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# HYBRID MANAGER–PROFESSIONALS’ IDENTITY WORK: THE MAINTENANCE AND HYBRIDIZATION OF MEDICAL PROFESSIONALISM IN MANAGERIAL CONTEXTS

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We examine the ‘identity work’ of manager–professional ‘hybrids’, specifically medical professionals in managerial roles in the British National Health Service, to maintain and hybridize their professional identity and wider professionalism in organizational and policy contexts affected by managerialist ideas. Empirically, we differentiate between ‘incidental hybrids’, who represent and protect traditional institutionalized professionalism while temporarily in hybrid roles, and ‘willing hybrids’, who developed hybrid professional–managerial identities during formative identity work or later in reaction to potential professional identity violations. Questions about willing hybrids’ professional identities led them to challenge and disrupt institutionalized professionalism, and use and integrate professionalism and managerialism, creating more legitimate hybrid professionalism in their managerial context. By aligning professionalism with their personal identity, and regulating and auditing other professionals, willing hybrids also position hybrids collectively as elite within their profession.

## INTRODUCTION

Professions such as medicine, law, accounting, and academia (distinct from occupations like management) are closed collegial, self-regulating expert occupations. Professional autonomy is legitimated by professionals’ claims of socially valuable ‘indeterminate’ (Jamous and Peloille 1970) expertise, which only professionals can understand or regulate (Abbott 1988; Freidson 1994). ‘Professional’ is an exclusive identity, developed through qualifications, training, and socialization, creating social identity boundaries and enhanced careers (Exworthy and Halford 1999).

Professionals have historically resisted new ways of organizing professional work that challenged professional dominance and autonomy (Mintzberg 1989; Flynn 1999; Harrison and Ahmad 2000; Reay and Hinings 2009), including ‘managerialism’ – governmental public policy diffusing managerial thinking into public organizations to measurably improve organizational efficiency (Flynn 1999). However, in practice, professionalism is often ambiguous, plural, dynamic, and complex and affected by changing organizational contexts and cases, which some scholars suggest is creating professional–managerial hybridization (Noordegraaf 2007, 2011; Reay and Hinings 2009; Waring and Currie 2009; Muzio and Kirkpatrick 2011; O’Reilly and Reed 2011; Thomas and Hewitt 2011).

‘Hybrids’ are professionals engaged in managing professional work, professional colleagues, and other staff (Fitzgerald and Ferlie 2000; Montgomery 2001). ‘Hybrid’ roles, framed by both professionalism and managerial logics, diffused across healthcare systems globally, including ‘physician executives’ in the USA (Montgomery 1990, 2001; Hoff 2000) and ‘medical-managers’ in Canada and the UK (Fitzgerald and Dufour 1997; Fitzgerald and Ferlie 2000; Kitchener 2000; Denis *et al.* 2001), Australia (Iedema *et al.* 2004),

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New Zealand (Doolin 2002), Finland (Kurunmaki 2004), Denmark (Kirkpatrick *et al.* 2009), and the Netherlands (Noordegraaf 2007).

In the UK, managerial government policy (Department of Health 1990), introducing private sector-style management, measurement, top-down targets, 'quasi-markets', and quality improvement initiatives within the National Health Service (NHS) to improve quality and efficiency and overcome professional change resistance (Flynn 1999), supported the emergence of hybrid roles. 'Medical Directors' took roles on hospital boards, with management responsibility for doctors. Hospitals were reorganized into 'Clinical Directorates', with professional 'Clinical Directors' responsible for clinical services, budgets, managing professionals, and quality (Fitzgerald and Ferlie 2000; Kitchener 2000). In primary care, the Medical Director equivalent is the Professional Executive Committee (PEC) Chair, with a General Practitioner (GP) commonly filling the role.

High profile scandals drove stricter medical professional regulation and managerial accountability in the UK. Murders committed by GP Harold Shipman and the deaths of babies undergoing heart surgery at Bristol Royal Infirmary exposed serious malpractice, which had been unnoticed or unreported within the medical profession. Inquiries into 'Bristol' (Kennedy *et al.* 2001) and 'Shipman' (Smith 2004) challenged the General Medical Council's (GMC) pre-existing regulation. Professional autonomy was no longer tenable. Processes and responsible individuals were introduced overseeing professional practice, including annual medical appraisal, linked to 'revalidation' of GMC medical licences, with doctors providing evidence of 'good medical practice' and hybrids responsible for ensuring that regulatory requirements were met (McGivern and Ferlie 2007).

'Professional administrators' managing 'professional bureaucracies' (e.g. hospitals and universities) traditionally conformed with professional norms to retain credibility and influence (Mintzberg 1989). However, Freidson (1994) described a process of professional 're-stratification' in which elite professionals 'buffer' professions from managerialism and neo-liberalism by taking senior organizational roles, while developing authority over the professional 'rank and file'. Hybrids have since become a legitimate professional elite (Montgomery 1990, 2001). Organizations like the American College of Physician Executives and the British Association of Medical Managers, which closed in 2010 (see Simpson 2010) with the Faculty of Medical Leadership and Management later filling its place, became recognized as specialties representing doctors in management.

The way hybrids enact managerial processes may alternatively undermine professions (Harrison and Ahmad 2000) or have complex mixed effects (Exworthy and Halford 1999; Fitzgerald and Ferlie 2000; Noordegraaf 2007, 2011; Waring and Currie 2009; Thomas and Hewitt 2011). Some professionals reluctantly and others willingly perform hybrid roles (Fitzgerald and Dufour 1997; Kitchener 2000; Doolin 2002; Hallier and Forbes 2004). There is evidence of a correlation between clinical leadership and better healthcare performance (Goodall 2011; Dickinson *et al.* 2013). Some professionals embrace managerial, 'entrepreneurial' (Llewellyn 2001), or 'calculative' financial and accounting discourses (Kurunmaki 2004), using them to shape their identities and roles (Doolin 2002). Others resist managerialism or 'play' with managerial identities (Llewellyn 2001; Doolin 2002; Iedema *et al.* 2004), or 'balance' and 'blend' managerialism and professionalism (Montgomery 2001; Noordegraaf 2007, 2011; Waring and Currie 2009; Thomas and Hewitt 2011).

We know relatively little about the conditions under which physicians take hybrid roles, whether management training (e.g. MBAs) is necessary for professionals to identify with them, and how hybrids deal with external institutional forces (Gillmartin and

D’Aunno 2008). The antecedents of developing hybrid identities and how these later affect the enactment of hybrid roles and professionalism require further research (Hoff 2000). In this article we examine how and why professionals claim and use hybrid roles, how identity work is implicated in this, and the way hybrids draw on professional and managerial institutional logics as part of their identity work, and consequently affect professionalism.

