by the patient. It was seen as important to integrate the goals and needs formulated by the patient into the mutual care planning processes Physicians usually appreciated sharing office space with other care professionals since although it was "noisier", sitting together allowed unclear statements and wording to be clarified in real time, thus reducing the incidence of unclear diagnostic decisions, care plans and treatments	The nucleus of this perspective was physicians' experience that responsibility and potential problems were centered on the individual physician. Control was emphasized. To be seen as an expert with responses to "all" questions was a driver. "I" was central in this perspective When doing the ward round thorough preparation in advance was emphasized. The expectation was that the individual physician should go through the available medical records before meeting the patient. The aim was to establish a working hypothesis with the help of this information. During the patient conversation, the hypothesis was tested via questions to the patient, to come up with a confirmed diagnosis and related treatment decision. Nurses and assistant nurses could also provide information about the patient, but in the end, it was the physician who needed to come up with a diagnosis and also to be responsible if anything went wrong on account of the diagnosis and decisions about treatment Care planning was primarily undertaken in line with evidence-based guidelines and best practice. There was a striving towards an objective optimization of the patient based on recent advances in bio-medical sciences. The patient's more subjective perspective was seen as interesting but subordinate to the bio-medical aspects Physicians did not appreciate sharing office space with nurses and assistant nurses, although to have easy access to them was appreciated. However, this arrangement did not conform to the need for quiet times when preparing before the round, and it did not cater to any quiet times for pondering patient issues after the round. If necessary to share office space, then it would be better to share it with other physicians to be able to discuss diagnostic challenges and treatment alternatives

Table II.
The We-perspective and the I-perspective

processes theory (Stacey, 2011). Complex responsive processes theory argues that paradox is natural in human organizations and considers the paradoxically different ways of working the ward round linked to professional identity. This theory considers identity based on the multi-faceted balance between personality, educational and clinical experiences and clinical role models. Different understandings of medical

practice are, thus, a result of individual interpretation of the many conversations, experiences and interactions that each physician has been through.

The internal medicine department in our empirical case, striving toward patient-centered and team-based ward rounds, would not be able to resolve this paradox, according to Stacey (2011), but should continuously work with it to endlessly transform the paradox. While many management theories would consider that there is an abundance of optimal resources to be hired, swiftly resolving the paradox, this is often not the case in clinical practice. The theory of complex responsive processes is firmly grounded in everyday localities and provides a more pragmatic analytical way forward. Stacey (2011) suggest that there is no quick and easy fix; however, there are more or less considerate ways to make progress. Managers paying attention to whether physicians to be hired share their vision of rounding, is one practical and considerate step, toward evolving the paradox.

A mutual aspect between the *We-* and the *I-perspectives* seems to be finding an individual way of rounding that reduces the risk of making mistakes. Risk mitigation and finding a round structure that reduced the risk for the patient, thus, seemed to be a mutual key driver. Both perspectives share the same end-goal, but the means of getting there is different. The first paragraph in Table II is condensed into the following two key sentences further clarifying this:

> The *We-perspective*: Reducing the risk of errors by involving others.
>
> The *I-perspective*: Reducing the risk of errors by working harder.

The *We-perspective* seemed to enact a professional identity that enabled physicians to assume their medical responsibility at the same time as tasks and functions could be managed by others. It is likely that a positive spiral comes into play, consisting of experiences that their own errors were reduced when working together in a team. This in turn reduced the risk of errors actually affecting the patient and, thus, also reduced the risk of having one's medical responsibility as physician questioned. In contrast, the *I-perspective* seems to have had the experiences that to handle medical responsibility, the individual physician needed to have personal control and do the ward round the way "I as physician" was used to. Physicians with an inclination toward the *I-perspective* are likely to have had limited individual experiences of working close with others contributing to better care. Instead, there seem to be experiences that if I work longer hours and harder, then I have better control and then I can reduce potential errors.

The second paragraph in Table II is condensed into the following two key sentences:

> The *We-perspective*: Conversing with the patient to establish a working relation, before reading medical records ("what matters to you?").
>
> The *I-perspective*: Reading medical records to establish a working hypothesis, before conversing with the patient ("what is the matter with you?").

