

**A Grounded Theory of Employed Professional Role Identity:  
One Pathway to Understanding Professional-Organizational Relationships**

by

Gregory Ward Stevens

A dissertation submitted to the Graduate Faculty of  
Auburn University  
in partial fulfillment of the  
requirements for the Degree of  
Doctor of Philosophy

Auburn Alabama  
December 13, 2014

Keywords: employed professional, role identity, physicians,  
professional identification, organizational identification

Copyright 2014 by Gregory Ward Stevens

Approved by:

Malissa A. Clark, Chair, Assistant Professor of Psychology  
Daniel J. Svyantek, Professor of Psychology  
Stanley G. Harris, Professor of Management  
Jinyan Fan, Assistant Professor of Psychology  
Achilles A. Armenakis, Professor of Management

## **ABSTRACT**

An increasing amount of research has recently been devoted to the complex dynamics surrounding employed professionals, particularly from the standpoint of understanding the ways in which they identify with their roles in the workplace (e.g., as professionals versus organizational members or employees). Unfortunately, such research has typically been limited in terms of its ability to understand the full complexity of what it means to be an employed professional and how that meaning drives professional-organizational relationships. The current study addresses these gaps in the literature by providing a grounded theory of employed professional role identity, based on semi-structured interviews with 23 employed physicians working within a primary care network owned by a large healthcare system. Through these interviews and other sources of qualitative data (e.g., observations, archival documents), the employed professional role identity emerged as: a better understanding of the professional role in the workplace; the influence of that professional role in defining what it means to be employed; and finally, what that employment means for subsequent professional-organizational role relationships. Revealed through each of these components, the dominant source of professional-organizational interaction surrounds the facilitation of professional work, stemming directly from the professional role in the context of employment within an organization. More peripherally, yet the focus of much prior research, the role of the professional as a participant in the organization (e.g., supporting an organizational agenda or change, participating in committees and meetings) is much less tied to the meaning of the employed professional role identity. The theoretical and practical implications of these potential pathways are discussed.

## ACKNOWLEDGEMENTS

I would like to express my sincere gratitude to my advisor, Malissa, for your guidance and support throughout this lengthy project. The final manuscript is substantially improved (not to mention having saved quite a few more trees) as a result of your comments and suggestions that helped to focus in on the key findings and to tell a more compelling story around them. Thank you too for your insight around that tricky transition from student to working professional.

I would also like to thank my committee- Dan, Stan, and Fan- for your insight and feedback across the multiple iterations this project has gone through. From developing and framing early ideas, to polishing the research and interview protocols, and finally, to reviewing the finished product, I could not have successfully completed this research without all of your help.

Thanks are also due to the corporate sponsors for this research, as well as the clinic physicians and practice staffs who participated. Your willingness to provide access and your thoughtful participation made this study possible.

To my former advisors- Bryan and Jackie- thank you for your early guidance and insight, helping me to develop as a researcher and a professional in the field.

Last, but certainly not least, I want to express my gratitude to my wife, Erin, and my parents, Ward and Lynne. For helping me to deal with the many challenges of this project, more generally supporting me throughout graduate school and now as I work to find my own professional identity, I would not be where I am today if not for your love and support.

## TABLE OF CONTENTS

<b>CHAPTER ONE – INTRODUCTION</b> .....	1
Background and Context.....	2
Statement of Purpose and Research Questions.....	6
Overview of Research Design .....	9
Role of the Researcher .....	10
<b>CHAPTER TWO – LITERATURE REVIEW</b> .....	13
An Introduction to Identification in Context .....	13
<i>Identity and Identification</i> .....	14
<i>The Role of Identification in Organizational Contexts</i> .....	17
<i>Identification in Complex Organizations</i> .....	18
The Employed Professional and Social Identity Theory .....	20
<i>Social Identity Theory</i> .....	20
<i>Professional and Organizational Identification</i> .....	22
<i>Limitations of the Extant Paradigm</i> .....	29
A Shift towards Roles and Identity Theory .....	31
<i>Identity Theory</i> .....	32
<i>Development of the Research Questions</i> .....	36
<b>CHAPTER THREE – RESEARCH DESIGN AND METHODOLOGY</b> .....	41
Rationale for a Qualitative Approach .....	41
Study Setting and Context .....	44
<i>Selecting an Appropriate Site</i> .....	47
<i>Establishing a Relationship</i> .....	48
Research Design Overview.....	50
<i>Sample Selection and Data Collection</i> .....	51
Data Analysis and Synthesis.....	59
Trustworthiness in Qualitative Research .....	63
<b>CHAPTER FOUR – FINDINGS</b> .....	68
Centrality of Professional Role.....	69

<i>Core Professional Service</i> .....	70
<i>Professional Practice</i> .....	72
<i>Professional Work Practice</i> .....	74
Employment’s Role in Professional Work .....	77
<i>Employment Supporting the Individual Professional</i> .....	77
<i>Employment Supporting the Work Practice</i> .....	80
Organizational Role in Professional Work .....	83
<i>Professional Work as the Business</i> .....	83
<i>Success of Organization as the Business</i> .....	86
Other-Expectations of Professional Work .....	89
<i>Boundaries of Expected Support</i> .....	90
<i>Triggers for Expecting Support</i> .....	93
Professional Role in Organization .....	96
<i>Expectations of Organizational Participation</i> .....	96
<i>Professional Affiliation of Organization</i> .....	99
<b>CHAPTER FIVE – CONCLUSIONS</b> .....	103
Summary of the Key Findings .....	104
Theoretical Contributions .....	109
Practical Implications.....	114
Limitations and Directions for Future Research.....	117
<b>REFERENCES</b> .....	128
<b>APPENDICES</b> .....	141
Appendix A. Semi-structured Interview Protocol .....	142
Appendix B. Quantitative Measures of Professional and Organizational Identity .....	143

## LIST OF TABLES AND FIGURES

### **TABLES**

Table 1. Summary of Participant Demographics .....	123
Table 2. Summary of Meeting and Event Observations .....	124

### **FIGURES**

Figure 1. Graphical Illustration of the Research Question Structure .....	125
Figure 2. Data Structure Diagram for a Grounded Theory of Employed Professional Role Identity .....	126
Figure 3. Theoretical Model of Employed Professional Role Identity .....	127

## CHAPTER ONE - INTRODUCTION

“Properly speaking, a man has as many social selves as there are individuals who recognize him and carry an image of him in their mind. ... But as individuals who carry the images fall naturally into classes, we may practically say that he has as many different social selves as there are distinct groups of persons about whose opinion he cares.” (James, 1918, p. 294)

Despite having been written nearly a century ago, this epigraph accurately captures the inherent complexity of the social self—how individuals think of or define themselves in relation to other individuals in a social environment. Translated into more contemporary terms, this quotation speaks to the phenomenon of identity and identification, and the many different forms it may take (Ashforth, Harrison, & Corley, 2008; Ashmore, Deaux, & McLaughlin-Volpe, 2004). Indeed, in today’s world, one may have as many social selves as there are distinct groups, broader collectives, or even roles within social systems (Thoits & Virshup, 1997). Although James was speaking rather broadly, the context provided by increasingly complex organizations may provide an ideal setting to observe dynamics associated with role identity in particular, as the primary mechanism through which individuals accomplish work within complex organizations. Indeed, a subset of organizational members that tend to epitomize such dynamics are employed professionals, who may face the distinct meanings associated with their professional role, what employment means for enacting that role, and finally, how that sense of employment influences the unique patterns of interaction between the employed physician and his or her organization.

The current research project explores what it means to be an employed professional, and the identity associated with that role as employed within an organization. This holistic role

identity ought to provide a richer understanding of how and when professionals interact with their organizations, which role relationships are impactful sources of cooperation or interaction, and so forth. In this introductory chapter, a brief overview is provided of this project. First, I discuss the general background that has informed the development of the research problem, with particular attention to the appropriateness of using identity and identification as a lens to understand employed professionals' interactions with their organizations. Second, the limitations of the extant literature and the contributions of the current study are presented, set against the development of the research questions that address the overarching purpose of this study. Finally, I provide a brief overview of the research design, my role as the researcher, and the potential significance of the project.

### **Background and Context**

The dynamics surrounding professionals employed by organizations has often attracted the interest of researchers (e.g., Bamber & Iyer, 2002; Dukerich, Golden, & Shortell, 2002; Gouldner, 1957; Glynn, 2000; Hekman, Bigley, Steensma, & Hereford, 2009; Hoff, 2001; Johnson, Morgeson, Ilgen, Meyer, & Lloyd, 2006; Russo, 1998; Wallace, 1995) and practitioners alike (e.g., Bard, Conlon, Gartner, & O'Rourke, 2008; Beckham, 2001; Bolinger, 1999; Holm, 2000; Sanderson, Rice, & Fox, 2008). From a management standpoint, organizations often depend on the specialized skills and knowledge of the professionals they employ – be they physicians, chemists, accountants, or lawyers – with the general objective of aligning professionals' activities with the larger goals and strategy of the organization. Employed professionals, on the other hand, are rarely seen as quite so dependent on their organizations, often maintaining loyalty to their respective profession, enjoying the potential mobility



associated with skills and knowledge that easily transfer between organizations, and typically expecting large amounts of autonomy from their employers (Gouldner, 1957; Hoff, 2001).

Such dynamics are particularly apparent in the healthcare industry in general, and within large healthcare systems that employ physicians in particular (also known as organized delivery systems; Shortell, Gillies, Anderson, Erickson, & Mitchell, 2000; Zuckerman, Hilberman, Andersen, Burns, Alexander, & Torrens, 1998). Rather commonly, while employed physicians seek to retain their autonomy and professional authority, the administrators of the systems that employ them seek to improve upon the delivery of care through coordination, efficiency improvements, and the implementation of quality standards. Balancing these objectives has often proved troublesome, resulting in few of the benefits promised by implementing such systems (cf. Burns & Muller, 2008; Devereaux, 2000; Schramko, 2007). These dynamics, along with the larger issues of physician-system relationships, lay at the heart of this dissertation.

To investigate the working relationships between employed physicians and their organizations, this study focused on the constructs of identity and identification. It has been argued that identification provides a foundational concept that helps to explain why people think the way they do and why they act the way they do within organizational contexts (Albert, Ashforth, & Dutton, 2000; Ashforth et al., 2008), particularly in the absence of formal or effective incentive programs for behaviors that are more voluntary or discretionary in nature.

Prior research has almost exclusively examined such dynamics from a social identity theory perspective (Hogg & Terry, 2000; Hogg, Terry, & White, 1995), which describes the intergroup relations and processes that occur when membership within a group becomes self-defining (creating a “we” instead of “me”). Within this paradigm, the ways in which professionals identify with a profession (i.e., professional identification) or with an organization

(organizational identification) explains why certain individuals may engage in extra-role behaviors on behalf of the collective where others do not (cf. Dukerich et al., 2002; Hekman, Bigley et al., 2009). For example, Dukerich and her colleagues found that identifying with one's organization was positively related to pro-organizational behaviors, such as cooperation and participation; however, Hekman and his colleagues found that such a relationship only holds under conditions of low professional identification and is in fact largely negated by high levels of professional identification. Professional identification, in turn, was positively related to less support of organizational change. In general, such findings appear to support notions of administrator-physician conflict as a result of the dynamics discussed in the previous paragraph.

Unfortunately, the findings from these studies and those of other researchers investigating identification through a social identity theory lens (e.g., Apker & Fox, 2002; Bartels, Pruyn, De Jong, & Joustra, 2007; Johnson et al., 1996; Lipponen, Helkama, Olkkonen, & Juslin, 2005; Riketta & Nienaber, 2005; Van Dick & Wagner, 2002) tend to suffer from several methodological and theoretical limitations. As a result, a straightforward pattern of identification with either the profession or the organization, at the expense of the other collective, may not be tenable in all cases or situations; rather, a more useful approach may be through understanding identity stemming from the roles that one enacts and the ensuing patterns of role relationships that comprise the social landscape.

To provide a brief overview of those limitations, however, the extant literature on identification among employed professionals carries certain assumptions rooted in group dynamics, aligned with the basic tenets of social identity theory, which may not be generalizable to the complexities of modern organizations (Thoits & Virshup, 1997). For example, the literature often assumes that groups form homogenous entities through a process of

depersonalization and adoption of a common group prototype (Turner, 1985). As Hoff (2001) argues, the consequence is a given identity becoming a property that is wholly shared by a given collective (e.g., all physicians sharing the same professional identity), varying only in degree rather than acknowledging the likely variation among members. Relatedly, one must take into account the extent to which organizations comprise networks of interdependent roles as opposed to easily differentiable groups, limiting the influence or prevalence of group-based identities (Tajfel, 1981). Rather, an approach is likely needed that appreciates the interdependencies between individuals from different “groups” performing in role relationships (e.g., physician-nurse teams on behalf of patients, and so forth).

Furthermore, empirical research tends to rely on coarse assessments of professional and organizational identification (e.g., Mael & Ashforth, 1992; Cheney, 1983). More specifically, conventional practice involves administering these scales, modifying only the name of the collective, and tapping a one-dimensional structure of identity as a sense of “oneness” with the organization (Ashforth & Mael, 1989). This practice has typically failed to account for identification as a contextualized phenomenon, separating an individual’s identity from the situation and context in which it is evoked, which is a key part of explaining actions that stem from the identity through a shared meaning (Stryker & Burke, 2000). It also prevents the assessment of any interactions that may occur between the two targets of those scales (e.g., working relationships between professionals and the organizations that employ them). Such limitations stand in stark contrast to the potential complexity of identity in the real world.

It is against this constellation of factors that the current study seeks to make a contribution to the literature. Namely, this study investigates role-based identification in terms of individually experienced phenomenon instead of measured properties (Weiss & Rupp, 2011).

Weiss and Rupp make the argument for a paradigm shift in organizational studies: one that moves from a “between-entities” assumption to a more person-centric approach. In essence, the between-entities assumption refers to a model in which properties are assigned to individuals and then associations between those properties are examined (e.g., the Big 5 and job satisfaction, or in the current case, an identity score and a given outcome). More succinctly, such assumptions tend to focus on “identifying and measuring [a worker’s] properties instead of trying to understand how the worker looks at and experiences work” (Weiss & Rupp, 2011, p. 84). The person-centric approach is an attempt to accomplish the latter, which, interestingly, also lies at the heart of why identity has garnered so much interest within the context of organizations. Qualitative methods are uniquely oriented in terms of this ability to study a phenomenon from a contextualized and “experienced” perspective, relying on what is in the minds of individuals to contribute to theory in a given area (Albert, 1998). In so doing, such studies acknowledge the value of subjectivity in the experience of work through the lens of identity (see notable examples by Clark, Gioia, Ketchen, & Thomas, 2010; Ibarra, 1999; Pratt, 2000; Pratt, Rockmann, & Kaufmann, 2006; Russo, 1998). This perspective helps to inform the overall purpose of this study and the development of the research questions below.

### **Statement of Purpose and Research Questions**

As noted above, the chief need in this area is for research that contextualizes the phenomenon of employed professional identification and appreciates the complexities of their professional roles in the organizations in which they are employed. As such, this study advocates a paradigm shift in the form of sociological identity theory (Stryker & Burke, 2000), which considers roles within a larger social context rather than identity rooted in social groups. A growing body of literature has similarly begun to recognize the potential insight of role-based

theories above and beyond that provided by social identity theory (cf. Pratt et al., 2006; Sluss & Ashforth, 2008; Zhang, Chen, Chen, Liu, & Johnson, 2014). Although groups may be an adequate lens for certain phenomena (e.g., race, gender, certain teams), it is argued that physicians employed within organizations may be more appropriately understood in terms of their roles as professionals within larger organizational systems.

Briefly, identity theory states that individuals occupy roles, defined as positions within social structures, and possess identities that represent those roles when part of the self is defined through the enactment of that role (Ashforth, 2001). Furthermore, roles share reciprocal relationships with other roles in the social environment (i.e., counterroles) to form role sets. These sets contain the goals, values, beliefs and norms ascribed to each role, as well as the interaction styles and boundaries between roles. For example, counterroles for a physician may include the patient, nursing staff, office staff, colleagues, hospital staff and so forth; these possibilities suggest the need to move beyond conceptualizations of group membership to fully appreciate the dynamics facing employed professionals.

The current study proposes a role-in-context approach, where the employed professional role is seen holistically rather than pluralistically (Ashforth & Johnson, 2001). This means that aspects related to the professional role and to employment within an organization combine to form an amalgam, where the resulting role identity is more than the mere sum of the individual components that comprise it. It allows one to discuss employed professionals as professionals employed within organizations, rather than separately as employees and professionals as if those labels were wholly distinct from one another. To wit, professionals are often hired to provide a professional service for organizations, so any notion of employment must necessarily incorporate the professional role; similarly, the professional role occurs within a specific context, which must

necessarily incorporate the organization and the counterroles that result. In light of these observations, this study seeks to address the following overarching question: from a role-based perspective, what does it mean to be an employed professional, and how does that meaning contribute to the interactions between the professional and the organization?

To fully address this question, several individual research questions must be addressed in the following order, building from the core professional role to an understanding of employment, and finally to the role relationships that flow from those meanings:

*RQ1: Within the context of an employed professional role identity, what does it mean to be a professional?*

*RQ2: Within the context of the professional role, what does employment mean within an organization?*

*RQ3: Within the context of professional employment, what is the nature of professional-organizational role relationships, in terms of (a) the organization's role in the profession and (b) the professional's role in the organization?*

To provide a brief narrative of the logic underlying these questions, first I sought to define more clearly participants' understandings of their professional role, as that role lies at the core of what it means to be an employed professional and drives the subsequent meanings associated with employment and role relationships with the organization. Second, I sought to better understand what it means to be employed as a professional, as physicians are more likely to engage with the organization as a professional rather than a more traditional employee. Finally, I considered the nature of role relationships that stem from those prior definitions of employment, both from the perspective of the organization's role in the profession, and the professional's role in the organization. The nature of these role relationships lead to a better

understanding of the patterns of interaction and interdependencies between the employed professional and the employing organization.

### **Overview of Research Design**

In order to appropriately address these questions, the current study took a blended qualitative approach to collect rich data on the identities of physicians who are employed by a large primary care network, itself a member of a larger health system. This study primarily followed a grounded theory approach (Glaser & Strauss, 1967; Strauss & Corbin, 1998; Corbin & Strauss, 2008), incorporating aspects of case study (Yin, 2008) and ethnography (Van Maanen, 1979) as well. This combined methodology allows for the collection of rich descriptions of organizational phenomena from the perspective of individuals situated within those organizations as it entails extended contact with a given community through fieldwork, as well as allowing theory to emerge from those descriptions through an iterative process of analysis, data collection, and theory generation. Although the literature on employed professionals is quite rich from a social identity perspective, the application of a sociological identity theory lens is still nascent; thus, this study is more appropriately categorized towards the end of building theory, rather than expanding and elaborating current theory.

The primary source of data for this study comprised semi-structured interviews with 23 employed physicians, triangulated with observations of the organization and medical practices, archival documents provided by the organization, and informal discussions with physician and non-physician employees of the organization. Following approval from the university's institutional review board, this study utilized a semi-structured interview protocol to conduct interviews with each physician. Each interview was transcribed, and coded as the research study

progressed, aligned with a grounded theory approach of allowing emergent concepts to drive subsequent data collection and interviewing.

As previously mentioned, the setting for the current project was a large primary-care physician network that is a part of a larger health system. Within the network, the health system owns the facilities and other durable assets, employs the practice staff, and manages many of the back-office functions; the physicians, who are employed by the health system, earn a salary that is determined by practice performance, less fees for management services provided. This setting was deemed to be an appropriate context for the current research because it represents an extreme case of the constructs of interest – identification among employed professionals, autonomy dynamics, organizational and professional demands, and so forth (Eisenhardt, 1989).

### **Role of the Researcher**

As is standard practice with qualitative research designs, a brief discussion is warranted about the role of the researcher, including assumptions made with regard to the project. At the time of this project, I was enrolled in a doctoral graduate degree program for industrial and organizational psychology. At the same time, I was involved with the sponsoring organization in the form of an internship that largely focused on investigating physician-system relationships within the primary-care physician network. The current project is the end result of a cooperative attempt by myself and the project sponsors at the organization to develop research that was simultaneously theoretically and practically meaningful for all parties involved. In the interest of full disclosure, my wife was employed during this study by the larger health system of which the network is a part, yet she was unaffiliated with any of the staff from the primary care network. However, she did provide the introduction to one of the system executives, who also holds a position within the network.



Given the distance between myself and the research setting at the outset of the project, there may be an appropriate assumption of initial objectivity. However, along with such objectivity, there is the risk of a lack of critical insight into and understanding of the participant population, as well as the formation of assumptions that reflect such an “outsider” status. Additionally, studying in a field of management science, I must be careful in terms of assumptions that reflect socialization experiences of that education, resulting in perceptions of “taking the management’s side” over the interests of the physicians. A potentially ameliorating factor may lie within the perspective of my wife, as a representative of the physician community to act as a “sounding board,” as well as the eventual establishment of physician informants within the network that acted as member checks. In order to address these and potentially more implicit assumptions, I utilized procedural safeguards, including triangulation of data sources and methods and various forms of checks for trustworthiness (e.g., peer debriefs, maintenance of audit trails, full descriptions of the coding and research processes).

### **Rationale and Significance**

In closing this chapter, the rationale and anticipated significance of the research project stems from a general interest in the healthcare industry, as it faces nearly unprecedented changes to the way care is provided and the way business is conducted, as well as the general complexity of organizational solutions to those changes. The advent of organized delivery systems and other more recent arrangements (e.g., medical homes, accountable care organizations), for instance, has had a lasting impact on the way healthcare delivery has been managed, for better or for worse. Essentially, many of the issues that these health systems face stem from “people problems,” relationships that are more likely to be characterized by conflict or ambivalence than cooperation, due to the strong cross-role coordination that must occur. This presents a unique

opportunity for individuals in the management sciences to attempt to understand these relationships, with an eye towards not only improving business processes, but patient care delivery and employee satisfaction, as well. This latter point touches upon the potential significance of a project like this one. The findings from this research should provide insight into the complicated dynamics of employing professionals, a trend that only appears to be increasing. Armed with a thorough understanding of such dynamics, practitioners may be able to design more effective interventions or integration strategies that contribute to the well-being of everyone that is involved with these systems. From a theoretical standpoint, more insight into complex processes of identification may help to move the field forward, both in terms of appreciating the experience of individual workers rather than aggregate samples, and in terms of more nuanced understandings of what contributes to certain patterns of organizational thought and action.

## **CHAPTER TWO – LITERATURE REVIEW**

Undoubtedly, there are many lenses through which to view the dynamics surrounding employed professionals and their interactions with organizations. The most fruitful approaches have been those that have examined the identity and identification of this group, which attempts to explain why and when professionals might expend effort on behalf of the profession or on behalf of the organization. This chapter provides a review of this stream of research, orienting the reader with a broad overview of why identity and identification matter in organizational contexts and how those concepts have largely been addressed within social identity theory (Hogg & Terry, 2000). Although beneficial, this approach has been limited in its ability to address the complexity of the professional role in the context of employment and the organization. A role-based approach to identity, known as identity theory (Stryker & Burke, 2000), is proposed to offer additional insight and challenge certain assumptions of prior research. As a result, this chapter proposes a theoretical model of an employed professional role identity: a holistic role that incorporates the meaning of professional and professional-in-organization role relationships and interactions. The purpose in so doing is to reach a more robust understanding of the ways in which employed professionals think and act within the context of their employment within organizations.

### **An Introduction to Identification in Context**

One of the primary challenges facing many identity theorists lies in the sheer breadth and depth of the literature across numerous disciplines, including organizational studies, social psychology, sociology, and communications (cf. Ashforth et al., 2008; Owens, Robinson, &

Smith-Lovin, 2010). Several authors have commented on the difficulty of arriving at a single consensual definition for identity or identification (Ashmore et al., 2004, Brubaker & Cooper, 2000), primarily due to the numerous theoretical foundations with which such concepts are often approached. It is perhaps useful, therefore, to begin this discussion by establishing the boundaries on what is and is not captured by the terms identity and identification for the purposes of the current discussion.

### **Identity and Identification**

Broadly defined, identity may be thought of as a self-referential description that answers the question “who am I” or “who are we” (Ashforth et al., 2008). A critical aspect of that self-description is invoking a particular identity as one part of the self-concept in response to a given context or situation. An individual may possess as many identities as different contexts in which he or she exists, selecting the most appropriate one for the context in question (Brewer and Gardner, 1996). Identification, then, occurs when an individual’s beliefs about a given target (e.g., a role or group) become self-defining and integrated into one’s sense of the self (Pratt, 1998). In somewhat more metaphysical terms, identification is the “perception of oneness or belongingness to some human aggregate” (Ashforth & Mael, 1989, p. 21).

Although these definitions seem fairly intuitive and straightforward at first, as one begins to enumerate the various possible responses to the questions above, the complexity of identity and identification begins to emerge. For example, one may define oneself in terms of values or beliefs (e.g., “I am liberal” or “I am conservative”), physical or mental attributes (e.g., “I am intelligent” or “I am athletic”), roles or responsibilities (e.g., “I am a father” or “I am a manager”), social groups or categories (e.g., “I am an American” or “I am an employee of GE”), or potentially any combination thereof. Additionally, one may respond solely in terms of oneself

(e.g., “I am...”), as an individual member of some collective or the enactment of a social role (e.g., “As a X, I am...”) or in terms of the larger group in which that individual is a member (e.g., “We are...”). Given such complexity, it should not be surprising that theorists have tended to characterize identity in slightly different ways, although some commonalities may be perceived between the different approaches.