In the following section we outline theory about identity and institutional work, which we draw upon to explain hybrids and their impact on professionalism. Next we describe the qualitative research methods we used to gather, analyse, and theorize empirical data. We then present empirical data, first about how medical professionals claimed hybrid roles, and then the ways hybrids use their roles and affect professionalism. Finally, we discuss the theoretical and policy implications of our findings.

## IDENTITY AND INSTITUTIONAL WORK

Identity relates to questions about personal self (who am I?) and collective or social identity (who are we?). Identity is constructed in relation to the groups people belong to and compare themselves with, contexts, categories, discourses, and social interactions (Hogg and Terry 2000; Ashforth *et al.* 2008). Identity construction requires ‘identity work’, defined as ‘forming, repairing, maintaining, strengthening, or revising the constructions that are productive of a sense of coherence and distinctiveness’ (Sveningsson and Alvesson 2003, p. 1165). Transitions, contradictions, disruptions, confusions, and changing relations with professional and/or organizational contexts heighten the need for identity work (Sveningsson and Alvesson 2003; Kreiner *et al.* 2006; Chreim *et al.* 2007).

Professional identities relate to individual and collective identities and are associated with the enactment of professional roles (Ibarra 1999; Pratt *et al.* 2006; Chreim *et al.* 2007). Role identities, reflecting the extent to which people identify with roles, may be temporary or permanent, reflecting and affecting identity depending on perceptions of a role’s attractiveness (Ashforth 2001), socialization, motivation, role discretion (Nicholson 1984), and how incumbents interpret and enact roles (Pratt *et al.* 2006; Chreim *et al.* 2007).

Identity work is required to manage tensions between personal, social professional identities (Kreiner *et al.* 2006), professional roles, and during role transitions (Chreim *et al.* 2007), particularly when transitions are visible and deviate from institutionalized social norms (Ashforth 2001; Ibarra and Barbulescu 2010). Junior doctors have been found to develop new identities by testing colleagues’ reactions to ‘provisional selves’ (Ibarra 1999) and experience ‘identity violations’ in roles challenging pre-existing identities, triggering ‘identity reconciliation work’ to develop new professional identities, which they ‘validated’ with peers and mentors (Pratt *et al.* 2006). Little research has examined role and identity transitions later in professionals’ careers. Experience, maturity, professional legitimacy, and control over material resources may provide senior professionals with greater agency for reframing and re-enacting professional roles within wider institutional constraints (Chreim *et al.* 2007). Greater social status also enables professionals to diverge from institutionalized norms (Battilana 2011).

‘Institutional work’, defined as everyday ‘purposive action of individuals and organizations aimed at creating, maintaining and disrupting institutions’ (Lawrence and Suddaby 2006, p. 215), involves effort, intentionality, reflection, and using agency to influence institutional arrangements (Lawrence *et al.* 2009). Institutional work is needed to reconcile and hybridize institutional logics or maintain their independent coexistence (Townley 1997;

Hargrave and Van de Ven 2009; Reay and Hinings 2009; Creed *et al.* 2010; Goodrick and Reay 2011).

Professionalism and managerialism can be thought of as 'competing institutional logics' (Reay and Hinings 2009), representing alternative social frames providing meaning to activity, conditioning sensemaking, action, and identity (Friedland and Alford 1991; Thornton *et al.* 2012). Actors situated between different institutional arrangements have agency to apply institutional schemas in new contexts, reproducing or transforming institutions (Sewell 1992), interpreting institutional contexts in relation to past, present, and future, respectively using 'habitual', 'practical/evaluative', and 'projective' interpretive orientations (Emirbayer and Mische 1998).

Institutions and identities are fundamentally interrelated. Identity work is a form of institutional work because 'identities describe the relationship between an actor and the field in which that actor operates' (Lawrence and Suddaby 2006, p. 223). Institutions provide the raw materials for identity construction and identities function as institutional logics, affecting how identities are performed and how people interpret institutions (Chreim *et al.* 2007; Glynn 2008; Creed *et al.* 2010; Thornton *et al.* 2012). Narrative identity work has been found to underpin identity construction amidst competing institutional arrangements (Sveningsson and Alvesson 2003; Glynn 2008; Creed *et al.* 2010), legitimating collective identities by shaping the perceptions of audiences, outlining collective identities' purpose and practices (Wry *et al.* 2011), and providing an interpretive basis for the maintenance or transformation of professionalism (Oakes *et al.* 1998; Lawrence and Suddaby 2006).

Changing institutional logics or 'constellations of logics' (Goodrick and Reay 2011) may trigger identity shifts, as actors engage in the everyday enactment of identities, altering institutional logics as they become aware of and attempt to resolve ambiguity (Thornton *et al.* 2012). This can also catalyze an informal and diffuse emergence of new collective identities (Rao *et al.* 2003). Creed *et al.* (2010) explain how gay pastors' identity work resolved 'institutional contradictions' between their sexuality and religious roles by 'being the change'. They engaged in 'identity reconciliation work', 'recreating themselves in ways akin to how they transform institutions' (Creed *et al.* 2010, p. 1338), constructing self-narratives that denied institutional contradictions. Through 'role claiming and use' they changed institutional norms.

Identity work has been linked to the creation (Lawrence and Suddaby 2006), transformation (Oakes *et al.* 1998; Brock *et al.* 1999; Creed *et al.* 2010), and maintenance of institutional arrangements, including in healthcare relating to professional identities (Reay *et al.* 2006; Kellogg 2009; Reay and Hinings 2009; Currie *et al.* 2012). However the interrelationship between identity and institutions requires further explanation (Chreim *et al.* 2007; Creed *et al.* 2010; Thornton *et al.* 2012). Accordingly, we explore hybrids' identity work relating to professionalism in health contexts affected by managerialist institutional logics.

## METHODS

This article draws on comparable data from three studies of organizational changes in the English NHS: a study of the introduction of clinical appraisal (McGivern 2005); a project on role enactment and service changes in cancer, diabetes, and maternity services (Fitzgerald *et al.* 2006); and a project investigating healthcare networks (Ferlie *et al.* 2010). However, the design of the studies was similar on key dimensions enabling comparison. First, all studies adopted a comparative case study design. Next, they all utilized semi-structured

interviews as a core means of data collection, with open-ended questions, enabling interviewees to present narratives about their identity, role, and role enactment, and discuss colleagues’ reactions. Third, they examined the common theme of service improvement in the NHS in a similar time period (2003–09), with consistent contextual pressures.

Aggregating case studies to increase the generalizability of findings can be problematic, raising questions about ‘replication logic’ and whether cases are fundamentally comparable (Eisenhardt 1989; Yin 1999; Locock *et al.* 2005). To maximize replication logic, Yin and Locock *et al.* recommend that researchers have a common orientation and research protocols. Accordingly, authors 1 and 3 were centrally involved in all three studies, author 4 in two studies, and all employed a common research orientation.