When the historical power structures were changed, patients meeting the care team sitting in a chair instead of lying in bed, patients were starting to communicate more fluidly. While all physicians considered this beneficial, as it contributed toward a richer patient story, facilitating the diagnostic process, there were differences in focus between the two empirical perspectives. Physicians with a *We-perspective* emphasized the conversation with patients and actively worked to first meet the patient and stay

focused on that communication before looking into the medical records. However, physicians with an *I-perspective* focused on first reading available medical records to establish a working hypothesis, before conversing with the patient.

The third paragraph in Table II is condensed into the following two key sentences:

> The *We-perspective*: Balancing evidence-based optimization with patient expressed desires and goals.
>
> The *I-perspective*: Prioritizing evidence-based optimization over patient expressed desires and goals.

The two physician perspectives displayed different considerations relating to treatment and care-planning. The *We-perspective* seemed to adhere to a more comprehensive understanding of health care and was working toward balancing evidence-based guidelines with central concerns expressed by the patient. The *I-perspective* seemed to work more within a traditional bio-medical understanding of healthcare and was driving toward optimizing care plans based on evidence and guidelines, with limited responsiveness to input from the individual patient. Complex responsive processes theory concluded that humans are inherently complex and, thus, follow a non-linear logic and a transformative causality. This theory is implying that the two physician perspectives have different expectations about how predictable patient outcomes are considered, and this was affecting how physicians were working with patient treatments and care plans.

The fourth and final paragraph in Table II is condensed into the following two key sentences:

> The *We-perspective*: Increasing quality by interacting with other professionals.
>
> The *I-perspective*: Increasing quality by interacting with peers.

The drive toward increased quality and better patient care was a shared focus between the two outlined physician perspectives. Both perspectives aimed toward increasing quality, but the empirical material showed that different aspects were focused during ward-rounding to reach this shared goal. This was also manifested regarding localization. The *We-perspective* considered that sharing office together with other professionals was not easy; however, having the whole team responsible for "your" patients sitting together contributed toward reducing the incidence of unclear decisions, care plans and treatments. So the benefit from interacting with other professionals was considered more valuable than the loss of own pondering time. The *I-perspective* did not consider interactions with other professionals as important for increased care quality, and thus, it would be more beneficial to sit together with peers and further evolve the physician rule as expert. This is a parallel distinction as presented above when considering the first paragraph from Table II.

Discussion

Finding ways of working that are contributing toward reducing the risk of patient-related errors and striving toward improving the quality of care were of highest priority among the interviewed physicians, but ways-of-working toward this uniform aspiration was found to differ considerably between the empirically derived *We-perspective* and the *I-perspective*.

The two divergent physician perspectives found in the empirical analysis resonates with categories from Dall'Alba, who studied how individual physicians developed their understanding of medical praxis during their education (Dall'Alba, 2004; 2009). She concluded that there were large variations concerning how individuals understood their professional role as physician, and the individual understanding seemed not to undergo any transformative change. Dall'Alba (2009) presented six categories based on perception toward patients and toward the role as physician. These categories can be combined into two clusters: the traditional bio-medical understanding of the role as physician and a patient-centered understanding of the role. These two ways of understanding the role as physician have many similarities to the *We-* and *I-perspective* emerging from the empirical material. In line with Dall'Alba (2009), the *We-perspective* could be said to be more comprehensive than the *I-perspective*, as it added the patient-centered perspective to the bio-medical foundation.

All of the interviewed physicians experienced a reduction of their autonomy. As physicians' identity as autonomous decision-makers was being challenged, complex responsive processes theory (Stacey, 2011) suggests that all physicians were likely to experience anxiety; however, not all seemed to be affected. Physicians that had their rounding praxis for many years with an *I-perspective* had their professional identity challenged by the new ward round. Stacey (2011) suggests that this could lead to energy-draining experiences and underline that if a challenge to one's identity is not handled, then resistance toward that change is likely to follow. In a similar vein, Schein (2009) discussed that a person's doubtfulness about the possibility of living up to the new requirements does not trigger any extra energy, only resistance. Anxiety is a necessary ingredient to produce change; however, it is fundamental for anyone leading change to understand what it is that enables certain physicians to live with that anxiety, to facilitate for all physicians to experience excitement and energy to support them in the struggle toward a new meaning and a revised identity (Stacey, 2011). It is emphasized that managers need to create structures where individuals can have fluid conversations with peers to cope with anxiety and facilitate their transformation into an evolved identity. Lindgren *et al.* (2013) conclude that striving for professional fulfillment is a central motivational drive for physicians to engage in health-care development. Increased professional fulfillment from doing a better job as a physician in the new round are from the findings mostly seen among physicians with a *We-perspective*.