One of the most commonly made distinctions has been to conceptualize identity as comprising several different forms depending on which question the individual is seeking to answer, all of which make up part of the self-concept (cf. Thoits & Virshup, 1997). First, one’s *personal identity* tends to capture the “self-descriptions [that refer] to unique or highly specific details of biography and idiosyncratic experiences” (Thoits & Virshup, 1997, p. 107; also see Postmes & Jetten, 2006, Sedikides & Brewer, 2001); it is the sum of an individual’s unique constellation of traits, abilities, attitudes, and so forth, answering the question “who am I.” While a personal identity sets one apart as a unique individual, collective forms of identity serve to inhere individuals within the context of larger social groups or categories, either in terms of an *individual identity* (“who am I as a member of X”) or a *collective identity* (“who are we”; Thoits & Virshup, 1997). There is a largely historical explanation for the impetus for differentiating between these two terms: while sociologists have tended to investigate role-based identities within large social structures that contribute to a sense of individual identity (e.g., Stryker & Burke, 2000), social psychologists have tended to investigate group-based identities that contribute to notions of collective identity (e.g., Hogg & Terry, 2000; Tajfel & Turner, 1986). This distinction will be described in greater depth, as each perspective carries important assumptions about the targets of identification.

In terms of the components comprising identification with a given collective or role, Ashforth and his colleagues (2008) establish a “fuzzy set” of attributes, representing first a core set of attributes surrounded by the content that is associated with the identity. Aligned with Tajfel’s (1982) early conceptualizations, the core of identification represents: a cognitive awareness of membership and self-categorization within the target collective, an evaluative judgment pertaining to the value of membership in the collective or role, and an emotional investment in this awareness and evaluation (Ashforth et al., 2008). The content of identity surrounds this core, separated by a permeable boundary. This content is defined by Ashforth et al. (2008) as the various attributes (i.e., values, goals, beliefs, stereotypic traits, knowledge, skills, and abilities) that one may incorporate into the self from the collective or role. While the core represents the self-descriptive process of identification (e.g., “I am a family medicine physician...”), the content represents the meaning that is associated with that label (e.g. “... so I value providing care across the entire continuum and developing long-term relationships with my patients.”). The boundary between the core and the content of an identity is permeable to represent the fact that the content may not necessarily follow the core identity if such attributes are “unclear, emergent, in flux, conflicted, tacit, espoused but not enacted, and so on” (Ashforth et al., 2008, p. 330). Finally, at the broadest conceptualizations of identification, some theorists have included relevant behaviors (sometimes referred to as behavioral involvement; e.g., Ashforth, 2001; Ashmore et al., 2004; Van Dick, Wagner, Stellmacher, & Christ, 2004), while others have acknowledged the often tenuous link between attitudes and behavior (cf. Ashforth et al., 2008). Such behaviors, however, are often of interest when identification is examined in organizational contexts.

## **The Role of Identification in Organizational Contexts**

A valid question emerges in the sense of examining why identification matters in the context of organizations (cf. Albert et al., 2000; Ashforth et al., 2008; Edwards, 2005; Riketta, 2005). Presenting what has become something of a de facto standard among identity theorists, particularly in the management literature, Albert and his colleagues (2000, p. 13) have argued: identification and identity are powerful concepts “because they speak to the very definition of an entity...in short, [they] are root constructs in organizational phenomena and have been a subtext of many organizational behaviors.” Echoing this perspective, Ashforth et al. (2008) argue that identity and identification serve as critical concepts in understanding the ways in which individuals think and act within their social environment. Identification may help to explain, for example, why individuals join certain organizations over others, the ways in which they may interact with their coworkers, their decisions to expend effort for the benefit of the organization where others do not, or choose to leave an organization or otherwise alter their career trajectory.

A review of common correlates and outcomes tends to provide some support for the assertions above; for thorough reviews, see Ashforth et al. (2008), Haslam and Ellemers (2005), Riketta (2005), and Riketta and Van Dick (2005). In general, many of the concepts that have been investigated are buttressed by a common understanding that views identification as the process through which individuals become a “microcosm” of the larger collective, “such that acting on behalf of the [collective] is tantamount to acting on behalf of [oneself]” (Ashforth et al., 2008, p. 337). Variables illustrative of this connection have included those that reflect cooperation on behalf of the organization (Dukerich et al., 2002), participation and coordination within the collective (Blader & Tyler, 2009; Lipponen, Bardi, & Haapamaki, 2008), demonstration of reciprocity with the collective (Hekman, Bigley, et al., 2009), intentions to

support organizational action and change (Hekman, Steensma, Bigley, & Hereford, 2009; Jimmieson & White, 2011), and a range of citizenship behaviors and extra-role performance (Bergami & Bagozzi, 2000; Grube & Piliavin, 2000; van Dick, Grojean, Christ, & Wieseke, 2006). The common thread throughout this disparate range of outcomes is the willingness of the individual to exert some form of effort towards activities that benefit the larger collective. These forms of effort are of particular interest in the current study given that they represent a perspective that blends the theoretical and practical application of identification within organizational contexts.

### **Identification in Complex Organizations**

Given the foundational nature of identification in explaining organizational thought and action, it is important to address the ways in which identification may occur in complex organizations. For example, organizations are often comprised of multiple roles and multiple collectives that an individual may identify with. As noted earlier in this section, one perspective in addressing such complexity is to posit the presence of multiple identities, invoked based on different factors that are salient within the environment. Within this perspective, theorists have suggested that in any given situation, a single identity is invoked, either tied to a particular role or ingroup-outgroup distinction (Hogg & Terry, 2000; Stryker, 2008).

As an alternative, a second perspective assumes that multiple identifications may be invoked simultaneously in response to any given situation, whereby implicit importance (salience) is not seen as a zero-sum game, but rather taken to be more relative in nature (Ashforth & Johnson, 2001). Within this perspective, the management of multiple identities becomes an important factor to consider, in terms of how the identities are combined, bounded, or arranged (Kreiner, Hollensbe, & Sheep, 2006; Pratt & Foreman, 2000; Roccas & Brewer, 2002). A third



perspective is also possible that stands in contrast to the pluralistic notion of identification above yet considers the presence of multiple identities. Namely, this approach suggests that aspects of multiple identities combine to form an amalgamation, where the holistic identity is more than the sum of its individual parts (Ashforth & Johnson, 2001).

An example of the differences in each approach may be provided by physicians who also belong to management teams. In the traditional approach, these individuals identify either with the professional or the management aspects of their self for a given situation, with no interaction occurring between them. In the pluralistic approach, theorists argue that both the physician and management identities could be simultaneously salient (e.g., in response to a management meeting for clinical process improvement), yet remain distinct aspects of the self and subject to a host of intra-individual identity management strategies (Roccas & Brewer, 2002). The third perspective is similar to the latter, yet suggests that the physician and the management identities combine to form a single physician-manager identity, where the combination is meaningfully different from the influence of considering each simultaneously yet in isolation.

Although discussed theoretically, empirical research has yet to confirm the likelihood of one possibility over another, in terms of pluralistic versus holistic identities. However, it may be that pluralistic and holistic identities are largely dictated by the targets of the identification process. For example, where multiple collectives comprise the social environment as distinct entities (aligned with social identity theory), one may appropriately expect more pluralistic management strategies. If instead, one examines a role within a social environment that specifies the relationships between many collectives (aligned with identity theory), identification with that role may be more holistic in nature. With this distinction in mind, the next section will examine the specific case of employed professionals and their identification in the social environment. As

it turns out, the majority of work has tended to focus on collectives to which those employed professionals belong (i.e., profession, organization), with much less focusing on a more holistic role as employed professionals in context.

### **The Employed Professional and Social Identity Theory**

Up until this point, identity and identification have both been discussed in rather general terms, largely without reference to the specific theoretical paradigms that have influenced the development of this area of research. In these sections, the dominant perspective that has been applied to employed professionals- social identity theory- is described. Then, the specific stream of research that has focused on employed professionals is reviewed, alongside limitations that are inherent in that approach attributable to the assumptions of social identity theory.

#### **Social Identity Theory**

Social identity theory refers broadly to an integrative framework of prior theories of social identification emerging from social psychology. These theories converge around the centrality of group membership, and by extension intergroup relations, in self-identification processes (Ashforth & Mael, 1989; Hogg & Terry, 2000; Hogg et al., 1995). Primarily focused on intergroup dynamics, classic social identity theory (Hogg & Abrams, 1988; Tajfel & Turner, 1986; Turner, 1982) suggests that individuals form group prototypes, defined as fuzzy sets of features that achieve maximum distinction between ingroup and outgroup characteristics. When these prototypes contribute to the definition of the self (e.g., are meaningful or salient), they become a social identity, establishing a “we” instead of a “me.” This process is theorized to occur through the sequential combination of prototype accessibility (e.g., through chronic activation or importance) and determinations of fit within a given context (Hogg & Terry, 2000). The primary motive underpinning these processes is posited to be the individual’s need for self-

enhancement, such that groups to which the individual belongs are viewed more positively than groups to which the individual does not belong (i.e., achieving positive/optimal distinctiveness; Brewer, 1991; Tajfel, 1982).

Developed into an extension of social identity theory, self-categorization theory (Turner, 1985) shifts the primary focus from intergroup to intragroup processes. It suggests that internalizing a salient ingroup prototype into the self-concept results in a depersonalization process, whereby the self and other ingroup members are seen as representing varying levels of that group prototype, rather than being seen as unique individuals. In other words, depersonalization represents a cognitive shift in one's identity from the "me" level to the "we" level. Defining the self and others in terms of group prototypicality provides the basis for establishing shared group-oriented attitudes, values, behaviors, and motivations (e.g., conformity, normative behavior, mutual influence, stereotyping; Ashforth & Mael, 1989). The addition of self-categorization theory has also added an important motivational process to that of self-enhancement discussed above: subjective uncertainty reduction (Hogg & Terry, 2000). Through the depersonalization process, consensual interpretations of group values, behaviors, and cognitions are adopted in place of idiosyncratic and individual interpretations. The consensual nature, derived from the group prototype, provides group members with a sense of certainty regarding the appropriate cognitions and behaviors for the group, and by extension for themselves as group members.

Social identity theory has been a useful lens for investigating the working relationships of employed professionals as they face the challenge of simultaneously balancing a sense of belonging within multiple collectives: the profession and the organization that employs them (capturing professional and organizational identification, respectively). This stream of research

aligns with the classical distinction Gouldner (1957, 1958) has made between cosmopolitans and locals, and the corresponding influence of these orientations on organizational behavior (also Wallace, 1995). The cosmopolitan identity captures individuals who are more committed to specialized role skills and the larger profession rather than to a specific organization, capturing a sense of professional identification in which the profession is the defining ingroup and the organization is the outgroup. On the other hand, the local identity captures those who are more loyal to a specific organization than to a set of specialized role skills or external professional group, mirroring organizational identification in which the organization is the defining ingroup and the profession becomes more of the outgroup (Gouldner, 1957). As described below, the dynamics between professional and organizational identification are important in understanding the meaning surrounding employed professions.

### **Professional and Organizational Identification**

The discussion now shifts in favor of applying the social identity theory framework to a particular context, namely the dynamics surrounding employed professionals in general, and employed physicians in particular. To do so, however, requires a sense of the relevant professional and organizational dynamics that such individuals face, as well as an appreciation of how issues of identification relate to those dynamics. The nature of professions is first discussed, followed by the ways in which physicians have come to interface with organizations.

Over the years, several taxonomies of what it means to be a professional have been put forth (e.g., Etzioni, 1969, Hall, 1975, Hickson & Thomas, 1969, Lefkowitz, 2003). Because identity also concerns itself with what it means to be a member of a given group— in this case, professionals – it provides a useful lens with which to discuss the components of these taxonomies and the ways in which they may contribute to one’s sense of self. Structurally

speaking, a profession is typically organized around a systematic and theoretical body of knowledge, as well as a set of cultural values, norms and professional opinions, all which serve to separate and distinguish a given profession from general society. Furthermore, a long period of socialization, education, and training are typically required of professionals, the net result of which tends to be a professional attitude and a lifelong commitment to the profession. Finally, professions value autonomy, self-regulation, and authority over the body of knowledge of which they are considered experts, often exercised through professional associations and reflected by individual members. There are also a number of dynamics at the interface of the profession and society at large. Specifically, society tends to acknowledge the authority and power of professional groups with respect to their area of expertise, as well as acknowledge the importance of the services that professions provide, often which go beyond individual clients to society at large.

These characteristics contribute towards one's professional identity as a physician (Ashmore et al., 2004; Wallace, 1995). Perhaps the largest role stems from the extended period of socialization that physicians undergo and the content that is transferred to them during this process, which serves to: solidify one's membership within the professional collective and its values and norms; provide a narrative of one's membership as well as the profession as a whole; encourage a professional attitude and sense of value of the membership; and tends to provide for a sense of camaraderie among individuals undergoing the same experiences. The length of such training may also contribute to the chronic activation of the professional identity, increasing the degree of implicit and/or explicit importance. After the socialization process, there are a number of experiences that may reinforce these dynamics, stemming from membership in professional associations, relationships in the work environment with other professionals, and so forth.

Throughout, the elevated status of physicians in the eyes of society at large may help to contribute to the degree to which the professional identity is held in high public regard. The net result is likely to be a professional identity that is fairly strong, especially when considered against other work-related identities that are either more temporal or require less investment, for example an organizational or workgroup identity (Johnson et al., 2006). Although it is unlikely for all individuals to follow the same trajectory, or interpret their experiences in the same manner– or even have the same experiences, for that matter– this discussion nevertheless provides some insight into the ways in which the professional identity of physicians may be composed.

Expanding on this last point regarding variability among individuals' professional identities, it is perhaps useful to take stock of some of the assumptions that have typically followed such conceptualizations, particularly among physician samples. More often than not, treatments of professional identity have failed to acknowledge the potential for different instantiations of that identity, instead assuming that professionals share a group identity that means the same thing to each individual (Hoff, 2001). Concepts of professional identity have focused almost solely on physicians, for example, as a “unified occupational subculture that is both distinct from and often in conflict with the organization in which it is found,” ignoring differences among individual physicians (Hoff, 2001, p. 56). This view tends to be echoed rather loudly in the organizational sciences (e.g., Glynn, 2000; Gouldner, 1957; Hekman, Steensma, et al., 2009; Johnson et al., 2006; for an exception, see Wallace, 1995). In large part, this bias reflects the emphasis within social identity theory on processes of depersonalization with the collective and intergroup dynamics. Across these studies, a common dynamic plays out: a professional desire for autonomy versus the organization's desire for control, resulting in

resistance on the part of physicians and frustration on the part of management within large health systems.

There are two inherent limitations to such an assumption, however. First, as stated earlier, it ignores the variability among individuals' professional identities, some aspect of which may be invested in a need for autonomy, but other aspects that are not. In the dominant paradigm, these other aspects are largely ignored. Second, the focus on a homogenous physician identity also comes at the expense of other work-related identities. In other words, a given individual may have integrated various other identities with one's sense of being a professional. Common alternatives for physicians may include the roles of caregiver, economic decision-maker, and/or organizational member (Hoff, 2001). Each of these senses of self may contribute interesting dynamics to the relationship between professional and organization, beyond a desire for autonomy and beyond inherent conflict. These arguments are not intended to suggest replacing the traditional view of professional identity with other forms, but rather illustrate the need to appreciate the larger role of what it means to be a professional across contexts.

The next dynamic of professional identification concerns the interface between the professional and the work setting. The work setting in which professional is employed has important implications for the extent to which a sense of organizational identification may be presumed to occur. First, a note is perhaps warranted regarding the relationship between identification and the expectation of extra-role behaviors as an outcome of identification, particularly among employed physicians. Despite being salaried and under contract, it has been argued that professional employees' behavior is typically not as subject to incentives or punishments as would guide nonprofessional employee behavior (e.g., Dukerich et al., 2002; Johnson et al., 2006; Scott, 1982). This is particularly true for behaviors for which no formal

sanctions exist, such as cooperative and extra-role behavior. Rather, employed professionals' decisions to engage in such behaviors are likely to stem from the way in which they identify, or think about themselves in relation to a given context (Kramer, 1993). Furthermore, one's identification with a target has also been suggested as a mediating influence on other organizational variables that induce cooperation and other extra-role behaviors, such as justice perceptions and economic outcomes (Blader & Tyler, 2009). Taken together, these findings suggest a strong role for identification in explaining why some physicians might engage in pro-organizational behaviors, while others may elect not to.

That being said, the specific structures in which employment occurs are important to take into account. Three prototypical arrangements have been discussed in the literature around professionals in general (Hall, 1975; Scott, 1965, 1982; Wallace, 1995): self-employment as an independent practitioner, employment in an autonomous organization, or employment in a heteronomous organization. The autonomous organization is one in which the structures, norms, goals, and policies are established by one or more professionals, such that "legitimate control over the nature and quality of professional practice is vested in the professional staff and not the administration" (Scott, 1982, p. 216). In contrast, heteronomous organizations are defined as ones in which the work of professionals falls under the control of nonprofessional managers and administrators (Scott, 1982). This form of organization is perhaps the more common, particularly in terms of supporting some of the assumptions put forth in the previous paragraph regarding physician-administration conflict.

A further distinction among these categories that may be of relevance is the potential difference between organizations that are primarily professional versus those that are primarily nonprofessional (Wallace, 1995; see also Johnson et al., 2006). Professional organizations are



defined as those where the core services being provided are congruent with the direct practice of the profession. Examples might include private medical clinics, consulting firms, or private law firms. On the other hand, nonprofessional organizations are defined as those where the core work departs from that which the profession typically includes, yet where professionals are still employed by the organization. Examples may include a lawyer working for a manufacturing company, or a doctor employed by a pharmaceutical company and so forth.

Traditionally, these differences have been approached from the perspective of being rooted in formal organizational structures. However, it may also be possible that such distinctions may be formed by individuals' perceptions, particularly in organizations that are seen as complex and having multiple identities (e.g., Pratt & Foreman, 2000). For example, physicians working for a large health system may perceive the goal of the organization to be the provision of healthcare services (i.e., as a professional organization) or as a for-profit business which happens to be in the healthcare industry (i.e., as a nonprofessional organization). So, although these distinctions between different types of organizations are frequently presented as discrete categories, it may be more appropriate to view them as existing on a continuum, differentiated by the degree to which the domains of the professional and the administrative staff are positioned in relationship to one another, as well as the degree to which those features correspond to individuals' perceptions. These differences in work structures acknowledge the potential complexity with which a professional may perceive his or her role within the organization, thus contributing to a range of different patterns of identification with the profession and the organization.

Given the complexity of these organizational dynamics, it is perhaps not all that surprising that a variety of findings exist regarding the interaction of professionals and

organizations. In some instances, researchers have found that professional identification relates to fewer pro-organizational behaviors, particularly under high levels of perceived monitoring and administrator normative pressure (Hekman, Steensma, et al., 2009), as well as displays negative relationships with policy adherence and productivity (Hekman, Bigley, et al., 2009). Meanwhile, organizational identification has been found to lead to increased cooperative behaviors and participation (Dukerich et al., 2002), particularly when professional identification is low (Hekman, Bigley, et al., 2009). Research has also found that professionals appear to be quite capable of creating professional microcosms within organizations that allow them to retain a sense of autonomy and control (Wallace, 1995), or alternatively, tend to identify less with their profession when working in nonprofessional organizations but identify more with their profession when working in professional organizations, potentially alleviating conflicts of interest (Johnson et al., 2006). Bamber and Iyer (2002) found high levels of both professional and organizational identification among employees, but low levels of conflict between the two, the primary driver of which being the level of organizational identification. Finally, Golden, Dukerich, and Fabian (2000) found that conflicts between professional and organizational interests could be better understood as different interpretations of issues rooted in their roles, rather than in oversimplified stereotypes of opposition. As this latter example suggests, roles within complex and multi-faceted organizations may offer unique opportunities to address identification, above and beyond traditional conceptualizations of the ingroup-outgroup distinctions.

To date, although such research helps to further an understanding of professionals' varied interactions with organizations in terms of different forms of identification, it is nevertheless constrained by several issues. Namely, this research: assumes professionals comprise a

homogenous group without variability among individuals and are in conflict with nonprofessional groups; fails to consider perceptions with regard to the arrangement of professionals' relationships with the organization and the ways in which such arrangements either support or constrain professional behaviors; and more broadly, fails to consider other aspects of the context that may contribute to the way in which identification may occur. Finally, research has tended to focus only on two forms of identification- organizational and professional- despite a wide range of possibilities within the context of complex organizational structures and systems. As such, there is a clear need for a more phenomenological approach to the identification of employed professionals that acknowledges the potential for the larger social environment to play a role, particularly with regard to the identification-outcome relationship.

### **Limitations of the Extant Paradigm**

Throughout the preceding discussion, one may note the long and rich tradition of research and theory on social identity theory. There is typically, however, somewhat of a disconnect between the sophistication that is associated with theoretical developments and that of the way in which identity is empirically assessed, particularly with regard to the enactment of identity in naturalistic settings (although there are clear exceptions, e.g., Ibarra, 1999; Pratt et al., 2006).

Despite the influential nature of the ideas offered by social identity theory (cf. Hogg & Terry, 2000), it has not been without its limitations. Perhaps one of the most cogent set of criticisms stems from the difficulty in generalizing the processes described above— often confirmed in controlled laboratory settings using “minimal” groups— to the complexities of the real world experience of identification (cf. Thoits & Virshup, 1997). This may be particularly true of the dynamics within complex social systems of which individuals may be members (e.g., department and organization; social clique and organization; profession and organization) as they

exist in the social environment. Thus far, the answer to such dilemmas appears to be to take a blended approach, combining social identity theories with sociologically based theories, for example (Ashforth & Mael, 1989; Pratt, 2000). In so doing, the chief advantage seems to lie in relaxing certain assumptions associated with the concept of group prototypicality as a driver of identification, particularly: that a salient prototype be shared amongst group members; that a salient outgroup be present as a referent; and that identifications are generated “on the fly” in response to situational factors rather than stored as a somewhat stable cognitive schema (Turner, Oakes, Haslam, & McGarty, 1994).

Specific to self-categorization theory, the extent to which depersonalization replaces all manner of other self-conceptions in the process of establishing group membership may also come into question, particularly regarding the complexity of certain roles within an organizational context. For example, Tajfel (1981) noted that very little time may actually be devoted to the forms of identification that social identity theory sets out to investigate (i.e., “we”); rather individuals may tend to spend most of their time somewhere in between “me” and “we” in various role relationships. Second, social identity theory does not address the dynamics of role-based identification, which has been variously equated as the same process that occurs with larger collectives, or dismissed as inconsequential (cf. Thoits & Virshup, 1997). To the extent that collectives and roles are perceived as distinct (e.g., a physician’s role within the organization in contrast to a generic sense of belonging to an organization), it is important to capture those distinctions.

In examining the empirical landscape, there are several additional limitations that ought to be noted. One common approach is to assess identity via self-report measures, most commonly using the Ashforth and Mael (1992), Cheney (1983), or other similar scales (e.g.,

Bergami & Bagozzi, 2000; Shamir & Kark, 2004). In such research, parallel versions of the measure are administered, modifying only the name of the relevant collective (e.g., having “organization” and “workgroup” specific scales). The first limitation associated with this approach concerns the inability of individuals to self-select the relevant target, which may mask important differences in how individuals variously conceptualize that target, as well as confine the degree to which the appropriate target is invoked. The second limitation to this type of approach is the inability of parallel scales to account for any form of interaction (actual interaction in context, rather than interaction in a purely statistical sense; e.g., Hekman, Bigley, et al., 2009) between the identities in question, whether they are holistic or pluralistic in nature. A final limitation of much of this extant research based on self-report measures is the lack of contextualization with regard to the eliciting of certain identities. In other words, these measures assess identity with regard to a specific yet abstract target (i.e., profession or organization), and do not provide the type of information that illustrates when and why such identities may be elicited (Rousseau, 1998; also Ashforth et al., 2008). Such limitations stand in stark contrast to the acknowledged complexity of identity discussed earlier.

### **A Shift towards Roles and Identity Theory**

In light of these limitations, it appears that a paradigm shift is required in examining the identification of employed professionals. One available paradigm stems from the sociologically-based identity theory (Stryker & Burke, 2000), which considers roles within the larger social context rather than social groups collectives. Indeed, a growing body of literature has begun to recognize the value of this perspective in providing insight above and beyond that provided by social identity theory (cf. Pratt et al., 2006; Sluss & Ashforth, 2008; Zhang et al., 2014). Although social groups and collectives are adequate in describing certain phenomena, the

context of professionals employed in organizations may be more appropriately reflected in terms of roles within organizational systems.

### **Identity Theory**

Prior to describing the rationale and development of the research questions stemming from this paradigm shift, it is important to understand the historical context of identity theory and the ways in which it differs from social identity theory. Sociological identity theory represents a broad amalgam of microsociological approaches to the investigation of identification, many of which focus on processes related to role-based identities (Owens et al., 2010; Stryker, 2008). The primary traditions that comprise identity theory are referred to as role identity theory (McCall & Simmons, 1966) and structural identity theory (Stryker, 1968, 2008); both approaches are rather similar in scope, so for ease of presentation, this discussion will primarily focus on the more influential of the two, Stryker's (2008) identity theory.