Yin (1999) argues that case studies are ‘driven to theory’, rather than driven *by* theory or sampling, enabling researchers to ‘discover’ during research (Yin 1999). During initial analysis of interviews with 13 hybrids (defined as having qualified in medicine and occupied a formal managerial role) in the appraisal study (McGivern 2005), we ‘discovered’ differences between ‘incidental’ and ‘willing’ hybrids. We then tested the wider generalizability of this discovery, using interviews with all 17 hybrids interviewed in the role enactment study (Fitzgerald *et al.* 2006) and all 11 hybrids from the networks study (Ferlie *et al.* 2010), creating a combined data set of 43 hybrid interviews (see Appendix).

While reanalysis of interview data is common in social research, it raises potential ethical issues (Richardson and Godfrey 2003). Interviewees consented to participating in the original studies, and openly discussed their identities and role use. However, as Richardson and Godfrey note, it frequently happens, that gaining explicit consent to reanalyse data was not practically possible (because many interviewees had changed organization). Following Richardson and Godfrey, we therefore made an ethical judgement, weighing the potential benefits of our reanalysis (greater understanding of hybrids, which might lead to improvements in healthcare) against harm to research participants (which we judged minimal while maintaining anonymity) before deciding to conduct our reanalysis.

Our analysis and theorization was iterative, starting with the identification and classification of differing identity orientations and subsequently seeking to explain these empirical distinctions between hybrid types by classifying their identity work and its impact on professionalism. Thus we moved between data and theory, using induction and deduction to explain data (Eisenhardt 1989; Strauss and Corbin 1998; Pratt *et al.* 2006; Creed *et al.* 2010; Gioia *et al.* 2012). Initially, theory on professions, roles, and identity guided our coding and analysis. We then used theory about identity work and institutional work, reanalysing data and refining our theoretical model to best fit and explain the findings.

Drawing upon Creed *et al.*’s (2010) framework, we systematically compared hybrids’ narratives about how they ‘claimed’ and ‘used’ hybrid roles, using comparative tables and coding to display, compare, and show patterns and connections between data (Miles and Huberman 1994; Strauss and Corbin 1998), looking for replication of features across cases (Eisenhardt 1989). Following Gioia *et al.* (2012), we show how we moved from narrative data to theoretical concepts in tables 1 and 2. We present exemplar narratives against our initial ‘first-order’ analysis (using informant centric terms and codes) to exemplify key themes emerging from data. The next stage of analysis involved using ‘second-order’ researcher-centric concepts, themes, and dimensions, distilled further into aggregate dimensions, to explain identity work and its impact on professionalism.

Table 3 provides an overview of our findings, summarizing and displaying differences between willing and incidental hybrids’ identities, role use, and institutional and

TABLE 1 *Hybrid role claiming*

Exemplar narratives about role claiming	First-order concepts	Second-order constructs	Aggregate codes
'[Professional colleagues] said you will do a good job [as hybrid], I said no ... they put a bit of pressure on me.'	Hybrids volunteered into the role by professional colleagues	Passive professional obligation	Incidental hybrids
'The vacancy came about while I was on holiday and my [professional] colleagues decided in my absence. They said ... we think you should be the next Clinical Director.'			
'I was unhappy about how the Department was being managed and I saw others [professionals] feeling similar, so I thought I had to do something.'	Hybrids take role in reaction to problems affecting professionals or their department that they feel obligated to address	Reactive professional obligation	
'The reality is ... [management] is important and if we [professionals] take ourselves out of it and decisions are left to a clinician free zone then it's our own fault the mess that we [professionals] end up in.'			
'I was a bit older than some of the others [professionals], so I landed up as Head of Department.'	Hybrid role viewed as a senior professional role	Senior professional representative	
'I was basically the senior clinician, the boss in a department.'			
'By unplanned design or by chance, some of the things that I've done in my career have led me to this ... At quite a young age I wasn't just doing doctoring, I had to make the system work. I found that pretty challenging and very interesting ... I got interested in ... management ... So that is where my career ended up ... I almost don't practise medicine any more, but I like that ... I find the reward in trying to make ... [organizations] work.'	Hybrids enjoyed managing early in their careers, so a hybrid role is the fruition of formative identity work	Fruition of formative hybrid identity work	Willing hybrids
'I've had some good teachers ... a lot of the people I've worked for as a junior when they were consultants have gone into management. It instils things ... I picked up a lot.'			
'If you had asked me as trainee ... would you like to go into medical management, there was absolutely no way ... Managerial roles in the NHS are getting very interesting ... Medicine is changing. Actually it [medical management] is probably going to be quite a good career path ... A reasonable clinician ... [with] managerial skills ... that makes you an important part of the organisation.'	Hybrids had little interest in managing early in their careers but later hybrid managerial roles became attractive career opportunities	Mid-career opportunity	
'I never saw myself being a manager ... but this role plays to my strengths ... I would not go back to a clinical role.'			
'You kind of realise ... most medics could do management ... [but] lots of people don't want to, have other interests, or don't have the aptitude ... I do.'			

TABLE 2 *Hybrid’s role use and institutional work*

Exemplar narratives about role use	First-order concepts	Second-order constructs	Aggregate codes
<p>‘If you’re viewed as a management nark by your colleagues, to put it crudely, you’re not going to get their support. So we’ve got to be seen to be someone who represents people’s [professionals’] views ... On the other hand ... doctors quite frequently are rather unadventurous ... you have got to try and push the frontiers forward.’</p> <p>‘Influence change, doctors hate being told what to do.’</p> <p>‘Informal chats in corridors.’</p>	<p>Influencing professionals endogenously</p>	<p>Identity work maintaining professionalism</p>	<p><i>Influencing the maintenance of professionalism</i></p>
<p>‘History ... tells you ... leaps in biological insight virtually never come from directed programmes.’</p> <p>‘In the olden days people felt they were doing a tremendous job for the community and that it was a privilege to work for the health service ... Maggie’s children changed it.’</p>	<p>Interpreting professionalism historically</p>	<p>Valorizing, demonizing, and mythologizing, Habitual interpretive agency</p>	<p><i>Representing and protecting professionalism</i></p>
<p>‘I represent my consultant colleagues ... protecting and working for clinical colleagues, not trying to denigrate them. A facilitator of the process rather than the actual process itself.’</p> <p>‘Helping your colleagues and dealing with the bureaucracy ... protect them from wasting their time ... enable and support them.’</p>	<p>Representing Protecting</p>	<p>Buffering Boundary work Protecting</p>	
<p>‘Appraisals with me were like a parallel universe ... Having created a cocoon ... with somebody protecting the boundaries, they [professionals] can get on and do their thing ... we’ll put our own professional spin on it ... translating professional speak into managerial.’</p>	<p>Cocooning Protecting boundaries</p>	<p>Buffering Concealing Boundary work</p>	
<p>‘It is not some kind of surgical carve up with your mates, this is not how we do business.’</p> <p>‘Everyone has been vaguely worried about this man ... because of appraisal we’ve actually got a quantifiable thing [to address his poor practice with].’</p>	<p>Challenging poor professional practice</p>	<p>Identity work disrupting poor or outdated professionalism</p>	<p><i>Challenging professionalism</i></p>
<p>‘The clinical mentality is always I need more ... that’s not the world we’re in.’</p> <p>‘Doctors’ perceptions is that I just need to say what can I do, click my fingers and boom, [problem] sorted ... I know because of the [hybrid] job I do how long the process [resolving organizational problems] takes.’</p>	<p>Challenging outdated or unrealistic professional mentalities</p>	<p>Practical-evaluative /projective interpretive agency</p>	