Individual physicians seemed to appreciate the new ward round when their own view about professional identity matched the view made explicit in the new round structure. When a physician's own perspective was not aligned with the new round structure, resistance and skepticism were shown. Stacey suggests that defensive routines and resistance are likely to be triggered when identity is challenged and that a change at the workplace, for example, altering the ward round, implies a deeply personal change for the individuals, affecting identity (Stacey, 2011). The level of anxiety for an individual physician is likely to be related to how much her/his professional identity needed to change. This is especially the case when changes reallocate authority and demand new competences and when people feel doubtful about whether or not they can live up to the new requirements (Kets de Vries and Miller, 1984, Schein, 2009). Thus, an over-arching principle about individual physicians' different response to the new round seems to be related to whether their professional identity was challenged or confirmed by the new round.

Kegan and Lahey (2009) suggested that many of the challenges faced today require something more than only incorporating new technical skills into the current mindset. While a novice surgeon can become sufficiently skilled following the predefined scripts and manuals to acquire needed "technical skills" without much mental growth, they also said that more complex challenges can only be met by transforming the current mindset into a more sophisticated stage of mental development. Dall'Alba (2009) relates a similar distinction and describes how physicians' professional development traditionally focused on epistemological aspects – adding "technical skills" – using the term from Kegan and Lahey. She states that the ontological aspect – physicians' ways of being and who one is becoming in a change process – also needs to be focused when physicians' role in healthcare is evolving.

In line with arguments by Greenhalgh *et al.* (2014), complex responsive processes (Stacey, 2011) points toward a potential paradoxical downside of evidence-based medicine. If physicians are trained to believe that medicine is primarily about causal relations, then there is a potential risk that the professional identity of a physician becomes more oriented toward mechanically following rules and algorithms than honing the life-long journey toward sound judgment (Wen and Kosowsky, 2013). Complex responsive processes theory (Stacey, 2011) stated that non-linear causality, surprise and unpredictability are always present in healthcare, when seen as a complex organization. Thus, evidence-based medicine is not enough, or maybe more adequately expressed, also needs to include the evidence from complexity sciences that surprise is inevitable no matter how well-informed, competent and well-behaved individual physicians are. Physicians' capacity to act in spite of the unknown, to still take responsibility for the consequences and to manage results to the best of their ability has always been and still is a critical quality that needs to be acknowledged and developed accordingly.

Patient-centeredness and working in teams are central capabilities for health professionals to integrate into their professional identities, moving forward (Frenk *et al.*, 2010). In Sweden, a new law was launched in 2015 to strengthen the position of the patient. The way the national associations of physicians will "publicly" talk about patient-centeredness will be affecting how this new law is taken up in the local conversation-based interactions, forming and evolving individual professional identity among Swedish physicians.

A challenge faced by physicians adhering to a more bio-medical *I-perspective* is that individual physicians had not previously experienced any need, internal or external, for changing their rounding praxis. In the wards, everyone was used to the situation where physician had her/his own way of rounding, and the other health professionals were capable of adapting to individual rounding styles. From the empirical material, there seemed to be no ongoing conversations between senior physicians about pros and cons relating to different ways of rounding. So until there was an explicit definition about how the round was to be carried out, there existed no benchmark or golden standard to compare individual variation against, and thus, the paradox about very different ways of rounding in the same ward was neither uncovered nor made visible. In line with complex responsive processes theory, we conclude that physicians' individual rounding praxis was not part of the local conversations between physicians, forming and re-forming identity.

Within complex responsive processes, moral and ethical aspects are the most important criteria for judging the quality of any action, according to Stacey (2011). The societal demand for increased patient-centeredness might also benefit from an examination of the political leaders' moral and ethical position. The finding in this study, that many physicians have a bio-medically oriented professional identity (*I-perspective*) resulting from historical educational structures and earlier societal demands, needs to be acknowledged to calibrate societal expectations about the pace of this transformation of physician professional identity toward a patient-centered *We-perspective*.

Study strengths and limitations

One of this study's strong points is the stringent use of a qualitative method for both data gathering and analysis. We have used a variation strategy to establish a diverse group of interviewees. Interviews were performed face to face in a separate room at the hospital facility, which enabled the physicians to be open about their experiences and provide the study with rich empirical information.