Identity theory generally acknowledges that individuals occupy roles in various social structures, and as a result, have identities representative of those roles. Broadly, a role is defined as a position in a social structure, aspects of which are institutionalized within that structure (borrowing from the structuralist perspective) and other aspects of which are emergent and negotiated between role partners (borrowing from the symbolic interactionist perspective; Ashforth, 2001). A role identity is subsequently defined as the part of the self that is enacted through that role, including many similar features to earlier definitions of identity: capturing the goals, values, beliefs and norms ascribed to that role. A unique feature of role identities however is their embedded nature within larger social systems and networks of associated counterroles, known as role sets (Katz & Kahn, 1978). Embedded within the role identity are the interaction styles and boundaries that occur within a role set. For a physician, counterroles may include the

patient, nursing staff, office staff, colleagues, hospital staff and so forth; the single role identity captures a variety of interaction styles and boundaries for each of these individual role-counterrole relationships.

Stryker (2008) also posited that role identities are arrayed in a salience hierarchy structure, whereby the higher the salience of a given identity, the more likely it is to be invoked in situations where the individual is able to exercise some degree of volitional control. Stryker further describes salience as a function of interactional commitment (“the number of relationships linked to a given identity and ties among networks of relationships”) and affective commitment (“emotional attachment to others in networks of relationships”; 2008, p. 21), both of which are differentiated from commitment as discussed in the psychological literature. It is also worth distinguishing between identity theory’s conceptualization of salience, which represents a somewhat stable characteristic associated with an individual’s various identities, and salience as conceptualized in social identity theory as a dynamic characteristic associated with a given situation.

Extended to the notion of the professional role and the importance that is typically associated with that role– based on the earlier discussion of what it means to be a professional– these observations suggest that the professional role comprises a large part of the self across situations. Thus, it likely forms the basis for subsequent relationships between the professional and the organization, particularly from the perspective of the role sets that comprise such interactions. This stands in stark contrast to the notions of organizational identification which considers the individual’s membership in the organization independent of the profession.

Whereas these elements of identity theory have focused on structural aspects of identity choice, a subsequent development - identity control theory (Burke, 1991; Burke & Reitzes, 1991;

Burke & Stets, 2009) - explains the ways in which enacted role identities interact with an individual's behavior. Burke and his colleagues proposed a feedback control system in which an identity's situated meaning (i.e., as interpreted through the linked meaning of behaviors in a particular situation) is continuously compared against a corresponding identity standard (i.e., the internalized self-meaning with respect to a particular social role across situations). The aim of this feedback system is to regulate action so as to simultaneously affirm the identity in question, as well as to reduce potential discrepancies between the identity standard and the way the identity is enacted in a given situation. Identity control theory stands as an example of the type of cognitive processes that complement the largely structural perspective taken by identity theory, particularly as it relates to the experience of multiple role identities (Stryker & Burke, 2000). Interestingly, this process seems to reflect work in the psychological literature that has focused on behavioral commitment and resulting changes to one's self-schema through processes of behavioral consistency (e.g., Salancik, 1977; Weick, 1995; see overview in Pratt, 1998). All of this suggests the need to examine the meaning of the professional role more closely than has been accomplished within the social identity theory paradigm, particularly in terms of how that meaning influences appropriate action within the scope of the professional-organizational relationship.

Although identity theory and social identity theory have developed in relative isolation from each other, there are several examples of a growing awareness of the potential usefulness of forming bridges between the two theories (e.g., Hogg & Ridgeway, 2003; Hogg et al., 1995; Pratt, 1998; Thoits & Virshup, 1997; Stets & Burke, 2000). Where some see the potential for integrating the theories (e.g., Stets & Burke, 2000), others suggest that the two may play complementary roles in focusing on different phenomena (e.g., Hogg et al., 1995). Much of this



debate centers on the differences between identity theory and social identity theory in terms of their respective foci. Whereas the former focuses primarily on dynamic identification of the self with a collective (i.e. “we”), the latter tends to examine the self through chronic identification within a particular social role (i.e., “I as a...”; Stets & Burke, 2000). To the extent that an individual interacts with others through a role rather than as a member of a group, there may be certain benefits to approaching professional identity from that role-based perspective. This is not to argue that group membership is wholly unimportant; rather, the influence of group membership may simply be more of a distal force and roles a more proximal one in terms of the interactions that individuals have, especially within the highly role-differentiated setting of complex organizations.

Another important consideration is the relationship of the core entity to other social entities. Within the social identity theory tradition, the focus on ingroup-outgroup distinctions suggests an almost forced dichotomy. If we assume the profession is a salient ingroup, the organization must either take the form of the referent outgroup (i.e., when identification with the profession is salient) or an alternative ingroup outside of the profession (i.e., when the organization itself is the target of identification). Within identity theory, the professional may also identify with the professional role or an organizational role depending on salience, yet there is a crucial difference in the availability of alternative arrangements.

The chief benefit of discussing roles is the explicit acknowledgement of role sets, capturing the network of interdependent relationships between a role and its counterroles and the ensuing role identity as the enactment of one’s self within that role context. Where the profession and organization are interdependent, the role set of relationships between those two entities is more likely to mirror the reality of work arrangements, rather than assume zero sum

identification with discrete collectives, capturing the work environment in higher fidelity than is possible from a social identity theory perspective. For example, even though a professional may not wholly identify with an organizational role, there is still the opportunity to capture the interdependence between the profession and the organization in the form of those role relationships. This perspective is lacking in the dominant social identity theory paradigm, yet forms an important part of the social system of the organization employing professionals.

### **Development of the Research Questions**

Noted throughout this review, the majority of prior research on the identification of employed professionals has been approached from the dualistic perspective of social identity theory. This tack typically involves positing a discrete professional identity and organizational identity (or other workgroup related identity), assessed independently and associated with different profiles of behavior. The current study proposes that a solution to these issues is offered through a paradigm shift in how the identity of employed professionals is conceptualized.

Rather than continue to struggle against limitations imposed by thinking of the profession and the organization as collectives, a more beneficial approach may lie in defining the employed professional as a singular and unified role, following more of a sociological identity theory approach. In other words, when a professional is employed by an organization, such employment typically centers on the work accomplished through the professional role, emphasizing the importance of that role. Second, a complex role set exists around that professional role and the ability to perform professional work as a condition of the employment arrangement, capturing the interdependent nature of profession and organization. These role relationships, as a part of the role identity, will subsequently drive thought and action within the context of the organization that employs professionals.

To date, few if any studies that have sought to define the employed professional as a holistic role in the context of identity theory. However, doing so offers a parsimonious explanation of the complicated dynamics that surround professionals who are employed within organizations: as professionals rather than as more traditional employees. Clearly, relationships between professionals and their employing organizations are more interdependent than social identity theory might allow, and the number of unique collectives within complex healthcare delivery systems would soon become unwieldy. Rather, it is far simpler to understand the unique roles that professionals and other members of the organization play in delivering professional services. Given the lack of empirical attention, this study proposes a grounded theory methodology to more fully understand these dynamics, and addresses this overarching question to seek to more fully understand what it means to be an employed professional: from a role-based perspective, what does it mean to be an employed professional, and how does that meaning contribute to the interactions between the professional and the organization?

There are several components to this question that must be answered in order to develop a fuller understanding of the role of the employed professional. The relationship between these sub-components and how they address the question posed above are illustrated in Figure 1. First, one must attempt to understand the professional role itself, as it exists at the center of subsequent role relationships with the organization. This study will seek to define more clearly the meaning of the professional role as it exists across individuals and also across situations. One benefit of the identity theory approach is the explicit acknowledgement of the importance of the meaning in tying a role to a set of behaviors. Thus, to understand the downstream patterns of thought and action, it is important to understand what meaning embedded in the professional role contributes to that thought and action. A focus on the specific content of the professional role, as Postmes

and Jetten (2006) argue, “allows us to predict what the effects of identification and identity salience will be. Without content... identity is rudderless” (p. 259). As a result of these observations, the first step in understanding the employed professional role is to better understand the content of the professional role at its core:

*RQ1: Within the context of an employed professional role identity, what does it mean to be a professional?*

Alongside the content of the professional role, it is important to acknowledge what form the professional’s relationship to the organization may take. Indeed, this statement itself is something of a paradigm shift from the prior literature, because it acknowledges that a professional is more likely to engage with the organization as a professional rather than purely as an individual. While social identity theory suggests that the individual perceives membership in each of many distinct collectives, either the profession or the organization, identity theory offers a role-in-context approach through which to capture those same relationships. Within the latter perspective, the interaction between social entities becomes more impactful. These statements are not to suggest that individuals do or do not identify with an organization, but rather argue that the more impactful lens is the nature and interpretation of employment in the context of the professional role.

Although employment can exist as a role in and of itself— capturing the norms, expectations, goals, and interaction styles between a traditional employee and an organization— the current study argues for a holistic employed professional role in which employment qualifies the nature of the professional role rather than standing on its own with a unique set of role relationships. To date, research has not examined the nature of professional employment outside a pure sense of organizational membership, despite the potential for more complex expectations

to exist on both the professional and the organizational side. The definition of employment may contribute to the definition of the professional role in terms of specifying any number of expectations around the professional-organizational role relationships. As such, it is important to more fully understand the meaning of employment to the professional.

*RQ2: Within the context of the professional role, what does employment mean within an organization?*

Within the context of employment, then, an important consideration extends to the nature of role relationships between the professional and the organization. The definition that the professional brings to employment is theorized to impact the manner of downstream relationships that a professional has with the organization in either facilitating or hindering the reasons that a professional has sought out employment. As a result, one must consider the role of the professional in the organization, in terms of what expectations exist around that professional's membership and participation, as well as the role of the organization in the profession, in terms of what type of resources and support are provided, and what the boundaries are between those two different forms of relationships. The plurality of the role relationships and interactions between the professional and the organization become possible in a role-based paradigm. For example, within the context of both the professional role and notions of employment, it is possible to enumerate the varying role-counterrole relationships that comprise the role set between the profession and the organization, including the counterroles that are distinct from either of those collectives (i.e., the patient) or simply require more refinement than prior research could offer (i.e., differentiating between the immediate clinic and the larger organization, between different levels of management).

An additional set of issues revolves around the problematic nature of how a sense of professional and organizational identification contributes to a willingness to expend effort and the directions in which such effort is expended. Within the paradigm of social identity theory, the inherent assumption is that effort tends to be expended on behalf of groups with which one has identified: either for the profession above the organization, or for the organization above the profession. Within the scope of the employed professional role, however, the domain of the profession within the organization and the organization within the profession are made clear, such that participation becomes more than acting on behalf of a single collective. Instead, the meaning that is contained in the employed professional role through the professional-organizational role relationships will drive relevant thought and action. As such, the final research question seeks to more fully understand the nature of those role relationships as influenced by the meaning of employment.

*RQ3: Within the context of professional employment, what is the nature of professional-organizational role relationships, in terms of (a) the organization's role in the profession and (b) the professional's role in the organization?*

In summary, this study seeks to provide a better understanding of the professional role in organizational settings, through the employed professional role identity. Seen as a holistic role, with influences of both the profession and how that profession is employed within an organization, it is posited to provide a better understanding of physician-system relationships and the meanings and interactions that stem from such a role-based perspective.

## **CHAPTER THREE – RESEARCH DESIGN AND METHODOLOGY**

The current study was conducted using a blended qualitative approach, utilizing aspects of case study (Yin, 2008), ethnography (Van Maanen, 1979), and grounded theory (Corbin & Strauss, 2008; Glaser & Strauss, 1967; Locke, 2001; Strauss & Corbin, 1998) to develop a better understanding of the employed professional role. The primary source of data for this study was semi-structured interviews with physicians employed in a large primary care network, operated by a large health system. These interviews assessed the nature of the physician role within this network, and patterns of interactions and expectations between the physicians and their employing organization. These data were further contextualized through the collection of observations of the practice setting in which physicians worked, the organization's headquarters, and through the collection of archival documents. As these forms of data were somewhat more peripheral to an understanding of the employed professional role identity, they were not formally analyzed alongside the interviews. The interview data were analyzed using a grounded theory methodology (Corbin & Strauss, 2008; Gioia, Corley, & Hamilton, 2013), following an iterative process of coding first-order informant categories, second-order theoretical concepts, and second-order aggregate dimensions. The research process is described in full detail in the sections below, beginning with the rationale behind a qualitative approach.

### **Rationale for a Qualitative Approach**

Given the state of the current body of literature on identification in organizational settings among professionals, it is proposed that a primarily qualitative approach is both appropriate and timely on several grounds. First, research is needed that acknowledges the richness and

complexity of the identity of employed professionals. Inherent in this objective is a shift towards capturing individuals' contextual experiences. An ethnographic approach (Van Maanen, 1979, 1988) provides a useful tool in accomplishing just such a purpose. Briefly, ethnography typically entails extended contact with a particular community, primarily through fieldwork, with the goal of “uncover[ing] and explicat[ing] the ways in which people in particular settings come to understand, account for, take action, and otherwise manage their day-to-day situation” (Van Maanen, 1979, p. 540). As a result, such qualitative accounts provide rich descriptions of organizational phenomenon from the contextualized experiences of organizational members.

As Miles and Huberman (1994) note, many traditions have built upon and subsequently modified the ethnographic approach, which in its strictest form is relatively unstructured and relies exclusively on fieldwork. For instance, both grounded theory (Glaser & Strauss, 1967; Locke, 2001) and case study (Yin, 2008) approaches retain the emphasis on rich descriptions of a given context or phenomenon, yet also advocate a more structured approach to obtaining such descriptions (i.e., development of more formalized research questions, systematic data collection and analysis procedures), as well as on information from non-fieldwork settings (e.g., existing theory from the literature, archival documents). As these latter approaches have largely overtaken the original conceptualization of ethnography, particularly in the organizational sciences (cf. Miles & Huberman, 1994), the term as it is used in the current study refers to a more structured instantiation of ethnography while retaining the primary focus on the importance of capturing organizational members' experiences in rich detail.

The second basis upon which a qualitative approach is generally warranted stems from the typical lack of integration between theoretical and empirical progress in the identification literature. As the prior chapter suggests, theory has largely outpaced empirical work, particularly



with regard to the phenomena of multiple identification, as well as how forms of identification may or may not contribute to thought and action. As a result, there is a need to codify extant theories and perspectives, identifying those aspects that are influential versus those that are less so, particularly from the perspective of individuals in organizational contexts, as well as to identify areas where existing theories may be expanded or elaborated upon. Rather than an attempt to solely test theory, this project is more appropriately conceptualized as an attempt to build upon and integrate existing theories, allowing phenomena to naturally emerge rather than constrain them to a specific model.

In pursuit of this objective, a grounded theory approach (Glaser & Strauss, 1967; Strauss & Corbin, 1998; Corbin & Strauss, 2008) provides a useful methodological tool. Grounded theory involves an iterative process by which an investigator moves between the development of theory and the analysis of data, cycles which may be further embedded within a larger understanding of the relevant literature (in the case of theory expansion and elaboration more so than theory building per se). Given the current state of development in the theoretical identification literature, the current project necessarily begins by situating the proposed analysis against a thorough understanding of the various ways in which the literature has approached issues of identification. Such literature has primarily helped to inform the general purpose and the specific research questions that stem from that purpose, as well as eventually guiding the iterative cycles of data analysis and theory building. More specific information on the use of grounded theory techniques are provided in the data analysis section below.

## Study Setting and Context

The setting of the current research project focuses on a subset of employed professionals, namely physicians who are employees of North-Central Health Clinics (NCHC)<sup>1</sup>, a large primary care physician network. NCHC is a subsidiary of a larger faith-based, non-profit healthcare system, North-Central Health System (NCHS), comprising several large hospitals and other ancillary services (e.g., rehabilitation, home health, pharmacy, and so forth). NCHC employs approximately 41 primary care physicians across 20 practice locations, geographically distributed within and around a large metropolitan area in the southern United States. The majority of these practices are distributed around each of the major hospitals that anchor the health system, although several are also located in more rural areas or areas in which a former hospital was located but subsequently sold to another health system. NCHC practices range from 1 to 5 providers. In addition to the core business of managing primary care practices, NCHC is also contracted by the hospitals to provide hospitalist groups and to help establish certain specialties in and around the major hospitals based on need and business strategy. Overall, NCHS may be characterized as a hospital-driven system, in which NCHC exists to support those hospitals through referrals and capture of market share, justifying the lack of direct profitability.

Although the specific physician employment relationship may differ in select cases (e.g., where a physician still owns the practice building and charges himself rent), NCHC typically owns or leases the practice facilities and durable assets, employs the staff, and manages many of the back-office functions related to running the practice (i.e., start-up and strategic planning, billing and coding, finances and accounting, and human resources management), reducing the “business burdens” on the physicians. One point of particular mention is the dual authority

---

<sup>1</sup> This name and the names of related organizational units are pseudonyms for the actual organization and will be used here to protect the anonymity of the organization and its members. Furthermore, all individual participants will be referred to via a numerical coding system throughout this manuscript.

structure that is present within the practices, as NCHC employs both the practice manager, who is supervised by the operations director, and the physician, whose leadership within the practice is more informally based.

The physicians are typically employed under a productivity contract, where a salary is largely based on productivity less management fees and other expenses charged by NCHC. Alongside the salary, physicians receive benefits consistent with traditional employment (e.g., 401(k), paid-time-off), as well as professional requirements (e.g., liability insurance, malpractice coverage). Physicians who are just starting out are hired under a salary guarantee model, ranging anywhere from 18 to 24 months, in which a pre-specified salary allows that provider time to grow the practice. At the end of this period, the physician transitions to a productivity model. These employment models are relatively new to the current instantiation of clinic ownership; prior models within the organization were almost exclusively salary guarantee, which were related to many down-side risks for NCHC and very little risk for the physicians themselves.

Historically, there have been two paths through which a practice becomes a part of NCHC: acquisition of a pre-existing private practice, or establishment of an entirely new practice. In the mid-1990s, when various mergers resulted in NCHC, the more common path was the acquisition of pre-existing practices and was seen both as a way of achieving coordinated and comprehensive patient care across the healthcare continuum and across multiple providers (e.g., hospitals, physicians), and as a way of increasing and/or securing market share for the hospitals within the larger health system. Much of this activity was generally in line with the zeitgeist of the era, which was to follow this type of organized delivery system approach (Shortell et al., 2000). The promise of such systems was ideally accomplished by coordinating support functions and activities (also referred to as *functional integration*) and by coordinating patient care services

across different individuals and locations (also referred to as *clinical integration*). Perhaps the most common path, particularly early on, was that of *physician integration*, establishing a cooperative relationship between physicians and the system with which they are associated, typically through employment and vertical integration.

Another key aspect to consider is the cyclical nature that many health systems have had in terms of their relationships with owning primary care clinic network. Although organized delivery system models were largely criticized as being too costly without delivering much in the way of promised benefits (e.g., Devereaux, 2000), a resurgence in interest has recently occurred, beginning in the mid-to-late 2000s and early 2010s. Likewise, NCHC has undergone several cycles that reflect these larger trends, at times divesting and at other times investing in their clinic network and its management. This has been spurred in part by growing pressures that primary care physicians face: simultaneous decreases in reimbursement levels amidst rising costs of care, regulatory changes and the associated investments required for compliance, and a general transition to quality-focused or risk-sharing arrangements and managed care models (Budetti, Shortell, Waters, Alexander, Burns, Gillies, & Zukerman, 2002). Indeed, physician employment has not only become popularized by health systems looking to expand, but also by insurance companies, regional hospitals, and so forth, suggesting the increased competitive dynamics within the healthcare industry.

Although there is a growing acknowledgement of the importance of physician-system relationships and physician engagement (e.g., Schramko, 2007) and recognition of some successful implementation strategies that support those relationships (e.g., building new practices instead of co-opting existing ones, changes to the contract structures to encourage certain physician behaviors; see Moore & Coddington, 2009), many systems still face the challenges

associated with physician employment. In this environment, it is a worthy empirical and practical question as to how identification of employed professionals relates to the relationships between physicians and the systems to which they belong, particularly with regard to desired thought and action.

### **Selecting an Appropriate Site**

The selection of NCHC as a research setting represents a diverse organization with many dynamics that may speak to a diversity of identification paths. The physicians of NCHC, as the sample at the core of this investigation, represent varied career histories, working arrangements, expectations, and day-to-day tasks, despite sharing in some way the need to balance the sense of being a physician employee of NCHC. Such an environment provides the clear opportunity for a complex role identity to occur and for that identity to be readily apparent in everyday work activities. The presence of such factors mirrors many of the recommendations of selecting an appropriate research site (e.g., Eisenhardt, 1989; Glaser & Strauss, 1967; Miles & Huberman, 1994; Yin, 2008). First and foremost, these authors recommend the selection of a site of theoretical interest, where a given phenomenon may be readily and extensively observed. Pettigrew (1990) expands upon this point, suggesting that appropriate settings ought to represent extreme or polarized instances of the phenomenon in question, or where the phenomenon is particularly salient due to particular environmental characteristics.

In light of these recommendations, the selection of an appropriate research site for the current study was guided by the degree to which individuals were likely to experience a holistic role identity, as well as the degree to which the relationship between that identity and organizational action may be particularly salient as a result of external factors and other environmental dynamics. NCHC appears to satisfy these criteria, such that how physicians think

and act may be expected to be particularly salient given the historical development of NCHC as an organization, the physicians' personal histories with NCHC, and the degree to which external changes to the health care industry apply pressure to the entire system. With an essential understanding of the context in which the research will take place, the discussion now shifts to details of how the project originated with the organization.

### **Establishing a Relationship**

The current research project originated from a social encounter at an event for the health system's foundation with the president of NCHC, who also holds an executive position within the health system in charge of integration activities. A brief discussion about the state of current physician-system relationships, the strategic direction of the organization, and the potential benefit in investigating these issues from an organizational behavior standpoint led to several follow-up meetings. During these meetings, several issues were discussed as potential phenomena worthy of further investigation, the chief one centering on the need for cooperative relationships between the physicians and the system particularly with regard to the performance of extra-role behaviors and change adoption, and somewhat relatedly, the need for physician engagement in general. Working with the president and then the chief operating officer of NCHC, who became the project sponsor at the organization, a preliminary round of semi-structured interviews was conducted with corporate (non-medical) members and "alumni" of the NCHC management team ( $n = 6$ ). These interviews were intended to provide a sense of the organization's history, the current state of affairs, and the perceptions of the management team with regard to working with the medical staff.

Several dynamics emerged that bear relevance to the current project. Interestingly, the nested nature of NCHC within the larger health system created a wide range of different

expectations with regard to the amount of control over NCHC's physician employees. Whereas NCHC, which interacts more closely with the physicians, acknowledges the difficulty of "telling doctors what to do," the health system executives appear to demand of NCHC, "Tell your employees to do this." Further complicating this dynamic is the issue of dependency within the scope of the larger health system. In the system's view, "There's no NCHC without the hospitals," representing the fact that NCHC clinics are often cost rather than profit centers and rely on the hospitals' revenue to remain viable. The physician view, as voiced through NCHC management, is exactly the converse, "There's no NCHC without me." This is further echoed in the typical way that NCHC managers discuss their physicians as "The Talent" or as "Sports Stars," connoting a strong sense of asymmetrical dependency. What is clear from these interviews is the complexity of relationships within NCHC itself and as nested within a health system which is seen as hospital-dominant. Furthermore, a dynamic emerges wherein NCHC seeks to encourage its physician employees to direct behavior in organizationally beneficial ways without having the amount of control that may be typical of other employee groups.

From these interviews, and after a review of relevant literature, the current project began to focus more closely on the potential barriers to effective relationships between physician and system personnel, with the ultimate goal of reducing those barriers so as to more effectively function as an organized delivery system in delivering comprehensive coordinated patient care across the healthcare continuum. As the previous chapter suggests, identification provides an appropriate lens in terms of investigating potential barriers, particularly among employed physician populations (e.g., Dukerich et al., 2002; Hekman, Bigley, et al., 2009). Furthermore, identification is a useful concept, in that it not only focuses on the barriers per se, but also on the potential facilitators to effective relationships. For example, a theme throughout the preliminary

interviews suggests that among the physicians that are employed by NCHC, there are certain “champions” – defined as those that willingly serve on committees and are otherwise engaged in NCHC initiatives; “detractors” – defined as those that actively resist such initiatives and just “want to be left alone”; and the “enrolled,” which are neither actively engaged nor disengaged. Identification provides a potential way of illuminating the ways in which physicians understand their role, and subsequently think and act in terms of their own relationships with NCHC. With these ideas in mind, the discussion now turns to the specific methods that are proposed as a means to address the research questions presented in the previous chapter.

### **Research Design Overview**

The following sections detail the way in which the current project was carried out, beginning with a general overview of the research design. Following the preliminary interviews with the corporate members of NCHC, I conducted observations of the clinic operations in order to more fully understand the dynamics that occur at the interface of the physician and the organization (i.e., meetings, practice operations, training and orientations); the majority of these observations occurred between May 2012 and August 2012, but also continued through the end of data collection in May 2013. The semi-structured interview protocol was developed and refined, both with the insight gained from these observations and input from the management of NCHC, throughout the Fall of 2012. Semi-structured interviews with physicians were conducted between December 2012 and May 2013, and involved coordinating a suitable time through each physician’s practice manager, often requiring multiple contact attempts. Throughout the process of interviewing, data analysis and coding were conducted to examine emerging categories and provide insight into subsequent data collection, following a grounded theory approach (Strauss & Corbin, 1998; Corbin & Strauss, 2008). Finally, several methods for ensuring trustworthiness



were implemented throughout this process, including triangulation of sources and methods, thorough documentation of the analysis through an audit trail, and prolonged contact and persistent observation within the research site (Jick, 1979; Lincoln & Guba, 1985; Miles & Huberman, 1994).