TABLE 2 *Continued*

Exemplar narratives about role use	First-order concepts	Second-order constructs	Aggregate codes
'I don't think it is a government target, I think that if I had my granny waiting in A&E over 12 hours I wouldn't be happy. So we need to try and find a solution.'	Using targets to improve services and patient care	Constructing institutional arrangements as complementary	<i>Using and integrating managerialism and professionalism</i>
'If you want to have your service invested in, then you need to be made a target ... use the politics to your own advantage ... for patients ... to get where they want.'		Using practical/evaluative and projective interpretive agency	
'Targets are here to stay, you have to try and use them to your advantage ... selling to your colleagues [that reality] ... focus on patient experience ... to improve that and your lives.'			
'I'm getting quite a lot of inquiries from the GMC [UK medical regulator] ... I need ... evidence that this doctor did go through the appraisal process ... [Professional appraisal] is a national and organizational response to medical scandals ... a system that we can say confidently to the outside world, all our doctors are appraised, we know that they are OK.'	Demonstrating evidence of good professional practice	Policing, regulating, and auditing professionalism	<i>Regulating/auditing professionalism</i>
'Traditionally in healthcare we have assumed quality ... The Bristol case really demonstrated that you can't make that assumption ... I respect that society is not minded to believe that any more. They will believe that on the basis of evidence ... so we have to provide evidence.'			
'Challenge the data and you get back to us. Otherwise this will be the basis of what we use.'	Using data	Auditing	
'We insist that every single area has audit activity. We count numbers as much as we can. In any business ... you've got to be counting the volumes and ... quality.'			
'Managing hospitals like any other business – trading off volume, cost and quality.'	Managing	Delivering Improved services	<i>Improving services</i>
'Delivering improved services.'	Delivering better health services		
'Make some beneficial changes ... to benefit a group of patients.'			
'Redesigning services to increase productivity.'			

identity work. In the Appendix, we detail hybrids' medical background and managerial training, how we categorized their 'role claiming' and 'role use', and show the correlation between patterns of role claiming and role use, which we have explained as identity work targeting institutionalized medical professionalism. Finally, we checked the face validity of our analysis with several hybrids.

TABLE 3 *Incidental and willing hybrids*

	Incidental hybrids (N = 23)	Willing hybrids (N = 19)
Role claiming	<p><i>Passive professional obligation</i> to take a ‘turn’ in a hybrid role at professional colleagues’ request.</p> <p><i>Reactive professional obligation</i> to take a hybrid role to address departmental or wider organizational or managerial problems.</p> <p>Hybrid role is a senior <i>professional representative</i> (not a substantively managerial role).</p>	<p>Hybrid role is the <i>fruition of formative identity work</i>, involving early hybrid role models, positive experience of management, and inter-professional working.</p> <p>Hybrid role is a <i>mid-career opportunity</i> providing a permanent career or autonomy to organize services.</p> <p><i>Permanent hybrid manager–professional identity</i>, interested in managing and organizing healthcare services.</p> <p>Seen by professionals as a hybrid or sometimes a manager.</p>
Identity (personal) (relational)	<p>A <i>professional temporarily in a hybrid role</i>, engaging with management by necessity.</p> <p>Seen by professionals as a professional.</p>	<p><i>Permanent hybrid manager–professional identity</i>, interested in managing and organizing healthcare services.</p> <p>Seen by professionals as a hybrid or sometimes a manager.</p>
Role use	<p><i>Representing and protecting professionals</i>, professionalism and good patient care (constructed individually) from managerialism.</p> <p>Using <i>habitual interpretive agency</i> to valorize professionalism and demonize managerialism.</p> <p><i>Co-opting and loose-coupling managerialism</i> to conceal and buffer ongoing professionalism.</p> <p><i>Influence maintenance of professionalism</i> using institutionalized modes of professional communication.</p> <p><i>Validation of hybrid role use and professional identity from professional colleagues.</i></p> <p><i>Maintaining flat intra-professional relations.</i></p>	<p><i>Transcending/disrupting professional boundaries</i> to improve patient care (constructed collectively).</p> <p>Using <i>practical/evaluative and projective interpretive agency</i> to influence and challenge unrealistic and outdated professional mentalities and practices.</p> <p><i>Using/integrating professionalism and managerialism.</i></p> <p><i>Regulating and auditing professionalism, challenging indeterminacy and poor professional practice.</i></p> <p>Experiences in hybrid roles <i>validate a permanent hybrid identity.</i></p> <p><i>Positioning hybrid as an elite within their profession.</i></p>
Roles	Clinical Director; PEC Chair.	(Associate) Medical Director; Public Health Director; Network Director.
Institutional work	<i>Endogenous maintenance of professionalism.</i>	<i>Professional hybridization</i> aligning professionalism with managerial organizational and policy contexts.

## RESULTS

Two main antecedents explain hybrids’ impact on professionalism: at the macro level, the managerialization of healthcare, creation of hybrid roles, and professional regulatory reforms; at the micro level, endogenous agency and intra-professional variation, which we explore using Creed *et al.*’s (2010) framework of ‘role claiming’ and ‘role use’.

### Claiming hybrid roles

We found five hybrid role claiming narratives. The first suggested that professionals had been volunteered by professional colleagues for hybrid roles and felt obligated to do a ‘turn’. Here identity work downplayed agency and highlighted the maintenance of a *professional* social identity, justifying taking hybrid roles as a *passive professional obligation*.

The second narrative suggested that hybrid roles had been taken on out of a sense of obligation and in response to departmental or managerial problems. For example, Nigel (PEC Chair/GP, Roles 3) described ‘role conflict’ as he self-identified as a professional

but acknowledged the need to engage with management to maintain professionalism, which was a 'reality' other professionals did not see. His identity work maintains the professional social identity, while acknowledging the need for professionals in hybrid roles to buffer professionalism from managerialism. Role claiming is constructed as a *reactive professional obligation*.