A potential limitation is inherent in the fact that the analysis of interviews is always a matter of interpretation by the researchers. There is a risk that the researchers' own pre-understanding may overpower the voice of the interviewee and that the researchers will only notice what they expect. However, in our study, to reduce the risk of a single researcher's perspective having an overpowering impact on the findings, the analytical process was organized with five researchers reading and interpreting the empirical material. Those five researchers had different professional, as well as educational, backgrounds, as is further detailed under Methods section.

From an overall usability perspective, it needs to be considered that the participants came from an internal medicine department at a mid-size Swedish hospital. Thus, these findings might not be of benefit outside this context. However, with reference to arguments by Van Maanen and Barley (1984) and Wenger (2000), there is a high degree of communality among physicians in the Western world, often depicted as one occupational community of praxis; we suggest that there should be knowledge coming from this contextually study that could be of value elsewhere.

Conclusions

By the use of abductive analysis, starting with empirical findings and relating them to complex responsive processes theory, paradoxes from physicians' experiences of a patient-centered and team-based round were uncovered and better understood.

This study found two empirically divergent and seemingly opposing physician perspectives on enacting the role of physician during a patient-centered and team-based ward round, *We-perspective* and *I-perspective*, based on where the physician's professional identity was centered. The response from physicians to the new ward round related to whether the new round principles challenged or confirmed their individual physician's professional identity. Physicians with an inclination toward the more patient-centered *We-perspective* experienced alignment with their professional identity and seemed to appreciate the new ward round, while physicians with more of a bio-medical *I-perspective* experienced challenges to their professional identity from the new round principles and responded less appreciative.

Complex responsive processes theory emphasized a transformative and relational perspective, where professional identity is being formed and re-formed in everyday human interaction. When identity is challenged anxiety is aroused, and if anxiety is not catered to when change is introduced, resistance is likely to follow and changes are likely to be hampered. Scheduled time to facilitate conversations between physician colleagues about their own experiences of the new round is a theory-infused recommendation to evolve professional identity. Reflection on clinical experiences can alter the understanding of work and, as such, serve as a vehicle to evolve the more bio-medical physician identity (*I-perspective*) toward a more patient-centered identity (*We-perspective*).

Political and organizational leaders need to understand both the challenge and the potential to evolve physicians' professional identity toward increased patient-centeredness. For change processes affecting the clinical core, it is important to find a balance between what new knowledge that needs to be learned and who the physician is becoming.

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Appendix

Interview questions

Overall wide questions […] provide ample time for respondent, strive toward practical example:

(1) If you would tell how the ward round came about, how would you describe that?
   - *Follow up*: When did you first run into the new round? What did you think about it then?

(2) Where there any considerations and/or expectations about the new ward round?
   - *Follow up*: Your own, colleagues, other care professionals?
   - *Follow up*: How were considerations and/or expectations dealt with?
   - *Follow up*: What where the main arguments for change? How did you relate to those arguments?

(3) How would you describe the new ward round as per today?

(4) Do you find yourself working in line with the agreed ward-pm?
   - *Follow up*: Your colleagues, other care professionals?

(5) Has anything improved? What? Could you provide a practical example?

(6) Has anything become worse? What? Could you provide a practical example?

(7) Has anything changed that you did not anticipate would change?
   - *Follow up*: Your colleagues, other care professionals?

Thematic checkpoint […] if not already covered during the interview based on above wide question.

Impact on care quality? Has the new ward round contributed to any care quality changes? Is so what has improved?/what has become worse? Could you provide an example?

How do you find patients responding to this new ward round? could you provide an example?

Time usage? Has the usage of time changed with the new ward round? How? Could you examplify? Has the sensation of flow at work changed? Is anything consuming more time? Anything needing less time? Do you need to wait more or less? Do you need to track down other co-workers more or less?

The workgroup, communication at the ward, ease at work? Documentation?

The new ward round as such? How do you now find it? Positives/negatives? How do you find yourself participating in the ward round compared to previously? How is it to lead in the new ward round? How do you find interaction between different care categories function? How do you find the meeting with the patient?

Closing questions

(1) Is there anything you would like to change in the new way of working the ward round?
   - *Follow up*: Could you provide a practical example of what that change should lead to
   - *Follow up*: Thoughts about how that change could come about?

(2) Is there anything else you would like to bring up as it relates to this new ward round?

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