### **Sample Selection and Data Collection**

As mentioned earlier, the sample for the current study was drawn from the primary care physicians employed by NCHC ( $N = 41$ ); there were an additional 8 physicians who were either retiring or who were transitioning their practice out of NCHC, and were not available to be interviewed. Several attempts to contact each physician were made through their practice managers, who were largely responsible for the physicians' schedules. This process typically involved multiple attempts, both in terms of contacting the practice manager and in arriving at a time that fit within the physician's practice schedule. Of the 41 physicians, 23 were eventually interviewed for this study, for a participation rate of 56%, and representing 15 of the 20 practice locations. The remaining 18 physicians who were not interviewed were either unreachable after several attempts via telephone and email (9) or stated that they did not currently have the time to participate due to patient or administrative workloads (9).

Of the physicians who participated in this study, 65% were male and 65% were White/Caucasian. The average age of the physicians was 52 years old ( $SD = 11.9$  years). Family practice was the dominant specialty (16 participants), with the remainder specializing in internal medicine, pediatrics, or women's health. The average year of board certification in their respective specialties was 1995 ( $SD = 11.2$  years). The average tenure with NCHC was 10.4 years ( $SD = 7.1$  years). Roughly half of the participants in this study worked in practices of 1 or 2 providers, while the other half worked in practices with 3-5 providers. Fourteen physicians

reported working in another clinic arrangement prior to their employment through NCHC: 8 of those involved employment with another healthcare organization and 6 were in private practice. Twelve physicians in this study reported being involved in at least one committee as a result of their employment with NCHC, some examples of which include quality and compliance committees, information technology advisory groups, and board membership for NCHC. A summary of physician interviewee demographics is presented in Table 1.

The sample for the current study was selected using a purposeful sampling strategy, which is more appropriate than random selection strategies when working with qualitative data (Glaser & Strauss, 1967; Miles & Huberman, 1994; Patton, 1990). Early interviews were characterized by a maximum variation sampling strategy, which involved seeking out participants to represent the widest range of variation of a phenomenon of interest, with particular interest in balancing typical with outlier cases, and in confirming and disconfirming cases (Miles & Huberman, 1994). For the current project, physician interviews were initially sought out that represented the different poles of experiences within NCHC. For example, because tenure has often been associated with strength of identification (Riketta, 2005), participants represented both long-standing and relatively-new employees. Other examples of relevant factors included: those physicians whose practices were acquired versus those who were hired into a newly built clinic; those hired directly out of residency versus those with established careers; practices located near referral hospitals in the system and those that are more distant; single physician offices compared to multiple provider offices; physicians who do not get involved in committees and physicians who are more involved, to name a few of the dimensions under consideration.

Following an initial set of interviews, the subsequent sampling approach was guided by the criteria of theoretical saturation that determines when enough data have been collected, rather than specifying the desired sample size a priori. Theoretical saturation ideally refers to the scenario in which (relatively) little to no new information is provided by data analysis, although in practice typically captures the point at which new data does not add incremental value to a given theoretical explanation, since it is likely that there is always “new” data to uncover (Strauss & Corbin, 1998). An additional consideration pertains to establishing a sufficient sample size for case study-type research, which typically involves the degree to which the phenomenon of interest is straightforward versus subtle, analogous to conceptualizations of statistical power, and relatedly, the potential strength of rival explanations (Yin, 2008). As a result, and due to the complex nature of identifications, the current study made an attempt to interview as many members as possible of the 41 primary care physicians of NCHC. Although these strategies are primarily described in terms of selecting a sample of physicians interviews, it is important to note that they also adequately describe the selection of cases in general (i.e., data from observations, archival documents).

The majority of the physician interviews were conducted one-on-one in the physician’s office to ensure confidentiality and honesty in responses; a small handful of physicians elected to be interviewed in the practice break room, which was typically empty during the interview. First, permission to audio-record the interview was obtained; all physicians consented to have their interview recorded. The physician then signed the informed consent document and was offered the opportunity to ask any questions about the study’s purpose or structure. The interview began with a set of demographic questions on the physician’s history with NCHC and other organizations, where applicable. The semi-structured interview protocol was followed, which

allowed me to ask probing questions based on participant's responses, the on-going analysis, and data from observations and archival materials. At the conclusion of the interview, physicians were asked to fill out a brief quantitative survey of organizational and professional identification. Following each interview, the audio recording and notes were transcribed verbatim, with an effort to do so within 48 hours of each interview. Exceptions occurred where multiple interviews were conducted on the same day and took more time to transcribe. Interviews lasted 36 minutes on average, ranging from 25 minutes to 61 minutes, and resulted in between 7 and 15 single-spaced pages of transcription with an average of 9.7 pages.

These data were loaded into qualitative data analysis software (MAXQDA, 1989-2014), as they became available to allow for the initial analysis and coding process to begin, and also allow prompts within the interview to be refined. The analysis and coding process is described in more detail below, alongside more detailed discussions of the specific data sources.

**Semi-structured interviews.** The physicians in the current project were interviewed using a semi-structured interview format, presented in Appendix A. The first set of questions within the interview covered basic background information, asking the participant about their specialty, tenure with the organization, how the relationship was initiated, and any roles they hold with NCHC or other entities. These questions were developed to assess the participant's general background with regard to the practice of medicine, as well as his or her employment history and level of involvement within the organization.

The main portion of the interview comprised 5 questions to assess what it means to be an employed professional, still having a practice yet working within the context of a larger organization and what the interaction between the professional and the organization means to the individual participant. It has been acknowledged that researchers based in ethnographic and

grounded theory traditions do not necessarily know the right questions to ask, leading to the recommendation for interviews to focus on aspects of “what” rather than “why” or “how” (Foreman, 2001; Miles & Huberman, 1994; Yin, 2008). As a result, the interview protocol attempted to focus on these types of questions at the outset, allowing the eventual emergence of theory to guide structure and process questions.

The first question attempted to gather participants’ broad experiences as a physician working for NCHC, with additional prompts focused on issues of alignment and shared expectations between the individual as a physician and the organization. This question aligns to the first and second research questions, to investigate what the role of physician means to participants and how employment impacts an understanding of that professional role. The second and third questions address the interactions between the professional and the organization, in terms of integration activities and to use pressing issues as critical incidents to illuminate key patterns of interactions. These questions align with the third research question, speaking to the participant’s understanding of their role relationships with the organization, as well as contribute to levels of professional involvement, either broadly or within the scope of the organization. The fourth question was developed to assess the potential for identification with collectives rather than roles, seeking to determine whether physicians identify with a specific group within NCHC. The fifth question, which mirrors a question included in the organization’s physician satisfaction survey, attempts to gather the physician perspective on their role within the specific content of supporting the NCHC clinic network. After discussions with the project sponsor, this question was included largely to gather more data around physician’s thoughts on this topic, as well as for its natural alignment with the research questions presented earlier.

These interview questions underwent several revisions in order to ensure that physicians would be receptive to the wording of the questions, that the question would be succinct and to the point, and to ensure that the physician responses would contribute towards an understanding of the phenomenon of interest. In terms of the former goal, the text of the questions was reviewed by several physicians who are members of the larger health system but are unaffiliated with NCHC, as well as reviewed by the project sponsor at NCHC. The sponsor also helped to perform a “member-check” to verify that these questions aligned with the business interest in the project and addressed critical issues for them that were revealed in the preliminary interviews with corporate staff. In terms of ensuring that responses to the interview questions would represent the phenomenon of interest, the physicians that reviewed the text of the questions also helped to pilot test the items.

Although this is the form of the interview protocol at the initiation of the study, the protocol was refined as theoretical concepts began to emerge from the analysis of data. For example, most if not all of the physicians had difficulty describing any specific culture of NCHC physicians, so emphasis was shifted away from that question and towards a theme that had emerged in early interviews in terms of the organization making changes within the clinics or the physicians wanting to make changes. This question was: “What changes have you wanted to see made in the clinic? What changes has the organization wanted to make in the clinic?” As a useful critical incident, information from this question helped to illustrate some of the interactional dynamics between the physician and the organization.

In order to maintain any potential consistency between the extant literature on organizational and professional identification, at the end of the interview, participants were given a brief measure of identification, mirroring the typical procedure used in quantitative studies

(e.g., Hekman, Bigley et al., 2009; Hekman, Steensma, et al., 2009; Johnson et al., 2006). Specifically, parallel versions of Mael and Ashforth's (1992) measure were administered (see Appendix B). This scale consists of six items for each identification, with a 7-point Likert-type response format ranging from "Strongly Disagree – 1" to "Strongly Agree – 7." A sample item is "When I talk about [the collective], I usually say we rather than they," where the collective is replaced either with the organizational name or the professional group. In deciding the sequence of the interview and the measure, the benefits of having the measure last primarily lies in avoiding biasing potential responses to the interview questions about identity, which form the core of the study, and also achieving more contextually specific descriptions about identification prior to asking about abstract notions of identification. With the caveat of the small sample size, the reliabilities of these measures were reflective of prior studies using physician samples (e.g., Hekman, Bigley et al., 2009). The reliability estimates are .80 for the organizational identification measure, and .84 for the professional identification measure. As the study moved away from notions of these collective identifications and towards more complex and contextualized roles, these data are presented for informational purposes only (see Table 1).

**Non-participant observation.** The second type of data collected consisted of field notes from observations of organizational activities. These activities included observation of relevant meetings within the clinic and at corporate headquarters, daily activities and processes within the clinics, workflows, and interactions between the physicians and the groups with whom they work (i.e., other physicians, practice staff, practice manager, corporate operations manager, executive team members). Because the observations of these events will not carry any formal duties within the organization, they are appropriately classified as "non-participant observations" (Yin, 2008). An important point bears mentioning about this form of observation, however: one must consider

the extent to which the investigator is “known” to the organizational members that he is investigating (Lofland & Lofland, 1995). Although knowledge of an investigator’s presence may affect the environment and the individuals within it, known investigators may also be able to more thoroughly observe phenomena than if they were covert. Ideally, the role of an investigator may be structured, by becoming an “insider,” so as to maximize the benefits of observation and reduce the dangers of introducing bias (Foreman, 2001). In this scenario, a known investigator becomes somewhat of a fixture at an organization, so that employees are accustomed to his presence. However, the danger in this case is referred to as “going native” or losing one’s sense of independence from the research setting, which may introduce a considerable amount of bias (Miles & Huberman, 1994). Tactics to address such bias included cognitive strategies, such as thinking comparatively between cases, periodic and intentional distancing from the data, achieving multiple viewpoints, and verifying data against theory (Strauss & Corbin, 1998; Corbin & Strauss, 2008). In this way, one maintains an appropriate balance between objectivity and sensitivity to the phenomenon under investigation.

The sampling of events to observe followed the sampling strategy described above, first seeking out representative and nonrepresentative cases, and then transitioning to theoretical sampling strategies as the theory began to emerge from the data. Taking extensive field notes, a crucial aspect of ethnographic approaches (e.g., Miles & Huberman, 1994, Strauss & Corbin, 1998; Yin, 2008), was facilitated by being a known researcher within the clinics and corporate offices, which afforded the ability to take notes in real-time. Attempts were made to transcribe these notes no more than 24-48 hours after the event to ensure the accuracy of general impressions, comments, and observations. The types of meetings and events sampled are included in Table 2.



**Supplementary data.** The final types of data consisted of supplementary information gleaned from archival documents provided by the organization and from informal discussions with organizational members. Each of these forms of data has a unique role in the data collection process. Archival data – in the form of organizational memos, e-mails, strategy and planning documents, and so forth – provided a means of corroborating events or illustrating certain dynamics that are relevant within the organizational environment. Therefore, although they are not the primary means of collecting information about individuals' identification, they provide a sense of the conditions under which the phenomenon may exhibit itself. To provide a noteworthy example, during one interview, a physician remarked about the lack of quarterly get-togethers for physicians; a presentation provided by the organization however, suggested that just such a quarterly event had taken place the prior month. Through the archival data, I was able to probe more into the physician's comments to determine the source of these perceptions. Likewise, informal interviews and discussions with organizational members helped to supplement the data from the intensive interviews, as well as orient the investigator towards the organization. Informal talks like these also help to create a relationship between the investigator and the organizational members, which may help facilitate data collection (Foreman, 2001). Both of these forms of data help to triangulate the data (Jick, 1979), by providing multiple methods and/or multiple viewpoints on a given event or situation. They also contribute to a better understanding of the ways in which the phenomenon of interest tend to emerge and offer insight into the revision of the protocols or sampling strategies.

### **Data Analysis and Synthesis**

Although the data collection and data analysis strategies are discussed separately, it should be understood that they were carried out simultaneously and iteratively. The data coding

and analysis followed the general approach provided by grounded theory data analysts (Corbin & Strauss, 2008; Eisenhardt, 1989; Glaser & Strauss, 1967; Strauss, 1978; Strauss & Corbin, 1998; Yin, 2008; see also Locke, 2001). Although the terminology differs across some theorists in terms of coding steps, the current project follows the general conventions offered by Gioia et al. (2013) and Strauss and Corbin (1998; Corbin & Strauss, 2008). In this approach, coding and analysis of the data takes place in three interrelated and overlapping processes: a first-order analysis (i.e., open coding) and a second-order analysis (i.e., axial coding and selective coding). The outcome of the first-order analysis is a set of concepts, labels that describe the data, while the outcome of the second-order analysis is a set of themes that help to theoretically group multiple concepts. Finally, from these themes, aggregate dimensions are formed to capture the theoretical constructs behind related themes. It should be noted that grounded theory research entails conducting multiple iterations of this coding process, fluidly moving between first-order and second-order analyses. Also, throughout this process, the analysis was aided by the use of memos, as well as various graphical and display tools (see Miles & Huberman, 1994).

Particularly useful at the beginning of the interviews, the first-order analysis entailed a process of “giving voice” to the physicians, using their own words to form categories and labels for emerging ideas and thoughts. The essential task here was not to evaluate, but rather to label what had been said during the interviews and to discover categories that may be present in the data. To the extent possible, I attempted to use participants’ own language in the categories that were emerging, in the form of *in vivo* codes. The overall process also allowed me to uncover potential subcategories, properties (defined as “general or specific characteristics or attributes of a category”), and dimensions (defined as “the location of a property along a continuum or range”; Strauss & Corbin, 1998, p. 117). For the initial interviews, this coding and labeling

process took more of a micro-coding approach (Corbin & Strauss, 2008), in which interviews were coded line by line and at times, word by word to search for potential meaning.

Using this process at the beginning is a tool to help the researcher gain familiarity with the data, as well as help to challenge initial preconceptions about the sample being studied by closely examining the words they are using. To provide an illustrative example, one of the bigger issues discussed by the corporate office was the implementation of electronic health records as an organizational change, so I assumed this would also be an issue from the physician perspective and would encounter resistance towards these systems and the organization. During interviews, however, it became clear that this change was perceived as largely separate from the organization and was more of an industry-wide phenomenon (“everybody has to do it... whether you work for an organization or not”, 21); it was more of a source of frustration in the impediment to effectively seeing patients, but otherwise, largely unrelated to anything specific the organization was doing.

At the same time that these first-order codes were being captured, I conducted a second-order analysis, a method of reassembling data that was deconstructed during open coding. This process entails a process of axial coding – relating categories to each other on the basis of properties and dimensions, particularly with regard to identifying the conditions, actions/interactions, and consequences that are associated with a category (Strauss & Corbin, 1998). From these concepts, a process of selective coding was then conducted, in which aggregate dimensions are developed to represent the second-order themes. Essentially, this is a process of generating a storyline that follows a central category and its relationships to other categories and subcategories of interest (Strauss & Corbin, 1998). This is also the stage of analysis whereby the emergent theoretical model was refined vis-à-vis the data, accounting for

internal consistency, expansion or reduction as necessary, and the further development of weaker categories. Although these processes were described in a somewhat linear way, it should be noted that in practice, various cycles overlapped to a great degree as I moved between the data and emerging theory and back again.

To provide more of this dynamic picture of the analytical process, it may be helpful to describe how the coding process was refined across iterations. For the first iteration, which included a steep learning curve, I began coding as interviews were being conducted. For the first three interviews, for example, I captured 74 first-order concepts through the micro-coding process described above. Across all the interviews, the number of concepts exploded to over 200 codes. Simultaneously, I was developing second-order themes from these codes, ending up with approximately 45 at the end of the first iteration of coding. These themes were subsequently grouped into four aggregate dimensions (e.g., physician identity components, employed professional components, physician engagement and outcomes, and the organizational context). Between this first iteration and the final iteration reported in the results section, there were between 4 and 6 “rounds” of analysis and coding to further refine the model, in which concepts were either condensed or broken apart, formed new themes, or contributed to different dimensions. The information and structure of each round was retained in order to create an audit trail of how the concepts, themes, and dimensions changed over time. The final round resulted in 41 first-order concepts, 11 second-order themes, and 5 aggregate dimensions. The structure of this data and how the model moves from participant data to a grounded theory are illustrated in the data structure diagram in Figure 2 (cf. Gioia et al., 2013).

## **Trustworthiness in Qualitative Research**

A critical consideration in conducting qualitative research involves ensuring the trustworthiness of both the processes and outcomes of that research (cf. Lincoln & Guba, 1985; Miles & Huberman, 1994; Yin, 2008). Here, trustworthiness is broadly defined as the extent to which consumers of research may be assured of a study's quality in terms of truth-value, applicability, consistency, and neutrality (Lincoln & Guba, 1985, p. 290). The process of ensuring trustworthiness in qualitative research is often translated into the following four criteria, with their quantitative analogs in parentheses. Confirmability (objectivity) describes the case where the researcher has remained fairly neutral, such that the findings reflect the participants and not the investigator's motivations, interests, or biases, while dependability (reliability) refers to the degree to which the study was conducted in a reliable and consistent manner. Credibility (internal validity) refers to whether or not the conclusions are valid and authentic, and transferability (external validity) refers to the degree to which the findings are applicable to other contexts and settings.

The primary method used to ensure both confirmability and dependability involved a clear and transparent description of the research process above, as well as documentation of the process through which raw data were transformed during the analysis; these descriptions are intended to serve as an "audit trail" of the research. As Gioia et al. (2013) note, the chief benefit of the data structure diagram allows for others to see exactly how one has moved from participant data to theoretical concepts and themes, demonstrating objectivity and reliability of the process. With regard to dependability, it is also important to demonstrate that data collection occurred across the range of appropriate settings, participants, and times. As noted in the procedures above, the majority of clinic settings were assessed in order to ensure that the range

of settings were fully captured, and every effort was made to include participants that represented the diversity of the research in question, in terms of demographics, experiences, and values. Finally, that the research took place over a long time frame helped to ensure the likelihood that findings reflect more enduring phenomena rather than transient events (e.g., the implementation of a clinical electronic health record and the frustration typically associated with temporarily reduced patient loads and a steep learning curve).

Although some qualitative research opts to conduct various forms of inter-coder agreement or reliability, the practice is not without some degree of debate with respect to applicability (cf. Corbin & Strauss, 2008; Gioia et al., 2013). On the one hand, the debate centers on the particular theoretical paradigm to which one subscribes – as a positivist, with the assumption that reality exists apart from social actors in the sense of an objective truth, versus an interpretivist perspective, with the assumption that reality is a subjective construction of social actors and cannot be separated from their knowledge (Glaser & Strauss, 1967). Layered on top of these paradigms are various analytical strategies within qualitative research, which carry additional assumptions about the way theory emerges from data and as such, how reliability and dependability are defined.

The current study, which is rooted in more of an interpretivist paradigm, has sought to more fully explain what it means to be an employed professional, rather than how and when that role might become salient, for example (which would have followed more of a pattern-matching rather than explanation-building approach). As such, measures of inter-coder agreement tend to be less valid, while other measures to ensure dependability become more important- particularly the presence of a clear audit trail (i.e., the Gioia et al., 2013 data structure diagram), member-checks, and also peer debriefing. Within this study, the emergent findings were shared and

discussed with fellow graduate students, as well as physicians who were unaffiliated with this study, but were members of the larger health system in question.

Specifically in terms of confirmability, it was important for me to reflect on my own potential biases, resulting from my background as a researcher and a professional, throughout the interviewing and analysis process. By critically examining some of my own preconceptions about what it means to be a professional within the scope of a larger organization, I was able to separate my own values from the larger issues of what might impact the professionals' experience. For example, I may have my own preconceptions about the utility of organizational participation, so it was important to both ask questions and conduct the analysis in such a way that the concept of utility could be addressed as a broader concept rather than reflective of my own particular set of values.

An important technique for establishing credibility, or the "truth-value" of the study, is a combination of prolonged engagement and persistent observation in the research setting (Lincoln & Guba, 1985). The structure of the current study, rooted in both on-going observations of the practice and organization and in-depth interviews with the physicians was intended to ensure that the scope of the research issue was fully defined, and that the depth of that issue could be fully assessed. Throughout the research process, I also included informal member-checks as concepts began to emerge, to identify areas of alignment and misalignment between different physician accounts. The triangulation of multiple sources of data also allowed me to identify areas where data were either aligned, required more elaboration, or were misaligned and required further refinement. As mentioned earlier, triangulation occurred through multiple methods (i.e., semi-structured interviews, informal interviews, observation, and archival documents), as well as through multiple sources (i.e., physicians, practice staff, corporate managers, administration, and

“alumni” of the organization). Finally, an explicit attempt was made to test the emerging theory against the extant body of literature on identification. For example, the beginning of the study was heavily influenced by a social identity theory lens, yet through critical examination of some of the assumptions associated with that theory, a better fit was identified with the alternative theory of role-based identity.

The final criterion for trustworthiness, transferability, is largely demonstrated through the technique of capturing rich descriptions of the study context and being explicit about the scope of the current study and its connection to theory. For example, this study was conducted in a single health system, despite the multiple locations of clinics throughout the region. As a result, I attempted to describe both the historical background and current environment of that health system and its relationship to the clinics it owns in order to allow others to draw conclusions about generalizations to other sites. Where possible, I also attempted to connect the dynamics of this organization to larger trends in the industry; for example, this organization, like many others, followed a process of cycling through investiture and divestiture of clinic properties throughout the 1990s and early 2000s, leading to the current re-investiture. In terms of the scope of the project, it is important to be explicit about the population of employed professionals to which it applies, as this sample of physicians primarily comprised primary care specialties, employed in geographically dispersed clinics. Where similar microcosms of professional influence and distance to management occur, the findings are likely to be more transferable, than to other professionals who are more integrated within organizations (such as co-located with hospitals or multi-specialty clinics).

In addition to these four main forms of trustworthiness, Miles and Huberman (1994) also describe a number of other cognitive strategies to ensure data quality during the research process.



Throughout this study, I attempted to include as many of these strategies as possible, including: checking for representativeness and researcher bias, verifying “unpatterns” such as outliers and extreme or unexpected cases, and checking the validity of conclusions through rival explanations, replication or repetition of themes, and logical if-then tests to more fully think through participants’ responses.

## CHAPTER FOUR – FINDINGS

Overall, the physicians in this study described a complex and dynamic set of interactions to capture the role relationships between themselves as professionals and the organizations that employ them. The data structure diagram that illustrates how theory emerged from participants' data is illustrated in Figure 2, which demonstrates the first-order concepts described by physicians, the second-order themes that represent those concepts, and finally, the second-order aggregate dimensions that provide structure for those themes. The theoretical relationships between these concepts, as they comprise the employed professional identity from a role-based perspective, are illustrated in Figure 3, mirroring the basic structure from the research questions originally presented in Figure 1.

Rather than discuss the profession and the organization as collectives, the physicians interviewed in this study focused on the set of interactions that stemmed from their role relationship with the organization as a product of the expectations around enabling the physician to provide healthcare services. This notion of a work-centric role relationship captures the influential aspects of that relationship as a sense of engagement around that work, rather than around a specific collective.

The initial focus of this model hinges on understanding the content and centrality of the professional role (RQ1) within the larger, holistic employed professional role identity. Next, the model examines the ways in which employment is defined within the scope of this professional role (RQ2). The meanings associated with employment, both for the professional and for his or her clinic practice, set the stage for the subsequent role relationships between the organization

and the professional (RQ3). These interactions from the physician's perspective comprise two pathways. The more dominant of the two paths, concerning the organization's role in supporting the profession (RQ3a), comprises perceptions of the high-level focus of the organization vis-à-vis the professional work as well as the direct influence of that focus (and the earlier notions of employment) on the eventual expectations of physicians in having the organization support the day-to-day work of the profession. The second path, which concerns the professional's role in the organization (RQ3b), is regarded as more peripheral from the lens of accomplishing the professional work that forms the basis for employment; yet this role still may interact with perceptions of the organization's role based on an understanding of individual employment, and indirectly influence the nature of other-expectations of the organization. The following sections will follow this cascading logic of Figure 3, providing more detail around each of these components of the employed professional role identity.

### **Centrality of Professional Role**

A role-based perspective suggests an impactful source of identity for professionals occurs through the meanings associated with the work of their professional role. Addressing RQ1, within the employed professional context, the meaning of the professional role is captured through three components of work identified by study participants: (1) providing a valued service in a beneficiary-centric manner, (2) responsibility over the immediate professional practice that defines how those services are provided, and finally, (3) overall accountability for the context in which the professional work occurs. This conceptualization offers a profession-in-context approach (i.e., via the enactment of professional work) that will help to inform the subsequent research questions regarding how employment and then professional-organizational role relationships are influenced in turn by this central concept.