The third narrative positioned hybrid roles as senior professional positions, dismissing its managerial component. Rory (Clinical Director, Appraisal 53) commented: 'The bottom line is that I'm a surgeon first ... then I happen to be an administrator.' This identity work asserts professional identity, downplaying how the managerial component of hybrid roles affects enactment. Here professionals claimed hybrid roles as *professional representatives*.

A fourth narrative described hybrid roles as the *fruition of formative hybrid identity work* earlier in professionals' careers. For example, Henry (Medical Director, Appraisal 65) noted: 'At quite a young age I wasn't just doing doctoring, I had to make the system work. I found that pretty challenging and very interesting ... so that is where my career ended up.' Other hybrids mentioned role models who influenced them to move into medical management. John (Associate Medical Director, Appraisal 23) recalled 'a head of department when I was a young consultant, who ... taught me to use the system ... rather than see it as an obstruction.' Highlighting earlier managerial professionals can be seen as identity work legitimizing hybrid roles and identities.

These hybrids reconciled managing and professionalism as complementary. Some described clinical work as 'boring' (Clinical Director, Appraisal 25) and organizing and managing healthcare as more rewarding: 'I almost don't practice medicine any more but I like that and I am intellectually happy with that. I find the reward in trying to make these things [healthcare organizations] work' (Henry, Medical Director, Appraisal 65). James (Medical Director, Appraisal 34) noted that he could do clinical practice 'with my eyes closed, whereas management I find very tricky'. Thus Henry and James recalibrate *medical* management as more interesting and difficult than medicine, positioning medical management as an elite professional subspecialty.

The final narrative suggested that hybrid roles were an unexpected *mid-career opportunity*. Phil (Clinical Director, Networks C13) commented: 'I didn't see that I would like to move into management, but I like the ability to organize myself and my services ... as trainee you have different priorities ... to learn to be a good surgeon.' He noted that hybrid roles provided more job security than clinical roles. Claire (Clinical/Network Director, Networks P31) noted how she decided to move into medical management as her most promising career path: 'Education and research wasn't going to happen ... the clinical role, yes, but would that hold my interest? ... Then you kind of realize ... most medics could do management ... [but] don't want to, have other interests, or don't have the aptitude ... I do.' Claire was aware that 'as you go up the chain there's a distancing from your clinical colleagues, because you have to take on the corporate ethos' and she might be seen as 'selling out'. Nonetheless, she developed a permanent hybrid identity, remarking that Medical Director 'looks like the career path'. Here identity work is more individual than oriented towards the professional social identity, with hybrids unapologetically describing their role in managerial terms.

Combining 'passive', 'reactive professional obligations', and 'professional representative' role claiming narratives, we created an '*incidental hybrid*' type, where hybrid roles were essentially incidental to incumbents' professional identities. Combining 'fruition of formative identity work' and 'mid-career opportunity' role claiming narratives, we create a '*willing hybrid*' type, where hybrids proactively claimed hybrid roles.

Despite accusations from some professionals of ‘going over to the dark side’ (Phil, Clinical Director, Networks C13) or becoming ‘a poacher turned gamekeeper ... fraternizing with the enemy’ (Steve, Clinical Director, Appraisal 25), willing hybrids had developed permanent hybrid identities. While hybrids’ role claiming narratives may be post-hoc justifications, they represent identity work revealing attitudes towards professionalism.

Table 1 shows exemplar narratives, first- and second-order and aggregate incidental and willing hybrid role claiming codes. The Appendix shows how we categorized hybrids: 15 ‘fruition’ and 4 ‘opportunity’ narratives, making 19 willing hybrids; and 5 ‘reactive obligation’, 5 ‘passive obligation’, and 13 ‘professional representative’ narratives, making 23 incidental hybrids. One hybrid fell between willing ‘fruition’ and incidental ‘reactive obligation’ categories.

### Using hybrid roles

We next examine how professionals ‘use’ hybrid roles to ‘influence’ other professionals, and consequently organizations, in ways ‘as pure doctor you can’t’ (Steve, Clinical Director, Appraisal 25). We present four ‘role use’ narratives below.

#### *‘Representing and protecting’ professionalism*

Incidental hybrids tended to enact hybrid roles on a clinical basis, using their role to ‘represent’ professionals and maintain professionalism. For example, Peter (Medical Director, Roles H) commented: ‘I take clinical judgement and experience into the Medical Director role.’ Toby (former Clinical Director, Appraisal 33) noted the importance of being seen to represent professionals to ‘get their support’ rather than being seen as a ‘management nark’. He acknowledged professionals’ conservatism and the need to ‘push the frontiers forward’ but ‘influenced’ professionalism through ‘informal chats’ in traditional professional terms.

Incidental hybrids used their role to ‘protect’ professionals and maintain professionalism, glorifying past professionalism and drawing upon lessons from ‘history’ to interpret the potentially disruptive effects of managerialism. For example, Rory (Clinical Director, Appraisal 53) demonized ‘Maggie’s children’ (a reference to NHS managers introduced under Margaret Thatcher’s government) for undermining the sense from ‘the olden days’ that being an NHS doctor was ‘doing a tremendous job for the community’. Simon (former Clinical Director, Networks G29) noted: ‘History ... tells you ... leaps in biological insight virtually never come from directed programmes’, enacting his hybrid role by ‘helping colleagues and dealing with the bureaucracy ... to protect them from wasting their time’.

Clive (Clinical Director, Appraisal 35) demonized the political and managerial context framing appraisal ‘in terms of what beans can we count’ for the health minister rather than ‘issues that are of a genuine concern to professionals’ or what ‘patients want from professionals’. He contrasted being made to ‘jump through hoops and fill in lots of forms’ with his own ‘professionally appropriate ways of assessing your achievements’, ‘looking after patients ... within the constraints’, and ‘trusting’ professionals while keeping a professional ‘eye’ on them. Reflecting accounts of academic appraisal (Townley 1997), Clive therefore co-opted appraisal, conducting it ‘like a parallel universe’, completing ‘tick box’ paperwork to provide the impression of managerial regulation, putting a ‘professional spin on it ... translating professional speak into managerial’. Then, ‘having created a cocoon ... protecting the boundaries’, professionals were able to ‘get on and do their thing’.

In sum, incidental hybrids used hybrid roles and engaged in identity work to ‘represent’ and ‘protect’ professionals and maintain professionalism.

***Professional identity violations and reconciliation work***

Steve (Clinical Director, Appraisal 25) described how a potential professional 'identity violation' (Pratt *et al.* 2006) in a hybrid role changed his relationships with colleagues and institutionalized professional norms: 'I now ... understand that it is actually very complex, a hospital ... dependent on good managers and good clinicians in management ... My relationship with my colleagues has changed. Some definitely see that I have crossed to the other side ... It has been ... an eye opener for me seeing actually how some of my [professional] colleagues ... don't actually pull their weight.'

Steve's perception of professionals (the 'eye opener' that colleagues don't 'pull their weight') de-legitimizes professionals' superiority over managers. His relations with professional colleagues and social identification had changed ('I have crossed to the other side'). Consequently, he had to engage in 'identity reconciliation work' (Pratt *et al.* 2006; Creed *et al.* 2010), reconstructing his own understanding of good medical professionalism and relations between doctors and managers, identifying with 'team players' rather than professionals: 'The Medical Director and the Chief Executive and my own general manager, those are the three team players ... that I get sensible opinions off.'

Willing hybrids interpretively reconstructed professionalism as involving *inter-professional* teamwork, focused on delivering 'the best service' for patients *collectively*, in contrast with institutionalized mono-professional working focused on individual patients. Claire (Clinical/Network Director, Networks P31) noted: 'What motivates me? ... Team-working, delivery ... On a good day I can give the best service ... it's wanting to replicate that throughout the service.' Willing hybrids reframed patients' interests from individual to collective: 'As an individual doctor you're looking out for the individual patient, as a clinical manager you're trying to benefit a group of patients ... You must make changes for the benefit of the patient, because you will always be listened to if you say that' (Brian, Clinical Director, Appraisal 54).

Willing hybrids challenged professionals who ignored resource limitations in providing public healthcare. Claire (Clinical/Network Director, Networks P31) noted: 'The clinical mentality is always, I need more staff ... the latest machine ... more space, that's just not ... the world we're in.' Irene (Public Health Director, Networks P3) noted: 'Doctors can and do ration healthcare. It is just that I admit that I do it; I weigh up collective good versus individual needs.'

In sum, willing hybrids enacted their role in ways misaligned with traditional professionalism, by engaging with managers and managerialism, to the extent of being accused of losing their medical professional identity. This potential identity violation, combined with experiencing the complexity of delivering healthcare, led to personal identity reconciliation work in which willing hybrids reconstructed medical professionalism, disrupting traditional professionalism as outdated and unrealistic, reconceptualizing professionalism in terms of delivering the best care for patients collectively.

***'Using' and 'integrating' professionalism and managerialism***

Having engaged in personal identity work leading to a new understanding of professionalism, willing hybrids legitimized 'using and integrating' professionalism and managerialism. James (Medical Director, Appraisal 34), for example, positioned managerial targets and patient care as complementary: 'I don't think it is a government target, I think that if I had my granny waiting in A&E over 12 hours I wouldn't be happy. So we need to try and find a solution.' He argued that targets could be beneficial: 'If you want to have your service invested in, then you need to be made a target ... Rather than argue about your

targets ... the medical profession has got to be a lot cleverer about using politics to get where they want.’

Claire (Network/Clinical Director, Networks P31) similarly argued that professionals could ‘use’ targets to benefit patients: ‘Targets are here to stay ... [I am] selling to colleagues that we need to use [targets] to our advantage, focus on patient experience ... no one can argue with that.’ Claire re-frames targets using interpretive agency relating to the present and future (‘Targets are here to stay’) and then ‘sells’ using targets to benefit patients and professionals. However, the bottom line for all hybrids was maintaining professionalism by acting in patients’ interests.

In sum, building on foundational personal identity work, willing hybrids ‘use and integrate’ (Hargrave and Van de Ven 2009; Creed *et al.* 2010) professionalism and managerialism to legitimate hybrid professionalism within their wider profession.

### *Auditing and regulating professionalism*

Indeterminate professional practice is core to professionalism, providing the basis for regulatory autonomy (Jamous and Peloille 1970; Freidson 1994). However, Brian (Network Medical Director, Networks C21) describes what we call ‘auditing work’, which challenged professional indeterminacy to discipline professionals resisting service improvements. When surgeons tried to dismiss data showing that they needed to change how they conducted surgery (‘let’s discuss this one later in the pub’), Brian argued that this was illegitimate professional practice and ‘not how we do business ... Challenge the data ... otherwise this will be the basis of what we use.’ Willing hybrids’ auditing work therefore challenges *professional* behaviours undermining professional legitimacy.

Willing hybrids engaged with managerial processes as ‘regulating work’. For example, Henry (Medical Director, Appraisal 65) noted: ‘I’m getting quite a lot of inquiries from the GMC ... I need ... evidence ... a system that we can say confidently to the outside world, all our doctors are appraised ... are OK.’ Henry commented that ‘the strongly held view amongst my colleagues that nobody understands what they do except for themselves ... seems to me a pretty indefensible position.’ Patrick (Medical Director, Appraisal 66) describes how, following the ‘Bristol’ scandal, he maintained professional legitimacy by ‘respecting’ a society that no longer assumed that doctors practised well and wanted ‘evidence’: ‘Traditionally in healthcare we have assumed quality ... The Bristol case really demonstrated that you can’t make that assumption ... I respect that society is not minded to believe that any more. They will believe that on the basis of evidence ... so we have to provide evidence.’

Patrick legitimizes professionalism using organizational processes and calculative expertise to discipline poor *professional* practice. He also noted that appraisal ‘reinforces the authority of the senior people’ (hybrids) over the professional ‘rank and file’. Steve (Clinical Director, Anaesthetist, Appraisal 25) similarly commented that appraisal had enabled him: ‘To get to the bottom of what they [surgeons] actually do’, but noted that he only recorded problems discussed in appraisal documentation if they were dangerous to patients or subject to formal complaints because doing so could have ‘serious consequences’. Hybrids’ roles as gatekeepers of professional indeterminacy provide significant professional influence.

In sum, willing hybrids used their roles and engaged in identity work to ‘evidence’ and ‘audit’ professional practices in ways that could but did not necessarily make them more visible. Willing hybrids absorb managerialism into professionalism to maintain professional legitimacy, creating hybrid professionalism, whilst ensuring professional

(albeit hybrid) control over professionalism, and internally re-stratifying their profession with hybrids as an elite. Table 2 shows exemplar narratives linked to first- and second-order and aggregate codes about 'using' hybrid roles.

## DISCUSSION

'Hybrid' manager-professionals and their impact on professionalism and public services have long been of interest to academics and policy-makers (Montgomery 1990; Freidson 1994). Hybrids have moved from 'the dark side to centre stage' (Spurgeon *et al.* 2011), with growing evidence of their pivotal role in managing and organizing contemporary public healthcare (Noordegraaf 2007; Kirkpatrick *et al.* 2009; Ferlie *et al.* 2011; Goodall 2011; Buchanan 2013; Dickinson *et al.* 2013; Ferlie and McGivern 2014; Fitzgerald *et al.* 2013; McDermott *et al.* 2013).