## **Core Professional Service**

The core of what it means to be a professional reflects the value and importance of providing a professional service, both in terms of what is being provided (i.e., the set of healthcare services) and to whom it is being provided (i.e., service to the patient at the individual and community level). The physicians interviewed in this study described the essential purpose of their profession as being “engaged every day in people. Because what do we do? We’re engaged in trying to improve the health of individuals and then in some respects, doing that in the community” (17). Another physician echoed this sentiment: “We are engaged in the clinic, engaged in the community, engaged in our job. Being present, that’s what physician engagement is” (16). When physicians speak of this sense of being engaged in the various aspects of professional work- the clinic, community, and their job- they reflect the different ways in which each physician may give focus to providing those core services.

Several examples speak directly to some of the broader aspects that give meaning to the services being provided, described by some as a focus on chronic conditions, women’s health issues, and other areas of medicine, responding to needs that exist in their respective communities and patient populations, or providing access and education to healthcare services. As one physician described:

“It’s very important to me that individuals... things you can prevent in terms of health, in terms of obesity, smoking, cancer screening, education. I think that is my primary role, is to... try and get people access to that in terms of information and testing and follow through” (03).

So that they are able to provide the care and services described above, it is important for physicians to develop trusting and long-term relationships with their patients. As the physicians below describe, these relationships deeply impact the ability to truly care for that patient:

“To me, that relationship [with the patient] is really important, because I feel like in family practice you need to get to know the people you’re dealing with, so they’re not afraid to call you” (23).

“Putting the patient first, letting them know you care about them. You know, that’s what we’re here to do, to make it easy for you and try to make it as smooth a process as we can as well” (10).

For physicians, the core of their professional role is not limited to a specific set of healthcare services, but rather encompasses the entirety of the role relationship with the patient. Reinforcing this relationship, interactions with patients are deeply embedded in the physician’s day to day, either face-to-face in the exam room or through time spent on diagnoses and treatment planning for that patient. As several physicians remarked:

“You know, while you like to think of yourself as a part of a bigger organization, on a day to day basis, it’s really you and the patient. That’s what functions every day, that’s what you do every day, is have an interaction with the person in front of you” (23).

“It’s more important for me, to provide the necessary service for my patients and satisfy them, than it is to satisfy NCHC. Patients see me, they hire me to do a service for them. NCHC hired me to be that physician, to do that service. So my ultimate priority is to the patient first and to NCHC second” (14).

As the preceding examples suggest, there is something of an impermeable boundary around the sense of responsibility and advocacy physicians feel towards their patients (illustrated in Figure 3 by a solid line around the core professional service), both as a function of the core services they deliver to meet those patients' needs and the deep and personal relationships that exist between physician and patient. This sense of responsibility also extends beyond medical care to incorporate the patient's experience of the clinic as a whole, indicating the encompassing nature of the physician's core professional service.

### **Professional Practice**

The prior section largely focused on the “whys” of the professional role: the set of meanings and values that drive professional service. In the current section, the focus shifts to the “hows” as it relates to the physician's professional or medical practice<sup>2</sup>, detailing the values associated with how a given service ought to be provided in support of the core values discussed above. The most common aspect of the professional practice of physicians is the sense of responsibility and ownership in terms of treating the patient to the best of their ability: “to deliver the best patient care that I can” in the words of one physician (26). The physicians in this study describe a responsibility “to be current, to practice to the highest standards that can be achieved in my specialty” (20) and “try to maintain professional competence and keep up” with advancing medical and scientific knowledge (21).

To some extent, the quality of one's professional practice is covered by standards of care: “when you go into practice, there are standards of care, so that's going to be pretty straightforward” (13). However, there are other, more idiosyncratic aspects in addition to those

---

<sup>2</sup> It is important to clarify the ambiguity in lay descriptions of the term practice as it applies to a profession: used to refer both to the actual practice of medicine by the physician and to the physical location or setting in which medicine is delivered. Throughout this study for the purposes of clarity, the term professional practice or medical practice is used to capture the former, while professional work practice or clinic practice (or just clinic) is used for the latter.

standards to achieve quality. For example, one physician described his practice goals in the following manner: “to practice medicine and do the best job that I can, and take care of the patients with respect and try to generate the best outcome possible for the patients” (11). Another physician described hers as to “be efficient...provide excellent care, with a good attitude, and Christian service” (05). These “hows” - focusing on respect, efficiency, attitude, or faith-based service- alongside providing competent and up-to-date care, illustrate the emerging complexity of the professional role in context from a professional practice perspective.

Given the emphasis above on physicians’ responsibility for ensuring the quality and competency of the medical practice, several described their sense of ownership over the medical practice aspects in these ways: “I feel like I’m pretty independent, I don’t feel like there’s a lot of pressure to practice a certain way. I can have my own style of practice, prescribe how I want to do, treat my patients how I want them to be treated” (10), and “I should treat the patient the way I think is best for the patient, not what somebody else thinks is best for the patient” (06).

Part of the independence of the professional practice can be attributed to a desire for professional autonomy or the expectations of others in terms of professional responsibility. Still, there remain aspects that may be more appropriately attributed to the difficulty inherent in supervising professional work, as captured in the following example:

“I’ve done this under several different companies and I guess I don’t see the role of the physician part any different. The physician part is really not supervised in that sense. They monitor... there are checks and balances to monitor physicians, that are not related to my employment with anyone, and what I do on a daily basis would be really difficult to monitor anyway” (17).

Extending this discussion to the alignment of a professional practice within an organization then, physicians note that “from a medical perspective, I don’t think it matters who you work for” (13). Hence, any alignment between the professional and the organization tends to be driven by professional practice values, and not alignment for its own sake, as illustrated in the following quotations:

“I think the goals, going back to what I just talked about, trying to treat my patients as best I can, and I think that’s kind of what everybody wants to do, no matter if I worked for NCHC or whoever... you want to treat folks and do the best you can, but I don’t think that necessarily is a NCHC value. I think that’s just a ‘going into medicine’ value” (19).

“I feel that my goals in this practice parallel those of NCHC, but... you know, it’s mainly how I truly believe that I am supposed to take care of patients that’s most important to me, rather than what might necessarily be better for NCHC or NCHS” (14).

The key themes emerging from physicians’ descriptions of their professional practice rest on a sense of responsibility for the quality and competency of care on the part of the professional, and given this responsibility, little expectation of oversight or influence into the way in which they deliver the core professional service to patients. As the quotes above suggest, that is not to say there is not alignment between professionals and other entities, but rather, it is more important to understand the values and meaning where alignment does occur.

### **Professional Work Practice**

At the outermost ring of the professional role in Figure 3, the professional work context captures the set of meanings associated with the physical setting in which the professional



delivers care, capturing the physician's approach to the (primarily non-medical) "work" of the profession, and subsequently, the potential leadership over the setting in which that work occurs.

One important finding suggested by physician participants relates to the dual nature of professional work in context, as professionally and non-professionally focused. In order to enact one's profession in a clinic environment, a number of non-professional tasks and responsibilities are required to support the patient encounter (e.g., scheduling, documentation). Illustrative of this dual nature of professional work are the different perspectives of work: for one physician, medicine itself represents a calling- "You do family medicine, you do medicine because this is what you want to do. I can't imagine doing anything else"- yet at the same time, the actual practice of that medicine in the clinic as a part of an organization is perceived as "just a job" (02). Other physicians similarly interpreted their work as more job-like in addition to the professional services that are provided: "getting up, going to work, trying to do what little bit I can do" (01) and "I see myself as a physician, and that's only during the week. On the weekends, I'm not" (15).

These statements suggest the complexity and variety involved in translating a profession into professional work, particularly within an organizational context. For some, it is important to be involved with the entire scope of the clinic practice operations, to continually improve how that clinic practice supports the core professional work:

"While I'm the boots on the ground, I've also got to be the person who has the ability to take a bigger perspective on what's going on in the life of that person, and also in our office function on a day-to-day basis- how does it work, what works best" (23).

Others are perhaps more content with practicing medicine and allowing others to manage the clinic practice, so long as the necessary support is there for the physician to practice medicine:

“I’m one of those, if you just let me practice medicine, you know, however you want to run the business is fine” (14).

A crucial aspect shared by both of these perspectives, however, is the physician’s perception of non-professional aspects that may impact his or her ability to do the professional work, particularly in terms of impacting the practice of medicine. For instance:

“If it’s a medical kind of issue, then it should be the physician that has the authority to direct it” (08).

“To me, those things are just mechanics. They are not things that I really worry about, get concerned about or get frustrated about... To me, that’s not part of medicine, those are just mechanics” (17).

As a result, the primary concern of the professional as a “worker” rests on the functioning of the immediate clinic environment and the physician’s ability to care for patients, and less on external factors that are less relevant to the core values of supporting patient care:

“I’m really just concerned about my patients, and this practice, and this entire setup here, and am not too concerned about what’s going on in another clinic, or another office, or the entire organization” (11).

“But you know, in the long run, every day I don’t think about how the hospital is doing, I think about how my clinic is doing”(02).

The nested role components presented throughout this section capture some of the complexity in terms of the meanings that physicians perceive around their roles as professionals. As illustrated in Figure 3, the different aspects of the professional role exhibit different

relationships with how employment is interpreted. While the physician-patient role relationship associated with the core professional service is relatively distinct from any particular employment arrangement, both the professional practice and the professional work practice impact the meanings that each physician may attach to the status of employment within an organization.

### **Employment's Role in Professional Work**

Addressing RQ2, and achieving a better understanding of what employment means within the context of one's professional role, this section describes two distinct components to the professional employment relationship. Specifically, employment may support the individual professional, driven by professional practice and work practice preferences, as illustrated in Figure 3 (in addition to the more traditional notions of an exchange of compensation for some amount of work). Employment may also directly support the work practice of the professional, in providing a setting through which to accomplish the practice of medicine. Each of these forms of employment carries forward different expectations of the professional-organizational role relationship: while individual employment essentially forms a direct role relationship between the organization and the professional (aspects of which are professionally and others which are individually focused), practice-focused employment places the clinic as a critical intermediary in that role relationship, driving a focus on the accomplishment of professional work.

#### **Employment Supporting the Individual Professional**

Employment from the perspective of the individual professional was described by the physicians in this study as the pathway through which they were able to enact their desired professional values and preferences, receive some amount of steady compensation and benefits in exchange for that professional work, and also acknowledged certain constraints.

Individual employment supports aspects of the professional role that are related to both the professional practice and the work practice. As primary care physicians, the participants in this study expressed the importance of finding a match with their professional practice preferences. Such preferences exist both at the higher level of primary care in general, as well as focusing in on certain aspects within the scope of primary care, for example:

“They [NCHC] seemed to have the patient population that I was interested in too. Since I’m family medicine, I wanted to be in a place where I could see a variety of patients and that sort of thing (15).

“I got an opportunity to come down and... get a feel for the area and for the practice that it was. To see if it was a good fit [in terms of] patient demographics, diagnoses, types of patients seen” (14).

In addition to professional practice preferences, physicians also sought out employment based on preferences around how the professional work practice would be structured. For example, employment allowed physicians to focus on ambulatory care that did not include a hospital component (i.e., requiring the physician to follow their patients when they are admitted rather than just seeing them in the office): “I was looking for an outpatient opportunity, preferably with no hospital” (09) or with “associated hospitalists” (18). Additionally, the type of clinic practice was an influential factor in employment decisions, some preferring group practices (“I kind of wanted to be in another practice with another doctor. Five years of solo practice, it gets kind of old,” 05), while others preferred solo practices (“really the increased flexibility that not being in a multi-physician partnership provided,” 04). Employment for these physicians was a way to enact preferences associated with their professional role.

An additional driver of employment stems from the individual benefits and compensation that membership within an organization provides to the individual professional. For these physicians, attractive features range from steady compensation through opportunities for professional development:

“Pretty much, the loan repayment, the 401k plan, you know, starting salary, ability to expand in terms of clinically... patient growth and responsibility within the organization in terms of leadership” (03).

“I have basically a management contract with NCHC to manage my clinic, and they pay my employees and pay me a base salary and then if I make over that base, then I get bonuses, 401k benefits, insurance at NCHC volume rates, and things like that that I wouldn’t get if I was self-employed” (12).

In exchange for those benefits and opportunities, professionals provide the work in the form of professional services for the organization that employs them. Any constraints related to employment tend to be related to expectations around this work, profitability and coverage of the practice being the primary factors:

“The fact that my reimbursement is strictly production-related, you know, I don’t... they don’t really care how many patients I see as long as I’m covering expenses. As long as I accomplished what I needed to in the office, they didn’t require me to be here any specific hours” (04).

“Basically, they said, if you cover the practice, we don’t care whether you’re here or not as long as you keep the practice covered” (13).

Despite these expectations, there are certain constraints related to individual employment, around employee-related issues, such as time off and other policies, and particularly for those physicians under the salary guarantee phase of their contract:

“It’s difficult sometimes to be an employed physician, especially under that guarantee time... There are times I’d like to be able to just name my own hours and work when I want to” (10).

“Say I want to take some time off and then somebody will tell you, well Doc, you don’t have that many days off” (06).

While it is clear that physicians seek out employment for the individual benefits and the ability to practice as one desires, the pattern of that employment relationship is often complex and impacts the downstream role relationships between the professional and the organization. These dynamics are often further complicated by the fact that professionals seek employment not only for themselves, but also in support of their work environment.

### **Employment Supporting the Work Practice**

An additional aspect to the employment of professionals concerns the support of the work practice, which is influenced by the professional work practice component of the professional role, as illustrated in Figure 3. In contrast to individually-focused employment, professionals may also seek employment that supports their clinic practice, either in terms of starting up or maintaining that practice, facilitating the work of the physicians by taking over the “business burdens,” or achieving economies of scale in clinic operations. Contracting with an organization to provide these types of services allows the employed physician to enact the desired professional role, particularly in terms of preferences around the work of providing healthcare.

The chief benefit of practice-focused employment addresses the difficulty or inability of starting up a practice, due to the many requirements and regulations. As these physicians indicate, the increasing complexity of those responsibilities often necessitates some form of employment arrangement:

“I wouldn’t have wanted to go out on my own, coming out [of residency], just the main thing is trying to keep up. Because nobody can keep up with everything the way that medicine is evolving. So it helps to have them [NCHC]” (19).

“Unfortunately, I’m not sure that anybody can really go out and do it on their own any more. It’d be really hard to start on your own and take the initiative to get everything moving, and meet all the quality measures you’re going to have to meet, and keep up with all of that” (02).

In addition to managing the complexity of the on-going professional work practice, an important consideration must be given to the difficulty of simply building a practice and seeing enough patients to cover costs. For these physicians, for example, without the employment-based support for the practice, they would have been unable to remain in business and provide healthcare services to their communities:

“I think I went through the first three months and saw three patients. How would I have paid the staff, how would I have gotten paid? It wasn’t until the end of the first year when it started picking up. I don’t see how people do it” (18).

“Just my patient load is not going well right now. And you know, if I was not on a guaranteed salary, I’d probably have to find somewhere else to work” (03).

As a solution to some of these particular challenges, employment offers the professional an opportunity to leverage the knowledge and expertise of a large organization with the

experience of standing up multiple clinics, as well as the availability of different financial arrangements to help maintain the viability of the practice.

“It was already an established office. It helped me get my feet on the ground and NCHC had an idea of building primary care networks, if you will, to help integrate with their system of hospitals and I thought that was something that was appealing” (23).

“Their compensation... allows you to draw against future compensation if you get behind the first part of the year, which is a big thing for most physicians” (08).

In light of these numerous challenges facing the clinic practice and the physicians within those practices, a sense of professional employment carries a large emphasis on how that employment supports the clinic and by extension, frees the physician to focus on the reasons why he or she is employed in the first place: to see patients. As these physicians describe, the practice benefits of employment allows them to do just that:

“You can just come here, practice medicine, do your job, and not have to worry about a lot of the outside factors. I do like that a lot. I don’t like to have to worry about hiring and firing, and that kind of thing, that part of it. I really like having someone else in charge” (10).

“Working for NCHC is an opportunity for a physician to practice with a great deal of autonomy and use the reserves and resources of an organization, such as NCHS. A physician going out on his own does not have the same access to the same quality people, financial reserves, buying power, those types of things, to be able to function as efficiently” (14).



Across these instances, a common understanding rests on the shared benefits of having an organization to help support the professional work practice, both in allowing the physician to deliver care aligned with his or her desired professional role and to fulfill the expectations of his or her employment within the organization as an individual practitioner.

### **Organizational Role in Professional Work**

Given the nature of employment described above, in supporting both the individual professional and the work practice, the third research question seeks to understand the nature of professional-organizational role relationships and interactions that stem from that employment. As illustrated in Figure 3, and addressing RQ3a, the predominant relationship that is associated with professional employment concerns the perceptions of the organizational role in the professional work and the subsequent other-expectations of support from that role. The organization's role is driven by expectations of employment that allow physicians to practice in a manner and setting aligned with their professional role identity, and of employment that aims to relieve the operational burdens and challenges of the practice environment. As the participants in this study describe, the organization's role in professional work is largely captured in terms of how the core "business" of that organization is perceived vis-à-vis the professional work. Because large integrated health systems are often complex entities, these perspectives are not necessarily mutually exclusive and may in fact interact to influence the ways in which the organization is expected to support the physician in the practice.

### **Professional Work as the Business**

One set of perceptions around the organization's role as an employer of physicians and owner of physician clinics considers the extent to which the business is defined through the success of the professional work, creating a shared focus on the local clinic environment. This

perception of the organization as supportive and aligned with the professional work of the professional and the clinic practice overlaps with employment based on the physician's role as a professional, both in terms of how the physician practices and the environment in which he or she practices. As these physicians described:

“I think they align [the goals of the organization and myself], because the main thing is they want to give care. You know, they do... I do feel that they want to take care of the patients the best that we can, and they try to encourage us to do the best quality medicine that we can do” (02).

“I don't think there's a big argument between NCHC and our guys and our individual practice, our respective practices, on the major goals, because they're interested in good healthcare and we're interested in good healthcare. So basically the goals pretty well coincide” (12).

Implicit in much of this alignment is the relationship between organizational goals around the professional work and what the physician expects the organization's role to be within the practice, getting back to the notion of employment as a partnership in helping to drive the success of the individual practice. In order to provide good healthcare, this sense of partnership and alignment is important to have in place:

“Their expectations of me are to just be here and you know, treat patients appropriately and you know, try to squeeze in as many as I can. You know, those are my expectations too. I want things to run efficiently and see as many folks as we can” (19).

“I think it's important because we're all working towards one common goal: provide excellent healthcare with excellent customer service and we all have to be

on the same page. I can't have my way and his way and her way... Everybody being headed towards the same goal, at the end of the day— you get in, get the patients seen efficiently” (05).

A large part of this shared focus is seeing the clinic as a small business, and the intimate link between providing services to enough patients to stay in business, and staying in business in order to be able to provide those services to greater numbers of patients:

“Seeing more patients and provide quality care. So that when you see a patient, you know they want to come back... So that when you provide the best care, that patient will go tell their friends and family, and you get more people coming into the system. And if they don't want to come back, there's no point in us being here” (18).

This notion of the practice as a small business also reflects the inseparability of financial aspects of the practice from those of the clinical aspects. As described by these physicians, the appreciation of the need to create revenue goes hand-in-hand with their ability to keep the practice open and seeing patients:

“Bottom line, [the organization's expectations of me are] probably financial considerations. I share those to a certain extent too. You have to. Whatever practice you're in, whoever manages, it has to be a financially viable sort of operation” (21).

“Definitely, you need to create revenue. You need to pull your weight, so to speak, financially, by seeing the number of patients, by doing the stuff you need to do from a revenue standpoint in a practice, to make the business work... [so] if our practice is taking good care of people, seeing the patients in the community

and financially viable, you know, we're doing our part for the corporate part”  
(09).

When the organization's role is perceived to be locally focused on the professional work that occurs within the clinic, the business of the organization aligns with the physician's understanding of the practice: the need to balance the clinical services with financial considerations. In this sense, the organization and the physician are on the same page with the success of the practice as a shared goal, and providing the best healthcare possible as a shared value. This perspective contributes to the relationship of the professional and the organization within the clinic, particularly in terms of the specific expectations of support that will be discussed in a later section, as well as interacting with the potential for professional participation.

### **Success of Organization as the Business**

One must also appreciate that the organization has a dual focus, on running the individual practices, as well as the clinic network in support of the hospitals and other system facilities. It is possible to perceive the organization's role as being in the business of ensuring its own success as an enterprise, behaving more in the interests of the overall corporate entity, which may or may not relate to the interests of individual clinics or physicians.

For some physicians, the corporate vehicle of the organization is perceived as similar to many companies, regardless of industry, in that their interests lie in the overall ability to generate revenue. Describing their perceptions of NCHC as a corporate entity, several physicians described the organization's role in these terms:

“NCHC is like any corporate, they want to do the business. I think we are doing a pretty good job helping NCHC do the business of clinical medicine. NCHC may

say that we are trying to help the people... But actually, they are wanting to do the business, make money, period. I think we are doing a pretty good job” (06).

“[Their goal is] money, money, money [and] they don’t care how you get it. They don’t encourage good policies to take better care of the patient. They just encourage you to get your numbers” (16).

Examples like these demonstrate the perception that the organization is indeed in the business of medicine, but medicine emphasized as a revenue generating activity above a “helping people” activity. This perspective is further reinforced by physicians’ perceptions of the espoused values of the organization:

“Well supposedly, [their goals of] patient satisfaction and making a difference in the community... We have the same goals, but I see it differently. I’m doing it for my patients, not for NCHC. Because I don’t believe they really mean it” (22).

That the goals of medicine can be interpreted differently in an organizational context is further revealed through descriptions of the way in which the organization is structured, as well as the pressures to which it responds in the competitive landscape. The importance of the organization’s focus on these activities is recognized, yet at the same time, the role of the patient and the individual clinics may be less of a focus within this type of perspective.

“I think one of the big goals, and that’s why they set up some of the NCHC clinics, is to be able to funnel those patients into NCHS, into the system, either [this hospital or that hospital]. I think that’s the big goal, because you know, the specialists and the physicians that are at the medical centers, they’re tertiary. If they don’t get referrals, then they’re going out of business” (03).

“They’re trying to look forward to keep us active and alive in the market and to try to keep our hospitals alive... keep us strong in the marketplace, and to give us benefits, to make it be good, be better to be a NCHC physician” (02).

As the latter quotation suggests, the organization may view physician employees as a commodity for competitive advantage against its competitors, rather than focus on the care that the physician provides to his or her patients. This perception is reinforced in the following quotation, where practices and physicians are perceived as commoditized to support a corporate agenda, rather than as a valued resource through which the organization delivers care:

“I think over the years, because of changes that have happened, seeing all right, we’ve got to cut costs, we’ve got to let people go, we’ve got to downsize, we’ve got to re-organize, and then re-doing it all over again, now we’ve got to expand, and we need to add more doctors over here, and we need to open an office here. You go through cycles of this stuff, and at times, you get more of a feeling that I’m part of a corporate rather than a group of people that want to provide personal health care and it’s hard not to get that, just because there’s a very definite business side to it. I understand there’s got to be that. But you do sometimes get more of that sort of a feeling, that we’re looking at it from a dollars and cents standpoint rather as to ‘what are we really doing to help people’ standpoint” (23).

The net result from this perspective in shaping the interactions between physician and organization is largely reflected in the types of conflicts that occur between the interests of individual clinics and the interests of the organization. These conflicts can be felt from a financial standpoint, with the organization oriented towards their own bottom line rather than the bottom line of each of their clinics, or even an operational standpoint, where the organization is

more concerned about a broad need, and less concerned about the specific clinics that would contribute to that need:

“What I needed was the ability to build a practice, some room, some time to build up the patient volume and stuff, but the system needed more volume in general. So whether it was my volume or somebody else’s volume, from their standpoint, they just needed volume. And I get that, you know, it’s reality. But personally, it needed to be my volume, because that’s what would drive my practice and my ability to take care of patients and my staff” (09).

For some, this perception of the organization as focused on its own success works at odds with the perspective of that same organization when it is more focused on the success and performance of how professional work is enacted within the clinics that it owns. Yet for others, particularly physicians with higher visibility into the organization, having that dual focus is important to keep both the small business and enterprise businesses successful. Ultimately, the impact of the extent to which the organization is perceived as focusing on both of those perspectives will drive downstream perceptions of the extent to which the organization is involved in supporting the professional work and the professional’s role in the organization.

### **Other-Expectations of Professional Work**

While the prior section addressed the organization’s role in professional work in terms of the high-level focus and alignment of efforts with its professional employees and practices, this section addresses a critical second component to understanding the organization’s role (RQ3a). Namely, both through a definition of employment carrying expectations of support of the work practice and through the organization’s focus and goals described above (pathways illustrated in Figure 3), a primary point of interaction for the physician and organization is through the other-

expectations of the “on-the-ground” support provided by the organization within the clinic practice. These interactions associated with how the organization supports the professional work, rather than professional support of an organizational agenda, are more impactful consequences of employed professional role identity.

The physicians in this study described having this support both in terms of the specific boundaries around their expectations of the organization within the clinic practice and in terms of specific events that may trigger expectations of support around those boundaries. Whereas employment sets the broader framework for the professional’s interactions with the organization, and the organization’s role in the professional work sets the overall tone or direction for the role relationship, daily interactions tend to be enacted within professionals’ other-expectations discussed below.

### **Boundaries of Expected Support**

Physicians defined the boundaries around expected support largely as the extent to which the organization’s contributions in and to the clinic practice are circumscribed. Differing in where the particular boundaries are drawn, physicians may grant the organization a role as either an active partner in the functioning of the practice, as a player behind the scenes, or merely a tool to accomplish a narrowly defined set of responsibilities per the employment relationship.

Representing one end of that spectrum, physicians may expect very little in the way of support of their day-to-day practice. For them, the organization’s role is largely constrained to the back-end financial management of the practice, handling the revenue stream that the physicians generate and then reimbursing the physicians for that work. As the physician below notes, the majority of work within the clinic is the work that he does, both in terms of patient care and non-patient care:



“Well, you don’t really manage a practice if you’re remote. Just think about it, from a day to day standpoint, what can you manage? I come in, I go to work, I see patients, I put the codes in, I do the documentation. From that, you get billing. We don’t do the billing, but what’s actually managed?” (17).

Boundaries may also be established by a differentiation of function, rather than the distribution of work across those functions. For this physician, the organization’s sole function is to ensure that she is paid for seeing patients and should otherwise remain distinct from her work:

“NCHC is only my payer, no more than that. NCHC is just a company that collects the insurance money and gives me my share, and gets to keep its share... They don’t force me, they don’t impose themselves, which is good” (16).

While finances tend to be more of a back-office function, and perhaps more easily separated from the essential professional work of the clinic, another aspect of support to the physician comes in the form of practice management. Broadly, this term captures all of the activities that help support the patient visits, and spans both front-office and back-office functions. As the physicians below describe, the boundaries that are placed around the type of support that is expected are driven by clearly differentiated work within the clinic:

“I don’t feel like I belong to NCHC though. I feel like I’m in private practice with NCHC managing me. ..Well, they do the management part. I see the patients and that’s all” (22).

“You see, with NCHC, it’s the manager, it’s the management part of my practice... 90% is me and the practice” (06).

For other physicians, however, the boundaries established around the support of the organization are thought of in broader terms, at least in the form of capturing more of the

interdependent nature of the employment relationship. For example, there is more of an acknowledgement of what the organization ought to provide within that practice management space. The support of the organization is expected to serve the quality and efficiency goals of the physician, either by “provid[ing] us the tools to do that quality medicine” (02) or within the scope of handling those aspects of the practice that would slow the physician down:

“Provide basic organization to make it work, possibly a little more efficiently than billings and make sure that I have adequate staffing, that I have an office that works and is safe, that we have a computer system that is functional, that we have adequate support that the providers think they need, not necessarily what someone [at the corporate offices] thinks is adequate” (07).

Both of these physicians reflect some of the expectations of the support they receive, and to some extent, the support that they should not receive, establishing clear boundaries around the day-to-day management of the practice and the distribution of responsibilities.

At the other end of the spectrum, physicians may describe more permeable boundaries between their own work and the work of the organization in supporting the practice. For these physicians, the practice management role is seen as more active and the boundaries discussed thus far are somewhat more permeable, allowing support in a manner that blends the professional and the practice management aspects of the practice.

“It’s perfect. Our office manager is wonderful, and so she’ll do whatever, she’ll suggest things [economic, managerial, scope of practice]. Sometimes the other guys will balk at them, but I know she always has our best interests at heart” (13).

Across these examples, physicians’ expectations in establishing boundaries around the types and amount of support provided are important to consider in the overall employed

professional role. These boundaries form a large portion of the pattern of relationships between the professional and the organization, primarily centered on the work of the clinic practice. In the following section, instances are described where certain events or situations may trigger these established boundaries to change in terms of what is expected of the organization in supporting the work of the professional.

### **Triggers for Expecting Support**

The instances through which the employment relationship between the professional and the organization is made salient or changes on a daily basis are captured through trigger events. These trigger events essentially function to call attention to specific needs within the clinical practice environment where the physician expects to have the support of the organization.

As in the case of employment mentioned earlier, which allows the physician to focus more on the practice of medicine rather than the business of hiring and firing, triggers for expecting support tend to focus on maximizing the time physicians spend on patient care versus non-patient care within the clinic practice. As one physician described:

“The biggest issues I face are all the non-patient-care things that we’re having to deal with... Spending non-patient-care time trying to allow you to do what you want to do, which is the patient care... That’s one thing I’ve asked for, I’ve said, help me deal with these other things. Because you don’t get paid for that, there’s no income for filling out forms. So, by helping that, you allow me to do what I really should be doing, which is seeing patients” (23).

For this physician and others who face similar situations, the type of expected support is generally focused on ways the organization can contribute to the improvement of the practice. In similar fashion, physicians in this study reported reaching out to gain better insight into various

aspects of their practice, either in terms of the number of patients seen each day or by leveraging the knowledge and experience of the organization:

“You know, I would like to know what their ideas are, in terms of how things might be addressed in such a way as to improve the number of patients” (04).

“My interests in management is to see what I’m doing is, if I can do better and sometimes, I feel like I should have been doing better because, you know, NCHC is a large organization” (06).

“Tell me how, or give me insight as far as the business aspects of how I can do it better, because that’s not my strong suit” (18).

Several physicians also spoke to the role of the organization in either helping them to expand their medical practice or adding new services to the repertoire. For example, one trigger for a physician was driven by the need to see more patients and grow the practice, to which the organization responded with the opportunity to oversee a nurse practitioner based in an employer clinic. In other instances, the organization generally supports physicians seeking to offer new diagnostics or treatment options, helping to evaluate the relative costs and benefits of such a move. As these physicians described: “I mean, if I want something, they’ll do the research, and I’ll make the decision” (08) and “I think they’re pretty flexible in adding in things, if you want to change, if it’s cost-wise and not going to increase your malpractice and put us at risk” (02).

On a daily basis, however, negative forms of triggers also occur when problems arise that need to be addressed from a staffing or organizational standpoint or in addressing patient pain-points. Those problems form the trigger for the physician to point his or her attention to the ways in which the organization, and particularly the staff should be supporting the clinic and its patients. As one physician stated, “my basic challenge is patient care and what I expect other

people to do” (22). Often, operational issues within the clinic impact the patient, which going back to the notion of the core professional service, reflects poorly on the physician as the responsible individual. Thus, an important trigger point stems from instances where breakdowns in patient flows and scheduling drive a physician to expect organizational correction to the issue:

“I think in terms of patient flow, you know, I think we have had some problems with patient flow, but we have new people in the front office, and that’s improved some of the patient flow, in terms of people calling and wanting to be seen” (03).

It is important to note the extent to which these triggers form an everyday part of the clinic or whether they are truly only salient when a specific improvement is thought of or when a problem needs to be addressed. As some of the preceding and following examples suggest, the role of the organization in supporting the professional within the clinic practice is largely assumed as a function of employment, and thus tends to fade into the background unless there is a specific triggering event.

“NCHC doesn’t enter into my thoughts very often, except when they misbehave, or I perceive them as misbehaving” (12).

“Probably when I hear the complaints from the patients and the other staff that are complaining for other things, and I realize I can’t really make or effect the change that needs to be made. I can’t effect it; somebody else has to effect it” (02).

The primary way in which the professional interacts with the employing organization is through these expectations of support of their professional work, both in terms of the boundaries that are applied around the professional work and the ways in which it is expected to be supported, and specific events that trigger the physician to seek out specific action on the part of the organization. From the physicians’ point of view, engagement in the organization can be

defined through this expectation of support of their work, captured in some of these triggers and boundaries described above. In contrast, engagement as it has been traditionally defined, as the professional supporting the organization, remains a distinct phenomenon, and as will be described in the following section, is viewed as somewhat separate from the physician's ability to do his or her professional job.

### **Professional Role in Organization**

In addressing the professional role in the organization (RQ3b), physicians in this study described two major pathways: their participation in the organization and the subsequent value and impact that is associated with that participation; and the extent to which the organization is perceived as being professionally affiliated (e.g., physicians interacting with the organization are doing so through their relationships to or the perceived role of other physicians, or interacting with the organization as a medical entity). Both pathways tend to be influenced more by notions of employment that center on the individual professional's relationship to the organization. Although these pathways are largely distinct from the path that focuses on that professional work (depicted in Figure 3), there are nonetheless potential interactions between the professional's role in the organization and the perceptions of the organization's role as focused either on its own goals and strategies or on helping to support the practice of clinical medicine. For example, both participation and perceptions of professional affiliations may be higher when the organization is professionally-focused (or vice-versa).

### **Expectations of Organizational Participation**

While the majority of the physician's time is spent in clinical domains, and hence reflects a tendency to think solely of the organization in supporting the clinical sides of the practice, employment may also carry a degree of obligation for the professional to participate in the

functioning of the organization as a business (hence the interactions with the organization's perceived focus on the profession and the business). Often, this capacity occurs through work on various committees or board appointments, ad-hoc project meetings for various organizational initiatives, and similar non-professional commitments.

As the physician below describes, committee and board appointments serve an important need in terms of helping to steer and improve the organization of which they are a part. However, that need is expressed in much longer time frames and is not particularly salient for the individual professional, contrasting the immediate value of participation to what the physician wants to do, which is to see patients. When asked if there is value to sitting on the Board:

“Not necessarily for me, but it's something we all need. We need people on the board who want to help, and so I think, in the long run, it's probably benefiting me, but in the short run, I'm probably like, really?! That's honest, I just don't like politics...I think at first, when I got on the board, I was kind of like, what, why, I didn't agree to this. How did I get on the board?” (02).

This dynamic tends to capture one of the primary points of tension around organizational participation, comparing the perceived value of these types of activities with the value of seeing patients and providing healthcare. As these physicians describe, the value of meetings is less in terms of what outcomes or results, and more in minimizing the time that is required.

“[The Quality Committee] it's structured to not last too long” (08).

“To be perfectly honest, [the Electronic Medical Record Committee] it probably takes more time than its worth, but there is some value in it... the insight I can offer is valuable to them, and then you learn things” (09).

A similar perception exists for other organizationally-focused activities, for example, quarterly updates on the health system's performance. For the physician below, such updates could be provided in a more efficient and focused manner:

“I guess it depends on what the focus is. If the focus is just to tell me, ‘Hey we’re doing well or we’re not doing well,’ you could just say that in a couple minutes and tell me how we’re going to improve that and in what manner. I don’t think we all need to be together and kumbaya just to know what we need to do” (15).

In addition to balancing the value received from participation and the time that is required, another important factor addressed by the physicians in this study is the extent to which they are assigned to positions on committees without much in the way of advance notice or active agreement on the physician's part. Both the earlier physician's experience (“How did I get on the board?”, 02) and others (“No, [the Medical Records Committee] was assigned. Yeah, your name appears there and ‘why in the heck am I on that’”, 16) convey the initial reactions that accompanies such positions. Similarly, when physicians are simply appointed to participate without having previously expressed an interest, it creates a sense that the organization desires participation more in name than function. As this physician notes,

“It’s kind of an interesting relationship between the physicians and the management. Look at it both sides, in that they want us on board, but sometimes they make decisions and expect us to come aboard without any input on that decision process, such as with this kind of change. Probably would have done better if it had a little more physician input” (21).



In addition to this dynamic, the barriers to actual engagement during these meetings include perceptions of frustration of not being able to have an impact or questioning how one's input is taken:

“You know, the times I've served on committees, there's always the chuckle every time you're on committees is how much your input is being taken to heart, or have decisions already been made, and we're all just being given lip service on these committees, whether at the hospital or the corporate level” (23).

Such perceptions may frequently relate to the perception of where the corporate focus rests, returning to the earlier discussion of the organizational role in the professional work as either focused on a corporate agenda or on supporting the professional work.

So while there is a clear expectation on both sides of participating in the organization, there are a number of potential barriers to how that participation is actually enacted. For the most part, the value of such participation is constrained, either from the point of view of the opportunity costs of taking time away from seeing patients or from the point of view of providing input that will not contribute to outcomes in any measurable way.

### **Professional Affiliation of Organization**

Outside of direct participation with the organization, physicians described the ways in which they interact with the other professionals through the organization. Defined as professional affiliation, this concept captures the way in which professionals perceive the organization through its professional capacity, from their own point of view interacting with physicians or facilities, or the external image for their patients in seeing the organization through its medical staff.

At one end of the spectrum, certain physicians may experience very little professional affiliation with the organization, and in return, perceive a limited role within that organization for themselves as a result of that separation. Instead, the local clinic practice is the sole focus of the physician in terms of providing care, akin to a private practice environment for all intents and purposes. The role of the organization in these cases only comes into focus in limited circumstances, such as when a member of the administration visits the clinic or patients refer to the name of the organization, which may also contribute to perceptions of the detachment of the organization from being supportive of the professional work. As one physician remarked:

“I believe this clinic, [the other doctor] is the owner and we don’t have a bigger corporation. I remember that we have a bigger corporation when I see [the operations director] or when I see my patient that says NCHC or NCHS” (16).

Within the clinic, physicians’ interactions with patients are much more frequent than interactions with the organization itself; these interactions also impact the extent to which the profession is distinct from the organization rather than affiliated. Patients will come to see a doctor who they have always seen, regardless of shifting organizational employment and different signs over the office. The relationships between patient and physician often may not include a strong sense of which organization happens to employ that physician:

“I don’t think my patients see me as a NCHC physician either. They see me as myself. Because when they talk to me, they don’t talk to me like ‘You’re with NCHC.’ You know what I’m saying?” (22).

“To be very honest with you, people, you know in the community, they don’t come and see NCHC. They come and see the doctor, right?” (06).

In contrast, there are physicians who acknowledge the strong role that the organization's name plays in signaling professional and quality care to patients. This greater sense of professional affiliation may occur through the association that the clinics have with the hospitals of the health system, and the subsequent interpretation of the organization as being driven by that relationship. Certainly from a patient perspective, a clinic and hospital sharing the same name create a relationship between the physicians at both facilities, and contributes to the notion of the organization as supportive of the professional work:

“People see the name on the building, so they have a feeling that he's a part of this group. So they have an expectation of what they're going to get as far as hopefully care, but primarily interaction with the hospital and specialists, because they associate me with those specialists at those hospitals” (23).

It is possible to define the organization not in terms of its management ability or competency, but rather in terms of the sum of the physicians it employs and the quality that they practice to, bringing the professional affiliation into greater focus: “Basically, the quality of the physicians. Quality is your standard. If you don't have quality, then you don't have anything. And you need quality and the quality has to be the physicians standard” (20).

Whether the organization is perceived as more professionally affiliated with the physicians, through the referral networks and other physicians that are a part of the health system, the community perceptions, or the quality standards associated with that group of physicians, the implications for the physician's role within the organization are critical. As one physician put it, “I'm the guy down here, interacting as part of NCHC and NCHS, on that personal level” (23). Within the scope of the employed professional role identity, it is important

to understand how that personal level is translated up through the organization, by virtue of the perceived professional affiliation of the system.

The ways in which the professional role fits into the larger organization, through organizational participation or a sense of professional affiliation, illustrates the complexity of the professional-organization role relationship that extends from a sense of employment. Where prior research has largely focused on professional engagement with the organization (e.g., Dukerich et al., 2002), it has been largely limited to notions of organizational participation. This model shifts that understanding to view the complexity of how employment drives a reciprocal role relationship, comprised of both organizational and professional channels of engagement and interaction. Embedded within their understanding is an important consideration of the role of professional work: this work and the organization's support of it tend to be what is important to the individual physician, with the larger role relationship contributing to this other-expectation of support rather than being an end to itself.

## CHAPTER FIVE – CONCLUSIONS

In response to the rapid pace and increasing amount of change facing the healthcare industry (Kocher & Sahni, 2011; Shortell et al., 2000), healthcare delivery organizations are becoming increasingly complex. This is particularly true of the relationships that are established between physicians and those organizations, extending far beyond the traditional models of primary care doctors working in private practice settings. There are a number of competitive and market pressures that contribute to the formation of many of these new physician-organization relationships. From a physician perspective, the pace of change in medicine and the delivery of that medicine- alongside declining reimbursement and rising costs- all but necessitate some form of support for a sustainable practice. From an organizational perspective, increased competition and regulatory pressure around the quality of care signal a need for increased coordination alongside increased market footprints. As noted in the introduction, the solution to many of these pressures is toward models of professional employment, particularly within the primary care specialties.

The frequent challenges associated with employing physicians, as well as the increasing popularity of the trend necessitate a better understanding of the dynamics around employed professionals and their interactions with organizations. Where prior research has almost exclusively focused on the contributions of professional and organizational identification (Hekman, Bigley, et al., 2009; Johnson et al., 2006, Wallace, 1995), the current study proposed that a more fruitful approach may be to draw out those relationships through a role-based identity perspective. Roles, rather than collectives, are better suited to understand the relationships

between social actors in complex and multidimensional settings- relationships that are characterized by distinct work functions and responsibilities, yet are intimately tied to one another in order to accomplish that work.

This study sought to answer the question of what it means to be an employed professional within this scope, and how that meaning relates to the interactions between a professional and his or her organization. As detailed in the introductory chapters, it is important to understand several contributing aspects of the employed professional role: the professional role itself, how employment relates to that role, how relationships with the organization are defined through that notion of employment, and finally, what those relationships mean for the patterns of interaction and behavior between the professional and the organization.

### **Summary of the Key Findings**

This study presents a grounded theory of the employed professional role identity to capture the relationships between a professional and an organization, guided by the research questions above. In general, this theory adopts a holistic rather than pluralistic approach to identity (Ashforth & Johnson, 2001), through a physician-in-context role. Rather than posit distinct and separable influences of professional and organizational identification, physicians in this study exhibited an amalgamated role identity: a professional role in the context of the organization, such that interactions with that organization are experienced through the lens of what it means to be a professional and what it means to be employed as a professional.

At the center of this role identity is the professional role itself, capturing the importance of providing a service to the patient and community, the ability and responsibility to practice as one sees fit, and the management of the “work” of the clinic environment that enables care to be delivered. These notions of what it means to be a professional are an inseparable part of the

physician's role within the organization, as that organization is the larger vehicle through which health care and professional services are provided. Consequently, the employed professional role identity comprises the meaning of employment through that lens, specifically in terms of how the individual physician and the work of the clinic are supported. Although more traditional notions of employment are captured in the individual lens (e.g., the exchange of compensation and benefits for providing some amount of work), more complex relationships also exist in terms of enabling the professional practice and work styles of the physician (particularly under productivity models of compensation that tend to accord more freedom to the individual physician). There are also the dynamics associated with the way in which the clinic operations are supported through employment, as the setting in which the physician provides care.

The role of the clinic environment and the work that goes on there, largely unconsidered in prior research, is a key theme throughout the employed professional role identity, and further contributes to the inseparability of the professional role and the meaning associated with employment. As illustrated earlier, both forms of employment contribute to downstream perceptions of the organization's role in supporting the professional work of the physician (Figure 3). This support is the key aspect through which a physician and organization interact—the organization has hired a physician to do this professional work, while the physician has sought out employment in order to be able to focus on that same professional work. In existing research, these dynamics tend not to be represented in aligning oneself with one collective or another, yet become clear when one considers the roles one enacts within organizational contexts.

There are two forms of relationships that emerge from these interactions. First, the perceived role of the organization in the professional work is important to consider from the

perspective of the employed physician, representing the potentially dual focus of a large healthcare delivery system. On the one hand, the physician may perceive the organization as aligned with professional values of providing good healthcare, primarily accomplished through each individual clinic. In these settings, the clinic becomes something of a “small business,” where questions of service and sustainability are intimately linked, and also shared between the organization and the physician. In other words, both want the clinic to provide good care, to see enough patients to make the operation viable, and so forth. At the same time, however, it is important to recognize the potential influence that the organization, perceived as a larger enterprise, has on the identification of employed physicians. In this lens, performance is much more about the aggregate entity, the business of running a successful company, competitive advantage over competing health systems, and so forth. Although these perspectives may appear to be opposite ends of the same spectrum, the complexity of large healthcare systems suggests that these perspectives may be independent of one another, which aligns with prior research on the multiple identities of complex organizations (Foreman, 2001).

The second aspect considers the expectations that physicians have of the organization in supporting the professional work, driven both by the notions of employment mentioned earlier and by the perception of the goals and alignment of the system, locally and as an enterprise. Rather than focus exclusively on organizational participation or engagement in the organization (e.g., Dukerich et al., 2002; Hekman, Bigley, et al., 2009), the employed professional role identity suggest the more impactful path for interaction occurs through the work of the clinic. Employed physicians tend to construct boundaries around certain aspects (primarily professional) of the work in the clinic, some seeking passive support of practice management functions while others seek more active management of ongoing operations. While these



boundaries set the “ground rules” for interactions of the profession and the organization, there are nonetheless certain triggers that cue physicians to specifically seek out the support of the organization in enabling the professional work or the efficiency of the clinic. These triggers may be the result of staff problems that impact the patients’ care or experience, hassles related to the peripheral work of providing healthcare, or in the form of a physician proactively seeking to improve some aspect of his or her practice.

In a majority of prior research, outcomes have been examined that reflect the professional’s participation in organizational activities (Dukerich et al., 2002). Through this study, however, it became clear that such participation is largely peripheral to the physician’s day-to-day, which as mentioned above, concerns the ability to provide healthcare in an efficient and quality manner. Instead, one must explicitly recognize the distinction between those goals and the employed physician’s perception of his or her role in an organization outside of coordination around care. Indeed, such perceptions tend to be at least somewhat removed from the actual work of the clinic, and reflect more of the individual relationship between the professional and the organization. These aspects of the employed professional role identity concern the number of expectations and perceptions associated with organizational participation: both the value and meaningfulness of input in the organization, the time costs of serving on committees, traveling to meetings at corporate headquarters in an environment where patients are typically scheduled every 15 minutes (or double-booked into those same appointments), and the way in which such duties are typically assigned without interest or advance consultation.

However, there is another side to the professional’s role in the organization, which is primarily revealed through a sense of professional affiliation with various aspects of the health system. In these cases, physicians, and in some cases their patients, think of and interact with the

organization as less of a corporate entity, and more through the other professionals that are employed by the organization. For example, physicians who use the name of the health system may do so in reference to the network of specialists they typically have relationships with and provide referrals to, or that label may represent their professional colleagues; others using that same name or label do so in reference to the administration and management teams of the organization, which suggests a limitation with prior methods of assessing identification with quantitative scales and abstract labels to which individuals assign their own unique meaning. Another key aspect of the level of affiliation occurs through the image that patients, and sometime other doctors, have of the physicians associated with the health system. Although some patients come to see their doctor regardless of the system to which he or she belongs, other patients see a doctor because they are affiliated with a certain system and thus expect a certain level of care as a result of that affiliation. These dynamics reflect a key limitation of the prior literature, in terms of the inability to capture the different meanings of broad and complex collectives. Within the scope of the employed professional role identity, these aspects are important to consider, particularly in terms of shaping perceptions of the organization's role in the professional work, based on the affiliated nature of the physician's role within the organization.

Overall, this model of the employed professional role identity is an important first step in arriving at a better understanding of how professionals interact with their employing organizations through an identity-based lens. Instead of individuals' sense of belonging within competing collectives, however, this theory suggests it is more important to look at the patterns of interactions that occur as a result of individuals' identification with a role-in-context.

## Theoretical Contributions

There are a number of theoretical contributions that stem from a theory of an integrated and holistic employed professional role identity, particularly with respect to the extant literature. Perhaps the largest implication stems from a paradigm shift in how engagement by employed professionals may be conceptualized, particularly as a result of identification processes. A majority of research has sought to understand why and when professionals expend effort on behalf of their employing organizations (Dukerich et al., 2002; Hekman, Bigley, et al., 2009; Hekman, Steensma, et al., 2009; Johnson et al., 2006; Wallace, 1995). Unfortunately, this stream of research has only examined one potential aspect of what it means for a professional to be engaged in an organization. A summary of those findings suggest the only pathway to increased engagement is through high organizational identification and low professional identification, where engagement is largely defined as support or participation in the organization's agenda, participation in meetings and committees, or compliance with mandates (Dukerich et al., 2002; Hekman, Bigley, et al., 2009). The model developed in this study suggests that those activities are one small part of the entire spectrum of interactions between a professional and employing organization; but for those interactions to become salient, one must look beyond each collective as an independent entity to the role that forms the basis for interactions between those collectives.

Indeed, the role relationships between collectives allow for much richer targets of professional engagement. As illustrated in Figure 3, there are two distinct pathways through which a professional may interact with the organization. One mirrors the approach taken by a majority of previous research, in terms of better understanding the professional's perceived role in the organization through participation and also perceptions of the extent to which the

organization is known and interacted with through its professional staff versus its administration. The contribution of the current theory, however, is to understand the somewhat more peripheral nature of these aspects with respect to the professional's day-to-day work. In other words, when a physician is seeing and treating patients all day, his or her participation on a committee unrelated to the care that is provided to those patients may not be the most influential aspect of the relationship between the physician and the organization.

To the extent that physicians are engaged in these types of organizational activities, the model suggests that rather than a broad sense of organizational identification, a more impactful driver may be linking the meaning of the employed professional role to the topics of those meetings or the content of certain mandates. This returns to the point raised by Burke and Reitzes (1991), as well as Postmes and Jetten (2006), in which identification drives behavior as a result of a shared underlying meaning. To the extent that physicians perceive the organizational agenda as improving their ability to provide care or improving quality for the patients (or concerns their personal employment), they are more likely to become engaged and supportive. The exact nature of that engagement, however, is a complex phenomenon, which is also likely driven by the perceptions of how the organization is perceived in terms of its role in supporting the professional work. All of this suggests the need for a broadened understanding of physician participation in organizational activities.