Analysts sometimes presume that hybrids are homogeneous, affecting professionalism and public organizations uniformly. Responding to calls to analyse the interrelationship between institutions and micro-level identities (Lawrence and Suddaby 2006; Thornton *et al.* 2012), our analysis reveals more complexity and variation. It suggests that the impact of hybrid roles and hybrids' enactment of managerialism and regulation, and consequent effects on professionalism and public services, depend on the extent to which they are enacted in practice or loosely coupled (cf. Townley 1997), which largely depends on hybrids' identity work.

Some professionals reluctantly and others willingly enacted hybrid roles and we found an association between 'incidental' and 'willing' hybrids' role claiming identity narratives and role use (see Appendix). Table 3 summarizes differences between willing and incidental hybrids, which we discuss below.

Incidental hybrids maintain their personal and social professional identity and traditional professional norms, rhetorically positioning themselves temporarily in hybrid roles by obligation. They use 'habitual interpretive agency' (Emirbayer and Mische 1998) to 'represent and protect' professionalism, 'influence' colleagues to maintain traditional professional norms, and use regulatory processes such as appraisal to 'repair and conceal' (Lawrence and Suddaby 2006) misalignments between professionalism and its managerial context. Incidental hybrids' identity work reflects previous accounts of hybrids 'buffering' (Freidson 1994) professionalism from managerialism permeating public services.

Willing hybrids' identity work is more novel. Some willing hybrids described formative identity work, often involving hybrid mentors or role models, during which they had internally reconciled contradictions between professionalism and managerialism. Hybrid roles were therefore salient to willing hybrids' identities. Others experienced potential professional identity violations as hybrids (accusations of 'selling out' or 'turning to the dark side'). Threatening questions about professional identity led hybrids to critically reflect on professionalism in contemporary managerial contexts and engage in 'identity reconciliation work' (Pratt *et al.* 2006; Creed *et al.* 2010), which for willing hybrids involved *becoming* a hybrid.

Willing hybrids' personal identity work laid the foundation for 'being the change' (Creed *et al.* 2010) and enacting hybrid professionalism. Hybrid roles took professionals' identities to the limits of legitimate professionalism. To avoid becoming a 'management nark', losing professional credibility and influence, hybrids either needed to conform to conventional professional norms or to realign norms with their personal self. Whereas incidental hybrids conformed, willing hybrids used 'practical' and 'projective interpretive agency' (Emirbayer and Mische 1998) to disrupt and 'challenge' 'unrealistic'

and ‘outdated’ professionalism, highlighting its relationship with present and future patient care. They interpretively ‘influenced’ the reconstruction of professionalism as being about delivering patient care *collectively*, which legitimated ‘using/integrating’ (Hargrave and Van de Ven 2009; Creed *et al.* 2010) managerialism and professionalism to create hybrid professionalism, and then ‘validated’ (Pratt *et al.* 2006) permanent hybrid personal identities.

Willing hybrids’ identity work involved intra-professional battles for jurisdiction over professional work (Abbott 1988; Reay *et al.* 2006; Currie *et al.* 2012). By legitimating hybrid professionalism, willing hybrids position the work of ‘regulating/auditing professionalism’, interpreting professionals’ legitimacy in managerial healthcare contexts as crucial for maintaining wider professionalism. Willing hybrids challenged the indeterminacy of *poor* professional practices, which they judged to undermine professionalism, but maintained the need for professionals to judge professional practice. Hence, professional control of professional practice continued, while bolstering the elite position of hybrids collectively within their profession. This identity work, developing institutional conditions supporting the nascent hybrid sub-professional collective identity, reflects Rao *et al.*’s (2003) account of informal and fragmented identity work and identity movements, which gradually transform wider professional norms.

Little research has examined the relationship between identities and institutions, despite their fundamental interrelationship (Chreim *et al.* 2007; Thornton *et al.* 2012). We explain interrelations between institutionalized professionalism, and personal and collective identity work. We describe how hybrids’ personal identity work, in relation to professionalism and managerialism, provided a foundation for their construction and enactment of hybrid professionalism, which in the case of willing hybrids created institutional conditions enabling the fragmented emergence of hybrid professionals collectively. We speculate that this identity work may produce similar further cycles of identity work shaping hybrid professionalism and a growing hybrid collective identity.

The prevalence of willing hybrids in our study (19/43 – see Appendix) may signal that medical management is considered a legitimate sub-specialty within the medical profession. Empirically, this is an important development, which extends earlier research on hybrids. Recent empirical studies (McDonald *et al.* 2009; Currie *et al.* 2012) have similarly noted increasing stratification of the medical profession in response to managerialism. However, the similarity between incidental hybrids and hybrids in earlier studies is also striking, suggesting that the maintenance of institutionalized professionalism remains powerful.

We found a correlation between hybrid roles and identities (see table 3). Incidental hybrids were often in Clinical Director or PEC Chair roles; willing hybrids in Medical, Network, or Public Health Director roles. Accordingly, it could be argued that being in increasingly senior hybrid roles *produces* more managerial hybrids’ identities. However, we suggest that the underlying driver for claiming senior hybrid roles is identity work. Many hybrids in Clinical Director roles chose not to advance in their careers as hybrids because they did not want to lose their professional identity. Professionals would not willingly claim senior hybrid roles, and become distanced from professional colleagues, without first cultivating a hybrid self.

Formal managerial training, career paths, and financial rewards did not appear to significantly affect professionals’ decisions to take hybrid roles. Only two hybrids whom we interviewed had MBAs, and few noted being affected by managerial training; as one Clinical Director (Appraisal 25) commented: ‘[Management] courses ... when I became

a Clinical Director were useful inasmuch as you met other people in the same boat ... doing the same role.' A former Clinical Director (Appraisal 48) described his experience as a hybrid as 'not a very happy one' due to 'the lack of support' in learning how to enact his hybrid role. He had consequently learned 'never ever to take a job like that without a defined job description'. Recent research (Buchanan 2013; Dickinson *et al.* 2013) suggests that while managerial training and career paths for medical leaders may be improving, they remain patchy, providing inadequate support for many hybrids, and financial rewards do not appear to significantly motivate professionals to take hybrid roles either. Likewise, hybrids we interviewed noted that the financial rewards from hybrid roles were small compared with those from private medical practice.

Montgomery (2001, p. 224) suggests that more important for professionals than managerial 'preparation' is 'willingness' to enact hybrid roles. Similarly, our research suggests that learning to *be* a hybrid may therefore be more important than learning to *do* management. As one hybrid interviewee noted: 'most medics could do management but don't want to.' The foundation for professionals wanting to take hybrid roles, and enact them in ways that transform professionalism and healthcare, appears to be formative identity work or later identity reconciliation work. Socialization before and after role transitions affects how roles are enacted (Nicholson 1984). Therefore, hybrid 'role modelling' (Cruess *et al.* 2008) and 'identity-based leader development' (Ibarra *et al.* 2010), in which professionals develop hybrid identities validated by peers and mentors (Ibarra 1999; Pratt *et al.* 2006), may be the most effective training for future hybrids, with the most significant impact on professionalism and public services.