There is another pathway for engagement suggested by the current model that is currently missing from the extant literature, yet overlaps with the notion above of a more relational approach to the physician's role in an organization. The majority of current research has looked at engagement as a largely unidirectional phenomenon, in terms of how professionals support a corporate agenda. In terms of role relationships specified by the current model, however, the

opportunities for engagement in the organization become much more bidirectional, particularly as driven by the meaning of employment. One of the main sources of interaction through the professional-organizational relationship centers on the support of the professional work. From an organizational perspective, this work is the reason for employing the physician in a majority of cases (although there are some more strategic decisions, reflected in the “success of the organization as a business,” that are less related to the actual work of the professionals being employed). From the professional standpoint, likewise, employment provides the means to accomplish that professional work in a manner desired by the physician. Thus, for both entities, engagement may be defined in terms of how the professional work is supported.

As the model suggests, in fact, support of the professional work is the more influential aspect of the professional-organizational relationship, driven more strongly by the central professional role, the day-to-day work of that role, and the ways in which that work is either facilitated or hindered as a result of the employment relationship. Engagement therefore is the extent to which the professional is engaged in organizational activities that support or are related to his or her ability to see patients and provide care. While certain examples of this form of engagement might include some overlap to participation in meetings discussed earlier (e.g., design changes to an electronic health record through committee work), there is much broader potential for engagement around the actual clinic (e.g., working with the organization to define a more efficient workflow or intake process). The domain of potential opportunities for engagement and cooperation is defined solely by the physician’s perceptions of the boundaries around which aspects of the work ought to be supported, and by events that trigger expectations of cooperation. Where prior research has largely focused on engagement with those activities that align with one collective versus another, the current model focused on role-based

identification shifts that focus to instances where engagement occurs as a result of interdependency based in role relationships between members of different collectives.

Given the prior discussion of a paradigm shift in the types of targets for engagement between professionals and their organizations, it is important to re-examine the utility of traditional notions of professional and organizational identification. In part, this criticism stems from Tajfel's (1981) initial observation that individuals may spend very little time in forms of collective identity, and instead more commonly experience identification through the roles they enact on a daily basis. Indeed, based on the current model, professionals may spend very little time thinking of either their professional or organizational collectives; rather, they are likely to interact with patients and staff through (employed) professional role relationships. One may question whether the professional role is indeed distinct from the employed professional role, however, and the patterns of engagement that each role may hold with respect to the organization (and relatedly, whether there are true differences between those roles and the traditional notions of professional and organizational identification, or whether those are just semantic differences).

A part of the issue with the prior research of professional identification- and relatedly, with a singular and distinct professional role identity- is the lack of context that such conceptualizations carry. The argument here is not to suggest that such forms of identity do not exist (indeed, they are likely capable of being primed, as evidenced in much of the minimal group-based research of social identity theory), but rather when applied to a work context, it is necessary to account for the richness and complexity of a role-in-context. In the current theory, employment serves an important function in the enactment of the professional role, both in terms of the way in which the physician practices and the way the work of the clinic is structured. As a result, a logical argument may be made that each individual customizes his or her professional

role based on their understanding of what it means to be employed as a professional in a specific context. This position is consistent with those in the field that advocate for holistic rather than pluralistic identifications (Ashforth & Johnson, 2001). The benefit of such an approach is a greater appreciation of distinct patterns of engagement through those unique role identities, rather than assuming that a professional role is isomorphic across individuals, as much of the extant literature has done (cf. Hoff, 2001).

Another reason to cast off notions of professional and organization identification are the implicit assumptions of conflict that have tended to follow those concepts (Gouldner, 1957; Starr, 1982; Wallace, 1995). The current theory offers an alternative through the employed professional role, which explicitly captures the nature of interdependent work and interactions between professionals and the organizations that employ them. This is not to suggest that conflict may not arise out of this conceptualization; indeed, physician perceptions of the organization's role in the professional work, or the violation of certain boundaries around that work may create tension or conflict between the two entities, but such conflict is rooted in interactions between them and not in basic assumptions of the theory. A role-based approach is also beneficial in that it avoids the need to develop a superordinate identity to resolve identity-based conflicts (Fiol, Pratt, & O'Connor, 2009), which has been one recent solution to overcoming the gap between professionals and organizational administrators. Instead, individuals are able to maintain their differentiated role identities, yet still understand the ways in which their role is necessarily interdependent on other roles to accomplish some amount of work. This may be particularly important given the observation that professional aspects of the self are likely to be stronger than organizational affiliations (Johnson et al., 2006), and are unlikely to be subsumed under a temporally or situationally specific superordinate group.

The benefit of a role-based approach, as described throughout this section, contributes to a growing appreciation of the more sociologically based models of identity across various topics in the extant literature, including relational identification and the way in which that generalizes to other entities (e.g., Sluss & Ashforth, 2007, 2008), role-based theories of leadership identity (e.g., DeRue & Ashford, 2010), and professional role development processes (e.g., Ibarra, 1999; Pratt et al., 2006). All of these approaches share the same emphasis on understanding the social context of identity from a relational rather than collective perspective. Likewise, the current theory proposes a notion of employed professionals that centers on the interdependent relationships between that professional and the employing organization, and the work that stems from the interactions and role relationships between the two.

### **Practical Implications**

This grounded theory of employed professional role identity also carries several implications for practitioners, both for healthcare system administrations and for employed physicians of those systems. Generally speaking, the components of the employed professional role identity offer a deeper and more comprehensive understanding of the nature of interaction between a system and its employed physicians. This is particularly true of the role of employment in the professional work. From an administration standpoint, employment of physicians may be a strategic move to achieve vertical integration, with much of the attention being devoted to how those physicians will create a positive impact for the system overall. The current model suggests that administrations must also consider physicians' reasons for seeking employment as a way to support their professional practice and also on a more individual basis. For example, a physician seeking employment to remove the burden of insurance regulations will be more likely to expect that support within the clinic environment; if the organization is



unaware of these types of dynamics or otherwise expects the physician to handle such issues, there is likely to be tension and poor interactions. On the other hand, if the system engages physicians around solutions to such hassles, there is likely to be opportunities for increased engagement and cooperation. Such recommendations largely mirror the above discussion around the bias in the extant academic literature to examining the effects of identification on organization engagement, without truly considering the breadth of what organizational engagement might entail. In large part, this broader consideration may serve to buffer some of the negative consequences that healthcare systems have historically experienced in their integration attempts.

In a related vein, organizations must be explicit about the type and nature of participation that it expects from its physician workforce. A majority of the practitioner literature discusses physician cooperation as participation in organizational meetings and committees. As this model illustrates, however, to the extent that those activities are unrelated to providing care, they are unlikely to be a point of cooperation in the physician-system relationship. Organizations must also be careful in such instances where they ask for physician input through these types of meetings, to truly take that input and make it actionable rather than just to give it lip-service. Organizations that expect participation but do not value the resulting input are likely to decrease the perceived value of such participation, especially in comparison to clinical activities that have a clear and present value to the physician. On the positive end of the spectrum, organizations that encourage participation and input around clinical activities and other initiatives that support the physician's ability to provide care are more likely to tap into the aspects of the employed professional role that flow from the core professional role and carry expectations of the role of the organization in supporting the professional work. Through such activities, the organization

may be seen as less emphasizing of its own agenda and more focused on supporting its physician workforce.

For employed physicians, the current theory presents unique opportunities to explicitly develop a set of meanings that tie together clinical care and the organizational activities. Consequently, a physician is able to develop notions of interdependent work that does not require them to cast off their physician role identity and assume an organizational identity, yet still maintain an appreciation of the organizational role. For example, each physician seeks out employment for a set of unique reasons, which inform the pattern of relationships and responsibilities between him or herself and the organization. Accounting for these sets of meanings allows each physician to more formally establish and communicate the terms of the relationship as he or she sees fit: where support is required, domains where authority is expected, and opportunities to collaborate. From a developmental perspective (cf. Ibarra, 1999; Pratt et al., 2006), as physicians gain more experience with employment vis-à-vis their own styles and preferences that stem from their professional role, a knowledge of both boundaries and triggers may help to encourage a more beneficial negotiation of the physician-system relationship.

Finally, for all parties involved, the current theory may begin to offer insight into the more impactful opportunities for engagement and cooperation. Assessments of each component may be particularly useful, for instance, in determining the extent to which physicians perceive the relative focus of the system on issues of its own agenda versus the concerns of its physician workforce. Similarly, physicians may be surveyed to better understand the range of meanings underlying the reasons for seeking employment within a given system, and using that data to inform where opportunities for collaboration exist. Finally, one may evaluate the particular boundaries and triggers within each clinic to identify where the divisions of responsibility occur

and potential ways to resolve those divisions. Through an initial model of the employed professional identity, the theory offers valuable insight into the specific role-relationships between physicians and the organizations to which they belong.

### **Limitations and Directions for Future Research**

There are several limitations to the current study that must be acknowledged in any interpretation of the findings. First is the question of generalizability or transferability of the employed professional role as established in this study to other contexts, organizations, or professions. Although this is a limitation commonly associated with single-case qualitative research, an attempt was made throughout this study to adequately describe the setting and context, allowing comparisons to be made to other samples on the basis of factors within those descriptions (Miles & Huberman, 1994). For example, with regard to the specific context of this study, it is important to characterize the setting as a community health system with geographically dispersed clinics around the major hospital campuses, and with a majority of those clinics being small provider practices. As a result, in terms of the factors that one must consider when applying these findings to other health systems is the nature of the system as an academic medical center, for-profit or not-for-profit status, and the unique dispersion of clinics within those systems.

The balance of such factors may influence the relative influence of the various components of the employed professional model. For example, the perception of the system as a business may be less important to academic or not-for-profit systems. However, the development of the employed professional role, grounded in extant literature on role identity ought to provide a valuable framework for understanding such issues as they may uniquely arise for each health system, capturing the major avenues through which the role-based interactions between

physicians and administrations may be captured. Given the different configurations and structures for organizations in the healthcare industry, the issue of generalizability is indeed an important one. Perhaps the most common examples from the literature on physician-system relationship are systems in which system leadership is comprised of medical staff rather than professional staff (e.g., Golden et al., 2000; MacNulty & Reich, 2008; Scott, 1982). In general, such systems report higher levels of physician engagement and participation. Thus, an important question for future research is to determine whether the composition of organizational leadership influences the nature of the employed professional role identity.

Another aspect of the context that must be discussed as a limitation is the nature of the physician-system relationship. In the current study, physicians work under a productivity-based compensation system, are afforded considerable discretion within their clinics, and are under a structure whereby the clinic staff reports to the operations director rather than the physician. Each of these aspects creates important dynamics at the interface of the physician and the health system, and also a unique definition of what it means to be employed within a given context. Although the current study was conducted within a single version of this employment relationship, the theoretical components of the employed professional identity ought to provide future researchers with a structure for understanding the variety of relationships that may exist, for example, in terms of salary guarantees, size of physicians, staff mix, and presence of mid-level providers. Such future research would be well-served to apply this model to different settings to determine if this is indeed the case.

A final note on the issue of generalizability concerns the applicability of the employed professional role identity to other professions, both within the healthcare industry (i.e., specialists, hospitalists, mid-level providers and other professional staff) and to other industries

(i.e., legal, accounting, pharmacy, scientists, and so forth). The current study has focused on professions in which the professional work is a function of both the individual and a larger work practice, both of which are influenced by a sense of employment. For professions where these similar dynamics occur, the model is expected to be transferable, for example, to veterinarians (Johnson et al., 2006). Indeed, Wallace's (1995) finding that professionals are quite able to create professional microcosms within larger organizations suggests that even professionals such as lawyers and accountants might establish a work practice, furthering the applicability of the current model. Future research is required to affirm these dynamics, however, as well as to establish the applicability of the model to employed professionals of a wider variety, for example accountants (Bamber & Iyer, 2002), nurses (Apker & Fox, 2002), journalists (Russo, 1998), or symphony musicians (Glynn, 2000).

An additional set of limitations to the current study stems from having a single investigator conducting the research. Unfortunately, logistical limitations largely prohibited a research team from engaging with the research, given the distributed nature of the research sites and the distance from other potential investigators. A number of techniques were used to mitigate the potential impact from this limitation. First, decisions and processes were explicitly documented concerning the research protocol, including the nature of assumptions about the qualitative data (e.g., interpretivist versus positivist paradigms), sampling strategies, and so forth. Additionally, techniques such as the data structure diagram (Gioia et al., 2013) and member checks and peer debriefings (Miles & Huberman, 1994) were utilized to illustrate exactly how the data were transformed into theoretical concepts and dimensions and to ensure trustworthiness. Although the theory that was developed was grounded in the literature and the data from study participants, the nature of the interpretivist paradigm suggests that additional

researchers may yet come to their own unique conclusions regarding the data. As a result, additional research is required to either modify or confirm the findings of the current study.

In addition to the directions for future research mentioned above, there are several additional routes for additional investigation around the dynamics of employed professionals stemming from the current theory of a role-based identity. Perhaps most importantly is to integrate the components of an employed professional role identity with the change management literature (Dutton & Dukerich, 1991; Jimmieson & White, 2011; Reissner, 2010), especially given the fast pace of change within the healthcare industry around employment trends (e.g., Kocher & Sahni, 2011). There is a large degree of overlap between the types of cooperation and participation proposed by the current stream of research on employed professionals and the impact that change might have on those dynamics. Thus, research must be prepared to more fully understand the circumstances under which change triggers the salience of different aspects of the employed professional role identity, particularly with regard to support of initiatives that are seen as organizationally-driven versus those with a more professional impact.

Another fruitful direction for future research is to extend the employed professional role identity to include or incorporate other relevant aspects of the professional-in-context. For example, one notion that stems from the current study is the question of encouraging not only participation among medical staff within a health system, but going one step further to grow and develop physician leadership. A role-identity perspective seems particularly apt to answer these questions, especially given the progress using an identity lens to understand leadership more broadly (e.g., DeRue & Ashford, 2010). Future research may be well-served to investigate which components of the employed professional identity relate to one taking on more leadership roles, either informally within the space of his or her own clinic, or more formally within the larger

organization. Whether such dynamics are more related to one's notion of employment supporting the professional (i.e., joining an organization provides leadership opportunities), or one's expectations of organizational participation (i.e., to facilitate an ability to provide care, such leadership is required) remains an open question. Understanding these dynamics from the context of the employed professional role lens may be one valuable avenue.

Overall, the employed professional role identity provides a deeper understanding of some of the components that comprise the meanings associated with being a professional-in-context; in turn, these components may help answer questions that stem from physician-system relationships and improving collaboration and cooperation between the two. Although this theory is a single step towards this better understanding, it nevertheless calls out the impactful aspects of being an employed professional that may contribute to future research.

## **TABLES AND FIGURES**



**Table 1. Summary of Participant Demographics**

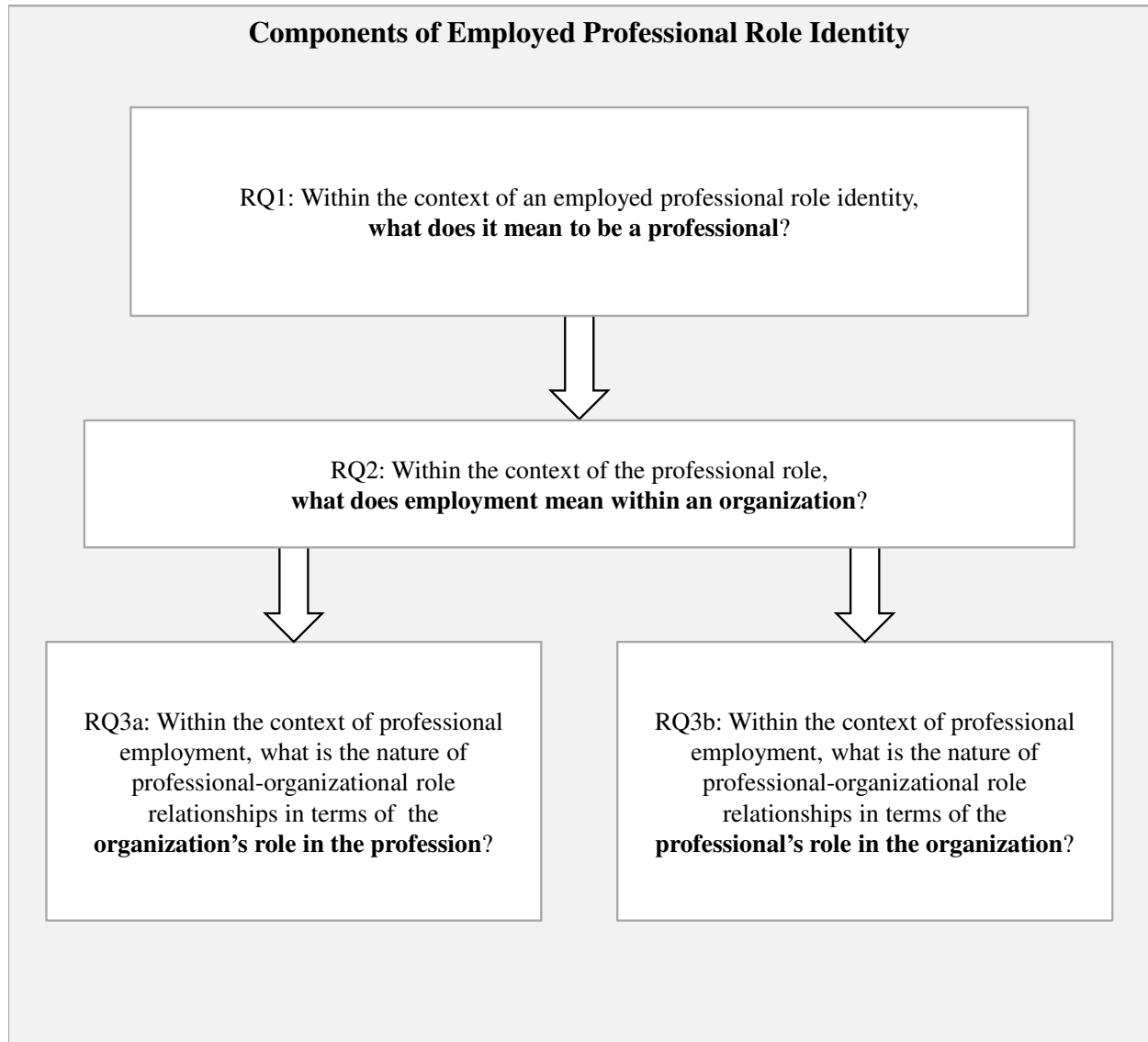
Participant ID	Tenure with NCHC	Organizational Role Held?	Prior Employment?	Organizational Identification	Professional Identification
				<i>M</i> = 4.64 ( <i>SD</i> = 1.13)	<i>M</i> = 5.28 ( <i>SD</i> = 1.10)
1	Mid	No	Yes (HS)	5.17	5.00
2	Mid	Yes	Yes (HS)	5.83	5.50
3	Junior	Yes	No	5.00	5.33
4	Senior	No	Yes (PP)	4.50	4.67
5	Mid	No	Yes (HS)	5.67	5.00
6	Senior	Yes	No	4.00	6.33
7	Senior	Yes	Yes (HS)	5.17	4.33
8	Senior	Yes	Yes (PP)	3.83	5.67
9	Mid	No	Yes (?)	4.00	6.00
10	Junior	No	Yes (HS)	6.00	6.00
11	Junior	No	Yes (HS)	4.67	5.33
12	Mid	No	Yes (PP)	5.83	6.50
13	Senior	No	Yes (PP)	3.33	5.17
14	Senior	No	No	3.50	5.33
15	Junior	No	No	3.67	2.50
16	Junior	Yes	No	3.50	6.17
17	Junior	Yes	Yes (PP)	5.67	6.33
18	Mid	Yes	No	5.00	2.50
19	Junior	Yes	No	5.00	6.17
20	Mid	Yes	Yes (HS)	6.33	5.83
21	Senior	Yes	Yes (PP)	3.17	3.83
22	Mid	Yes	No	1.83	6.67
23	Senior	No	No	6.00	5.33

*Note.* Tenure with NCHC was segmented by Junior (< 5 years), Mid (between 5 and 15 years), and Senior (> 15 years). Prior employment is further delineated by type of employment, where PP = Private Practice, HS = Health System, and ? = Unclear affiliation.

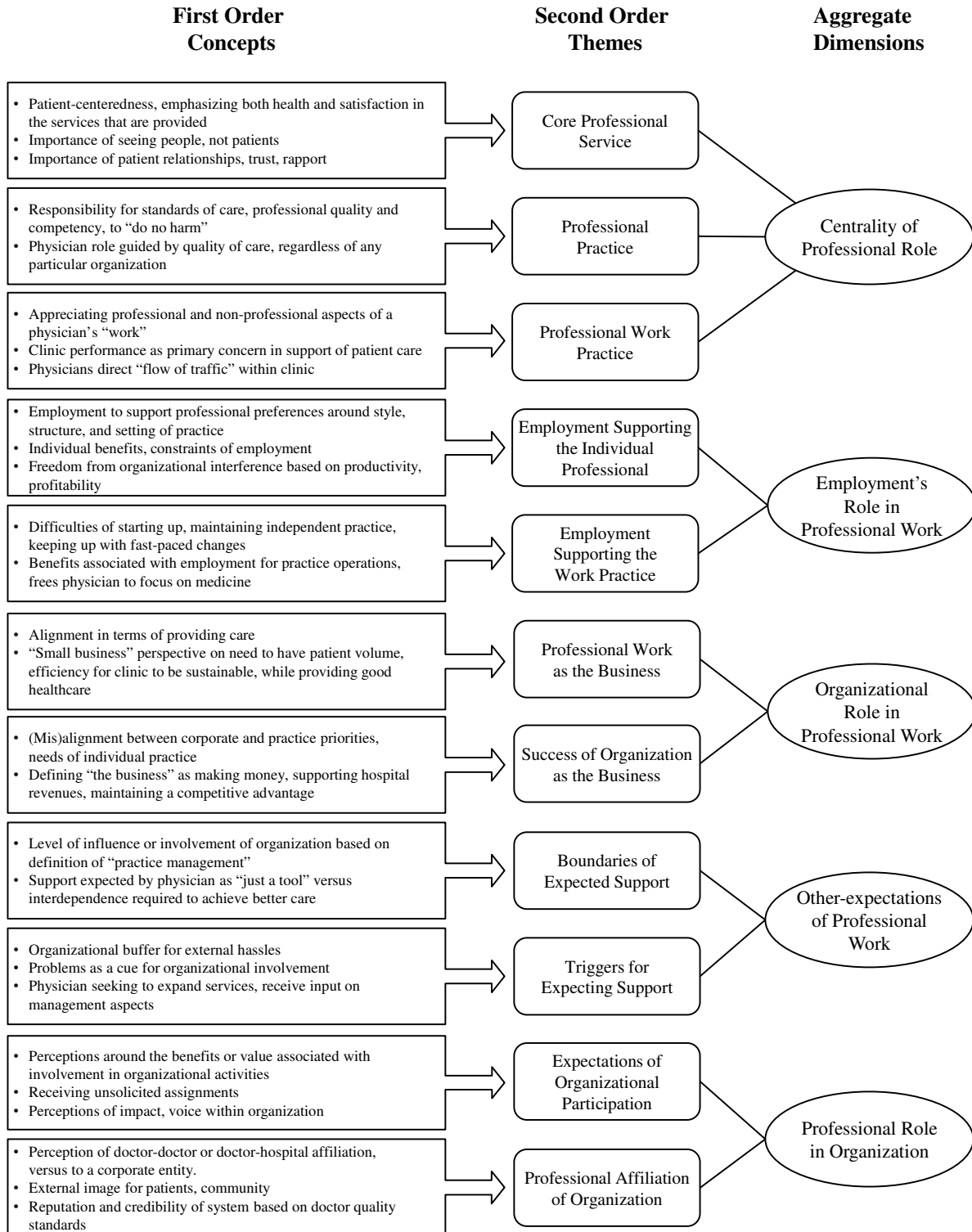
**Table 2. Summary of Meeting and Event Observations**

<b>Type</b>	<b>Location</b>	<b>Physicians Present?</b>	<b>Number Attended</b>
<i>Regular Meetings</i>			
Quarterly Market Presentations	Hospital Conference Room	Yes	3
Monthly Operations Meeting	Corporate	No	4
Monthly Practice Manager Conference Call	Corporate	No	3
Innovation Council	Corporate	No	2
Electronic Health Record User Group	Hospital Conference Room	Yes	1
<i>Ad-hoc Meetings</i>			
New Initiative Introductions	Corporate, Off-site	Yes	2
Physician Leadership Meeting	Corporate	Yes	1
Physician Onboarding and Training	Corporate	Yes	2
Change Kick-off Meetings	Clinics, Corporate	Yes	3
Staff Training	Corporate	No	2
<i>General Observations</i>			
Day-long Clinic Observations	Clinic	Yes	11
Operation Manager Shadowing	Corporate	Yes	2

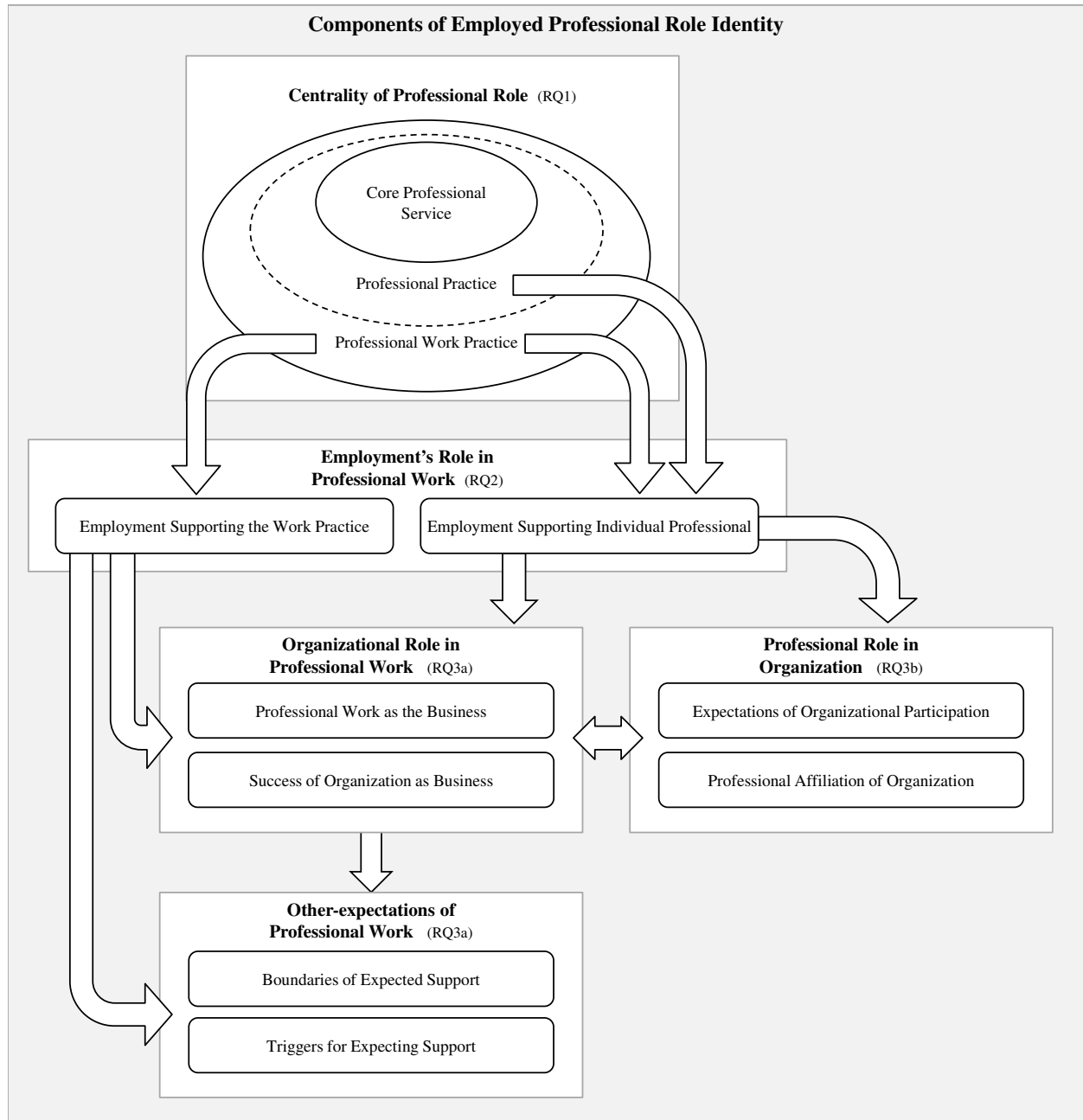
**Figure 1. Graphical Illustration of the Research Question Structure**



**Figure 2. Data Structure Diagram for a Grounded Theory of Employed Professional Role Identity**



**Figure 3. Theoretical Model of Employed Professional Role Identity**



## REFERENCES

- Albert, S. (1998). The definition and metadefinition of identity. In D. A. Whetten, & P. C. Godfrey (Eds.), *Identity in organizations: Building theory through conversations* (pp. 1-13). Thousand Oaks, CA: SAGE.
- Albert, S., Ashforth, B. E., & Dutton, J. E. (2000). Organizational identity and identification: Charting new waters and building new bridges. *Academy of Management Review*, 25, 13-17.
- Apker, J., & Fox, D. H. (2002). Improving RNs' organizational and professional identification in managed care hospitals. *Journal of Nursing Administration*, 32, 106-114.
- Ashforth, B. E. (2001). *Role transitions in organizational life: An identity-based perspective*. Mahwah, NJ: Erlbaum.
- Ashforth, B. E., & Johnson, S. A. (2001). Which hat to wear? The relative salience of multiple identities in organizational contexts. In M. A. Hogg, & D. J. Terry (Eds.), *Social identity processes in organizational contexts* (pp. 31-48). Philadelphia, PA: Psychology Press.
- Ashforth, B. E., & Mael, F. (1989). Social identity theory and the organization. *Academy of Management Review*, 14, 20-39.
- Ashforth, B. E., Harrison, S. H., & Corley, K. G. (2008). Identification in organizations: An examination of four fundamental questions. *Journal of Management*, 34, 325-374.
- Ashmore, R. D., Deaux, K., & McLaughlin-Volpe, T. (2004). An organizing framework for collective identity: Articulation and significance of multidimensionality. *Psychological Bulletin*, 130, 80-114.

- Bamber, E. M., & Iyer, V. M. (2002). Big R auditors' professional and organizational identification: Consistency or conflict? *Auditing: A Journal of Practice and Theory*, 21, 21-38.
- Bard, M., Conlon, P., Gartner, G., & O'Rourke, P. T. (2008, November-December). Physician alignment: Paths to partnership. *Health Progress*, 20-24.
- Bartels, J., Pruyn, A., De Jong, M., & Joustra, I. (2007). Multiple organizational identification levels and the impact of perceived external prestige and communication climate. *Journal of Organizational Behavior*, 28, 173-190.
- Beckham, D. (2010, June). Physician involvement in hospital strategic planning. *Trustee*, 6-7.
- Bergami, M., & Bagozzi, R. P. (2000). Self-categorization, affective commitment, and group self-esteem as distinct aspects of social identity in the organization. *British Journal of Social Psychology*, 39, 555-577.
- Blader, S. L., & Tyler, T. R. (2009). Testing and extending the group engagement model: Linkages between social identity, procedural justice, economic outcomes and extrarole behavior. *Journal of Applied Psychology*, 94, 445-464.
- Bolinger, J. E. (1999, June). Effective physician integration strategy. *Health Care Strategic Management*, 18-20.
- Brewer, M. B. (1991). The social self: On being the same and different at the same time. *Personality and Social Psychology Bulletin*, 17, 475-482.
- Brewer, M. B., & Gardner, W. (1996). Who is this "we"? Levels of collective identity and self representation. *Journal of Personality and Social Psychology*, 71, 83-93.
- Brubaker, R., & Cooper, F. (2000). Beyond "identity". *Theory and Society*, 29, 1-47.

- Budetti, P. P., Shortell, S. M., Waters, T. M., Alexander, J. A., Burns, L. R., Gillies, R. R., & Zuckerman, H. (2002, January-February). Physician and health system integration. *Health Affairs*, 203-211.
- Burke, P. J. (1991). Identity processes and social stress. *American Sociological Review*, 56, 836-849.
- Burke, P. J., & Reitzes, D. C. (1991). An identity theory approach to commitment. *Social Psychology Quarterly*, 54, 239-251.
- Burke, P. J., & Stets, J. E. (2009). *Identity Theory*. New York, NY: Oxford University Press.
- Burns, L. R., & Muller, R. W. (2008). Hospital-physician collaboration: Landscape of economic integration and impact on clinical integration. *The Milbank Quarterly*, 86, 375-434.
- Cheney, G. (1983). On the various and changing meanings of organizational membership: A field study of organizational identification. *Communication Monographs*, 50, 342-362.
- Clark, S. M., Gioia, D. A., Ketchen, D. J., & Thomas, J. B. (2010). Transitional identity as a facilitator of organizational identity change during a merger. *Administrative Science Quarterly*, 55, 397-438.
- Corbin, J., & Strauss, A. (2008). *Basics of qualitative research (3rd ed.)*. Thousand Oaks, CA: SAGE.
- DeRue, D. S. & Ashford, S. J. (2010). Who will lead and who will follow? A social process of leadership identity construction in organizations. *Academy of Management Review*, 35, 627-647.
- Devereux, P. (2000, October). Keep the doctors in-house. *Modern Healthcare*, 70-71.



- Dukerich, J. M., Golden, B. R., & Shortell, S. M. (2002). Beauty is in the eye of the beholder: The impact of organizational identification, identity, and image on cooperative behaviors of physicians. *Administrative Science Quarterly*, *47*, 507-533.
- Dutton, J. E., & Dukerich, J. M. (1991). Keeping an eye on the mirror: Image and identity in organizational adaptation. *Academy of Management Journal*, *34*, 517-554.
- Edwards, M. R. (2005). Organizational identification: A conceptual and operational review. *International Journal of Management Reviews*, *7*, 207-230.
- Eisenhardt, K. M. (1989). Building theories from case study research. *Academy of Management Review*, *14*, 532-550.
- Etzioni, A. (1969). *The semi-professions and their organization*. New York, NY: The Free Press.
- Fiol, C. M., Pratt, M. G., & O'Connor, E. J. (2009). Managing intractable identity conflicts. *Academy of Management Review*, *34*, 32-55.
- Foreman, P. (2001). *Managing identities in managed care: Top-management-team responses to organizational complexity and change*. Unpublished doctoral dissertation, University of Illinois at Urbana-Champaign.
- Gioia, D. A., Corley, K. G., & Hamilton, A. L. (2013). Seeking qualitative rigor in inductive research: Notes on the Gioia methodology. *Organizational Research Methods*, *16*, 15-31.
- Glaser, B., & Strauss, A. M. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York, NY: De Gruyter.
- Glynn, M. A. (2000). When cymbals became symbols: Conflict over organizational identity within a symphony orchestra. *Organization Science*, *11*, 285-298.

- Golden, B. R., Dukerich, J. M., & Fabian, F. H. (2000). The interpretation and resolution of resource allocation issues in professional organizations: A critical examination of the professional-manager dichotomy. *Journal of Management Studies*, 37, 1157-1187.
- Gouldner, A. W. (1957). Cosmopolitans and locals: Toward an analysis of latent social roles- I. *Administrative Science Quarterly*, 2, 281-306.
- Gouldner, A. W. (1958). Cosmopolitans and locals: Toward an analysis of latent social roles- II. *Administrative Science Quarterly*, 2, 444-480.
- Grube, J. A., & Piliavin, J. A. (2000). Role identity, organizational experiences, and volunteer performance. *Personality and Social Psychology Bulletin*, 26, 1108-1119.
- Hall, R. T. (1975). *Occupations and the social structure (2nd ed.)*. Englewood Cliffs, NJ: Prentice-Hall.
- Haslam, S. A., & Ellemers, N. (2005). Social identity in industrial and organizational psychology: Concepts, controversies, and contributions. *International Review of Industrial and Organizational Psychology*, 20, 39-118.
- Hekman, D. R., Bigley, G. A., Steensma, H. K., & Hereford, J. F. (2009). Combined effects of organizational and professional identification on the reciprocity dynamic for professional employees. *Academy of Management Journal*, 52, 506-526.
- Hekman, D. R., Steensma, H. K., Bigley, G. A., & Hereford, J. F. (2009). Effects of organizational and professional identification on the relationship between administrators' social influence and professional employees' adoption of new work behavior. *Journal of Applied Psychology*, 94, 1325-1335.
- Hickson, D. J., & Thomas, M. W. (1969). Professionalization in Britain: A preliminary measurement. *Sociology*, 3, 37-53.

- Hoff, T. J. (2001). The physician as worker: What it means and why now? *Health Care Management Review, 26*(4), 53-70.
- Hogg, M. A., & Abrams, D. (1988). *Social identifications: A social psychology of intergroup relations and group processes*. London, England: Routledge.
- Hogg, M. A., & Ridgeway, C. L. (2003). Social identity: Sociological and social psychological perspectives. *Social Psychology Quarterly, 66*, 97-100.
- Hogg, M. A., & Terry, D. J. (2000). Social identity and self-categorization processes in organizational contexts. *Academy of Management Review, 25*, 121-140.
- Hogg, M. A., Terry, D. J., & White, K. M. (1995). A tale of two theories: A critical comparison of identity theory with social identity theory. *Social Psychology Quarterly, 58*, 255-269.
- Holm, C. E. (2000, March-April). Economic models for physician-health system partnerships. *Journal of Healthcare Management, 78-82*.
- Ibarra, H. (1999). Provisional selves: Experimenting with image and identity in professional adaptation. *Administrative Science Quarterly, 44*, 764-791.
- James, W. (1918). *Principles of Psychology (Vol. 1)*. New York, NY: Henry Holt.
- Jick, T. D. (1979). Mixing qualitative and quantitative methods: Triangulation in action. *Administrative Science Quarterly, 24*, 602-611.
- Jimmieson, N. L., & White, K. M. (2011). Predicting employee intentions to support organizational change: An examination of identification processes during a re-brand. *British Journal of Social Psychology, 50*, 331-341.
- Johnson, M. D., Morgeson, F. P., Ilgen, D. R., Meyer, C. J., & Lloyd, J. W. (2006). Multiple professional identities: Examining differences in identification across work-related targets. *Journal of Applied Psychology, 91*, 498-506.

- Katz, D., & Kahn, R. L. (1978). *The social psychology of organizations*. Oxford, England: Wiley
- Kocher, R., & Sahni, N. R. (2011). Hospitals' race to employ physicians – The logic behind a money-losing proposition. *New England Journal of Medicine*, 364, 1790-1793.
- Kramer, R. (1993). Cooperation and organizational identification. In J. K. Murnighan (Ed.), *Social psychology in organizations* (pp. 244-268). Englewood Cliffs, NJ: Prentice Hall.
- Kreiner, G. E., Hollensbe, E. C., & Sheep, M. L. (2006). On the edge of identity: Boundary dynamics at the interface of individual and organizational identities. *Human Relations*, 59, 1315-1341.
- Lefkowitz, J. (2003). *Ethics and values in industrial-organizational psychology*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: SAGE.
- Lipponen, J., Bardi, A., & Haapamaki, J. (2008). The interaction between values and organizational identification in predicting suggestion-making at work. *Journal of Occupational and Organizational Psychology*, 81, 241-248.
- Lipponen, J., Helkama, K., Olkkonen, M. E., & Juslin, M. (2005). Predicting the different profiles of organizational identification: A case of shipyard subcontractors. *Journal of Occupational and Organizational Psychology*, 78, 97-112.
- Locke, K. (2001). *Grounded theory in management research*. Thousand Oaks, CA: SAGE.
- Lofland, J., & Lofland, L. H. (1995). *Analyzing social settings: A guide to qualitative observation and analysis (3<sup>rd</sup> ed.)*. Belmont, CA: Wadsworth.
- Mael, F., & Ashforth, B. E. (1992). Alumni and their alma mater: A partial test of the reformulated model of organizational identification. *Journal of Organizational Behavior*, 13, 103-123.

- MacNulty, A., & Reich, J. (2008, September-October). Survey and interviews examine relationships between physicians and hospitals. *Physician Executive*, 34, 48-50.
- MAXQDA, software for qualitative data analysis. (1989-2014). VERBI Software- Consult- Sozialforschung GmbH. Berlin, Germany.
- McCall, G. J., & Simmons, J. L. (1966). *Identities and interactions*. New York: Free Press.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative Data Analysis (2nd ed.)*. Thousand Oaks, CA: SAGE.
- Moore, K. D., & Coddington, D. C. (2009, December). Multiple paths to integrated health care. *Healthcare Financial Management*, 46-54.
- Owens, T. J., Robinson, D. T., & Smith-Lovin, L. (2010). Three faces of identity. *Annual Review of Sociology*, 36, 477-499.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods (2nd ed.)*. Newbury Park, CA: SAGE.
- Pettigrew, A. M. (1990). Longitudinal field research on change: Theory and practice. *Organization Science*, 1, 267-292.
- Postmes, T., & Jetten, J. (2006). Reconciling individuality and the group. In T. Postmes, & J. Jetten (Eds.), *Individuality and the group: Advances in social identity* (pp. 258-269). London, England: SAGE.
- Pratt, M. G. (1998). To be or not to be? Central questions in organizational identification. In D. A. Whetten, & P. C. Godfrey (Eds.), *Identity in organizations: Building theory through conversations* (pp. 171-207). Thousand Oaks, CA: SAGE.
- Pratt, M. G. (2000). The good, the bad, and the ambivalent: Managing identification among Amway distributors. *Administrative Science Quarterly*, 45, 456-493.

- Pratt, M. G., & Foreman, P. O. (2000). Classifying managerial responses to multiple organizational identities. *Academy of Management Review*, 25, 18-42.
- Pratt, M. G., Rockmann, K. W., & Kaufmann, J. B. (2006). Constructing professional identity: The role of work and identity learning cycles in the customization of identity among medical residents. *Academy of Management Journal*, 49, 235-262.
- Reissner, S. C. (2010). Change, meaning, and identity at the workplace. *Journal of Organizational Change Management*, 23, 287-299.
- Riketta, M. (2005). Organizational identification: A meta-analysis. *Journal of Vocational Behavior*, 66, 358-384.
- Riketta, M., & Nienaber, S. (2007). Multiple identities and work motivation: The role of perceived compatibility between nested organizational units. *British Journal of Management*, 18, s61-s77.
- Riketta, M., & Van Dick, R. (2005). Foci of attachment in organizations: A meta-analytic comparison of the strength and correlates of workgroup versus organizational identification and commitment. *Journal of Vocational Behavior*, 67, 490-510.
- Roccas, S., & Brewer, M. B. (2002). Social identity complexity. *Personality and Social Psychology Review*, 6, 88-106.
- Rousseau, D. M. (1998). Why workers still identify with organizations. *Journal of Organizational Behavior*, 19, 217-233.
- Russo, T. C. (1998). Organizational and professional identification: A case of newspaper journalists. *Management Communication Quarterly*, 12, 72-111.
- Salancik, G. R. (1977). Commitment is too easy! *Organizational Dynamics*, 6, 62-80.

- Sanderson, B., Rice, B., & Fox, M. (2008, December). Physician integration is back- and more important than ever. *Healthcare Financial Management*, 64-71.
- Schramko, T. D. (2007). The characteristics of an effective physician-hospital working relationship: An exploratory study. *Health Care Analysis*, 15, 91-105.
- Scott, W. R. (1965). Reactions to supervision in a heteronomous professional organization. *Administrative Science Quarterly*, 10, 65-81.
- Scott, W. R. (1982). Managing professional work: Three models of control for health organizations. *Health Services Research*, 17, 213-240.
- Sedikides, C., & Brewer, M. B. (2001). *Individual self, relational self, collective self*. New York, NY: Psychology Press.
- Shamr, B., & Kark, R. (2004). A single-item graphic scale for the measurement of organizational identification. *Journal of Occupational and Organizational Psychology*, 77, 115-123.
- Shortell, S. M., Gillies, R. R., Anderson, D. A., Erickson, K. M., & Mitchell, J. B. (2000). *Remaking health care in America*. San Francisco, CA: Jossey-Bass.
- Sluss, D. M., & Ashforth, B. E. (2007). Relational identity and identification: Defining ourselves through work relationships. *Academy of Management Review*, 32, 9-32.
- Sluss, D. M., & Ashforth, B. E. (2008). How relational and organizational identification processes converge: Processes and conditions. *Organization Science*, 19, 807-823.
- Starr, P. (1982). *The social transformation of American medicine: The rise of a sovereign profession and the making of a vast industry*. New York, NY: Basic Books.
- Stets, J. E., & Burke, P. J. (2000). Identity theory and social identity theory. *Social Psychology Quarterly*, 63, 224-237.

- Strauss, A. (1978). *Qualitative analysis for social scientists*. New York, NY: Cambridge University Press.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research (2nd ed.)*. Thousand Oaks, CA: SAGE.
- Stryker, S. (1968). Identity salience and role performance: The relevance of symbolic interaction theory for family research. *Journal of Marriage and the Family*, 4, 558-564.
- Stryker, S. (2008). From Mead to a structural symbolic interactionism and beyond. *Annual Review of Sociology*, 34, 15-31.
- Stryker, S., & Burke, P. J. (2000). The past, present, and future of an identity theory. *Social Psychology Quarterly*, 63, 284-297.
- Tajfel, H. (1981). *Human groups and social categories: Studies in social psychology*. Cambridge, England: Cambridge University Press.
- Tajfel, H. (1982). Social psychology of intergroup relations. *Annual Review of Psychology*, 33, 1-39.
- Tajfel, H., & Turner, J. C. (1986). The social identity theory of intergroup behavior. In S. Worchel, & W. G. Austin (Eds.), *Psychology of intergroup relations (2nd ed.)* (pp. 7-24). Chicago, IL: Nelson-Hall.
- Thoits, P. A., & Virshup, L. K. (1997). Me's and we's: Forms and functions of social identities. In R. D. Ashmore, & L. Jussim (Eds.), *Self and identity: Fundamental issues* (pp. 106-133). New York, NY: Oxford University Press.
- Turner, J. C. (1985). Social categorization and the self-concept: A social cognitive theory of group behavior. In E. J. Lawler (Ed.), *Advances in group processes (Vol. 2)* (pp. 77-122). Greenwich, CT: JAI Press.



- Turner, J. C., Oakes, P. J., Haslam, S. A., & McGarty, C. (1994). Self and collective: Cognition and social context. *Personality and Social Psychology Bulletin*, 20, 454-463.
- Van Dick, R., & Wagner, U. (2002). Social identification among school teachers: Dimensions, foci, and correlates. *European Journal of Work and Organizational Psychology*, 11, 129-149.
- Van Dick, R., Grojean, M. W., Christ, O., & Wieseke, J. (2006). Identity and the extra-mile: Relationships between organizational identification and organizational citizenship behavior. *British Journal of Management*, 17, 283-301.
- Van Dick, R., Wagner, U., Stellmacher, J., & Christ, O. (2004). The utility of a broader conceptualization of organizational identification: Which aspects really matter? *Journal of Occupational and Organizational psychology*, 77, 171-191.
- Van Maanen, J. (1979). The fact of fiction in organizational ethnography. *Administrative Science Quarterly*, 24, 539-550.
- Van Maanen, J. (1988). *Tales of the field: On writing ethnography*. Chicago, IL: University of Chicago Press.
- Wallace, J. E. (1995). Organizational and professional commitment in professional and nonprofessional organizations. *Administrative Science Quarterly*, 40, 228-255.
- Weick, K. E. (1995). *Sensemaking in organizations*. Thousand Oaks, CA: Sage.
- Weiss, H. M., & Rupp, D. E. (2011). Experiencing work: An essay on a person-centric work psychology. *Industrial and Organizational Psychology: Perspectives on Science and Practice*, 4, 83-97.
- Yin, R. K. (2008). *Case study research: Design and methods (4th ed.)*. Los Angeles: SAGE.

Zhang, S., Chen, G., Chen, X., Liu, D., & Johnson, M. D. (2014). Relational versus collective identification within workgroups: Conceptualization, measurement development, and nomological network building. *Journal of Management*, *40*, 1700-1731.

Zuckerman, H. S., Hilberman, D. W., M, A. R., Burns, L. R., Alexander, J. A., & Torrens, P. (1998). Physicians and organizations: Strange bedfellows or a marriage made in heaven? *Health Services Management*, *14*, 3-34.

## APPENDICES

## Appendix A. Semi-structured Interview Protocol

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Contact: \_\_\_\_\_ Duration: \_\_\_\_\_  
Specialty: \_\_\_\_\_ Organizational Roles: \_\_\_\_\_  
Location: \_\_\_\_\_ Other Roles: \_\_\_\_\_  
Tenure: \_\_\_\_\_

1. How would you describe your role as a physician in this organization? What does it mean to you to be a physician working for NCHC?
  - a. To what extent do the strategies and values of NCHC align with your own values and “personal mission statement”? Where do they diverge and why?
  - b. What are the expectations that you have of NCHC and that you perceive as NCHC having of you?
2. In terms of your integration with NCHC, what is and isn’t going well? Why?
  - a. What could be done to improve your satisfaction or engagement with the integration?
  - b. How would you characterize the opportunities for involvement, participation and/or communication?
3. What are some of the more pressing issues that you face (either coming from your practice, NCHC, or the external environment)?
  - a. How has NCHC supported or made more difficult your ability to face those issues?
4. How would you describe the culture of NCHC as it applies to physicians?
  - a. To what extent is that rooted in your working relationships with NCHC, with other NCHC physicians, hospital physicians, others outside of NCHC/NCHS?
5. How important is it to you, the extent to which your practice helps to achieve the goals of the entire NCHC clinic network (... and/or in addition to providing quality patient care)?

## Appendix B. Quantitative Measures of Professional and Organizational Identity

*Instructions:* Please respond to each item below, based on the extent to which you either agree or disagree with the statement provided.

1 Strongly Disagree	2 Disagree	3 Slightly Disagree	4 Neither Agree nor Disagree	5 Slightly Agree	6 Agree	7 Strongly Agree
---------------------------	---------------	---------------------------	---------------------------------------	------------------------	------------	------------------------

*About North-Central Health Clinics...*

- When someone criticizes North-Central Health Clinics, it feels like a personal insult.
- I am very interested in what others think about North-Central Health Clinics.
- When I talk about this organization, I usually say ‘we’ rather than ‘they.’
- This organization’s successes are my successes.
- When someone praises this organization, it feels like a personal compliment.
- If a story in the media criticized North-Central Health Clinics, I would feel embarrassed.

*About your profession...*

- When someone criticizes doctors, it feels like a personal insult.
- I am very interested in what others think about the profession.
- When I talk about this profession, I usually say ‘we’ rather than ‘they.’
- This profession’s successes are my successes.
- When someone praises this profession, it feels like a personal compliment.
- If a story in the media criticized doctors, I would feel embarrassed.