This article has limitations but these provide opportunities for further research. Our research was focused on one country (England), a single profession (medicine), and a reanalysis of interviews with hybrids from three wider studies. Our sample of interviewees cannot be presumed to be representative of the wider medical profession. We simply analysed the interviews of participants in the three wider studies who were or had been in hybrid roles. More research is therefore needed to test the generalizability of our model and findings among a wider and purposefully representative sample of hybrids in the UK and other countries.

We note hybrid roles in universities (e.g. academic heads of department, deans, and (pro) vice-chancellors) (Deem *et al.* 2007), social care, and education (Exworthy and Halford 1999). Our model may be transferable to other contexts around the world, particularly in professionalized public service organizations. More research is therefore needed to understand important questions about how hybrid professionals' identity work is shaping hybrid professionalism and professionalized public service organizations around the world.

## CONCLUSION

Examining the interrelationships between professionalism, and personal and social identity work, we explain how 'hybrid' manager-professionals maintain and hybridize professionalism in managerial organizational and policy contexts. We found two hybrid types. 'Incidental hybrids', professionals temporarily in hybrid roles, use hybrid roles to 'represent', 'protect', and maintain professionalism. 'Willing hybrids' developed authentic hybrid identities during formative identity work or later in hybrid roles during identity reconciliation work, reacting to potential professional identity violations. These provided a foundation for 'challenging and disrupting' traditional professionalism and 'using and integrating' professionalism and managerialism to create hybrid professionalism

more aligned with willing hybrids' personal hybrid identity and their managerialist healthcare context. Through 'auditing and regulating' work, aligning and legitimating professionalism with its managerial context, hybrids also position hybrids collectively as a professional elite.

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## APPENDIX

*Hybrid characteristics, role claiming, and role use*

Hybrid role, project code, medical and managerial training	Role claiming	Role use
Medical Director APPRAISAL 65, Haematology	Fruition	Improving services, challenging/influencing and regulating/auditing professionalism
Medical Director APPRAISAL 66, Respiratory medicine, MBA	Fruition	Improving services, challenging and regulating/auditing professionalism
Medical Director APPRAISAL 34, Intensive care medicine	Fruition	Improving services, challenging professionalism, using/integrating managerialism and professionalism
Medical Director ROLES N2, Chest and intensive care medicine	Fruition	Using/integrating managerialism and professionalism, challenging and regulating/auditing professionalism
Medical Director ROLES 13, Anaesthetics and emergency care medicine	Fruition	Improving services, influencing/challenging and, regulating/auditing professionalism
Associate Medical Director APPRAISAL 23, Neurosurgery	Fruition	Improving services, using/integrating managerialism and professionalism, challenging and regulating/auditing professionalism
Network Medical Director NETWORKS C21, Radiology	Fruition	Improving services, challenging and regulating/auditing professionalism
Network Director NETWORKS G25, Former Public Health Director	Fruition	Challenging professionalism
Clinical Director ROLES S, Radiology, MBA	Fruition	Improving services, challenging professionalism
Clinical Director APPRAISAL 54, General and emergency medicine	Fruition	Improving services, influencing/challenging and auditing/regulating professionalism
Clinical Director APPRAISAL 25, Anaesthetics	Fruition	Improving services, using/integrating managerialism and professionalism, challenging and regulating/auditing professionalism
PCT Chair ROLES E, Retired physician	Fruition	Influencing professionalism
Public Health Director ROLES L	Fruition	Influencing professionalism
Public Health Director ROLES B2	Fruition	Influencing professionalism
Public Health Director NETWORKS P7	Fruition	Challenging professionalism
Clinical Director & Network Clinical Director NETWORKS P31, Genitourinary medicine	Opportunity	Improving services, challenging professionalism, using/integrating managerialism and professionalism
Clinical Director NETWORKS C13, Urology	Opportunity	Improving services, challenging professionalism, using/integrating managerialism and professionalism
Public Health Director NETWORKS P3	Opportunity	Influencing professionalism
Public Health Director NETWORKS P8	Opportunity	Influencing professionalism
Former Clinical Director NETWORKS C15, Urology	Reactive/fruition	Influencing professionalism
Clinical Director ROLES 14, Obstetrics and gynaecology	Reactive	Improving services
Clinical Director ROLES N, Plastic (breast) surgery	Reactive	Representing/protecting and influencing professionalism

## APPENDIX

*Continued*

Hybrid role, project code, medical and managerial training	Role claiming	Role use
Former Clinical Director APPRAISAL 35, Immunology	Reactive	Representing/protecting and influencing professionalism
PEC Chair NETWORKS OPGM01, GP	Reactive	Influencing professionalism
PEC Chair ROLES 3, GP	Reactive	Influencing professionalism
National Programme Director NETWORKS C5, Oncologist	Passive	Representing/protecting professionalism, improving services
Medical Director NETWORKS G4, Neuropathology	Passive	Representing/protecting professionalism
Clinical Director APPRAISAL 51, Medical dentistry	Passive	Influencing professionalism
Former Clinical Director ROLES 8, Obstetrics and gynaecology	Passive	Representing/protecting professionalism
Former Clinical Director APPRAISAL 48, Urology	Passive	Representing/protecting professionalism
Medical Director ROLES H, Respiratory medicine	Representative	Representing/protecting and influencing professionalism
Medical Director ROLES 10, Emergency care medicine	Representative	Representing/protecting and influencing professionalism
Clinical Director ROLES 11, Vascular surgery	Representative	Representing/protecting and influencing professionalism
Clinical Director ROLES 5, Maternity medicine	Representative	Representing/protecting professionalism
Clinical Director NETWORKS G30, Medical genetics	Representative	Representing/protecting professionalism
Former Clinical Director NETWORKS G29, Medical genetics	Representative	Representing/protecting professionalism
Former Clinical Director APPRAISAL 33, Anaesthetics	Representative	Representing/protecting and influencing professionalism
Former Clinical Director ROLES 15, Obstetrics and gynaecology	Representative	Representing/protecting professionalism
PEC Chair ROLES F, GP	Representative	Representing/protecting and influencing professionalism
PEC Chair ROLES 4, GP	Representative	Influencing professionalism
Clinical Director APPRAISAL 53, Orthopaedic surgery	Representative	Representing/protecting professionalism
Clinical Director APPRAISAL 10, Endocrinology	Representative	Representing/protecting professionalism
Clinical Director APPRAISAL 57, Dermatology	Representative	Representing/protecting professionalism