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Understanding hybrid roles: the role of identity processes amongst physicians

Abstract

Increasing attention has been paid in both public administration and organisational theory to understanding how physicians assume a 'hybrid' role as they take on managerial responsibilities. Limited theoretical attention has been devoted to the processes involved in negotiating, developing and maintaining such a role. We draw on identity theory, using a qualitative, five year longitudinal case study, to explore how hybrid physician-managers in the English National Health Service (NHS), and the organisations they are situated in, achieve this. We highlight the importance of saliency – how central an identity is to an individual's values and beliefs – in managing new identities. We found three differing responses to taking on a hybrid physician-manager role, with identity emerging as a mitigating factor for negotiating potentially conflicting roles. The implications for existing theory and practice in the management of public organisations are discussed, and an agenda for further research is identified.

Introduction

Increasing attention has been paid in both the public administration and organisational theory literatures to understanding how physicians assume hybrid roles as they take on managerial responsibilities (Noordegraaf 2007; Ferlie and McGivern 2013). This partly stems from recent reforms in health policy that have spawned new arrangements for governing the performance of physicians and the emphasis on forming organisational structures that encourage physicians to work as managers (Boyte 2005; Newman 2001; Moran 2007). Typically, such arrangements require physicians to alter their role and correspondingly their identity – here the term refers to the way an individual constructs meaning credited to him or herself in relation to a specific role (Burke and Tully 1977). Such arrangements challenge physicians' sense of who they believe themselves to be in terms of the professional identity they wish to portray to the environment in which they are embedded (Pollitt 2009).

As new models of organising healthcare are emerging, it is becoming more important to consider the processes and impact of new hybrid roles (Miller and Rose 2008; Ferlie *et al.* 2012). Our research question asks how physicians assume hybrid roles as physician-managers, focusing on 'identity work' (cf. Pratt *et al.* 2006). An in-depth investigation of the identity work that physicians employ under these circumstances can offer a deeper theoretical understanding of the theory and enactment of hybrid roles in healthcare management (Fitzgerald and Ferlie 2000; Llewellyn 2001; Noordegraaf 2007; Waring and Currie 2009).

Empirically, the context for this study was one of the nine 'Collaborations for Leadership in Applied Health Research and Care' (CLAHRC). These were a new organisational arrangement in the English National Health Service (NHS), intended to facilitate knowledge transfer from research into practice (NIHR, 2007). The CLAHRCs can be seen as representative of a trend towards improving the quality and outcomes of healthcare services by emphasising evidence-based practice and changing how

managerial and clinical accountability for quality are organised and managed (Cooksey 2006; Ham 2009). Theoretically, our study draws from the public administration and identity theory literatures to shed light on the identity work that goes on when physicians take on additional managerial roles in this new healthcare landscape, within the context of one of the CLAHRCs. Our objectives are to explore the process of identity reconstruction by physicians inhabiting this role and new policy space. Our analysis draws attention to the cognitive and social dynamics that occur as a result of the emergence of physician-managers roles within the CLAHRC.

We show that variations in the enactment of hybrid roles by physicians contribute to an understanding how they cope with and assimilate new work roles into their identity, in order to keep up with the increased complexity and changing expectations of healthcare delivery. Understanding variations in the response to and enactment of physician hybrid roles allows us to conclude that the processes are more complex than merely combining certain beliefs or values, or demonstrating a combination of managerial and clinical competence. Overall, our findings suggest that physicians took proactive steps not only to preserve the salience of their identity but also to minimize conflicts and tensions that emerged from perceived identity threats. In revealing these cognitive and social-psychological dynamics, we contribute new perspectives to the theory and practice of the enactment of hybrid roles in the management of healthcare services in public organisations.

Medical professional identity and managerial discourse in the English NHS

The NHS is a large public-service professional bureaucracy historically dominated by a powerful cadre of physicians, who control their performance by virtue of their specialist training, expertise and knowledge (Currie and Procter 2005). Recent reforms to the organisation and processes of the NHS have spawned new models for governing the performance of physicians (Ferlie *et al.* 2012). The overriding model of governance has moved away from bureaucratic discourses to a new discourse dominated by collaborative networks and strategic partnerships, knowledge management, different

types of leadership and other forms of post-bureaucratic organisation (Currie and Suhomlinova 2006; Denis *et al.* 2005; Pollitt 2009). Within this new landscape physicians are often positioned as ‘physician-managers’. These new hybrids are embedded in a policy regime of measurement and transparency (Power 1999; Meier and Hill 2005), the desire to pursue ‘value for money’ (Dent 1995; Halford and Leonard 1999; Doolin 2002) and the alignment of professional autonomy with clinical performance (Ferlie and McGivern 2013; McDonald *et al.* 2006; Spyridonidis and Calnan 2011). As new managerial roles are introduced, physicians are now required to act or think from a managerial and medical perspective, in a new form of hybrid working. Assuming and negotiating the different roles within this new hybrid form provide the main vehicle for establishing normative values that underpin the physician-manager.

Identity processes are key to exploring how physicians react to this brave new world where their professional autonomy is newly controlled and where they need to accommodate government or other organisational targets and principles of economic rationality (Symon 2005). Identity theory can be used as a framework to explore how individuals secure their sense of belonging to various social/professional groups and practices. The implicit assumption is that identity is socially constructed, with elements of identity (such as differing roles) being continually constructed as part of an individual’s changing social interaction with their organisational environment (Halford and Leonard 1999).

Multiple selves

We are concerned here with the concept of identity as subjectively important and central to the individuals’ sense of self, highly relevant to his or her values and goals (i.e. ‘being a physician’).

Formal identity as a physician is what we term a ‘*cross-cutting*’ identity in that being a physician is likely to remain salient and cut across whatever else a particular individual might do. In other words, no matter what organisation the individual works for, the work role he or she is tasked with, or even

outside the work environment, that individual is always a physician (cf. Ashforth and Johnson 2001). Within this subjectively important identity are contained other nested, multiple identities that underlie the very specific differentiated roles an individual enacts at work (Burke and Tully 1977). These *nested identities* are contained within work projects, the work unit, department, division and overall organisation (Ashforth and Johnson 2001).

Professional autonomy

The importance of clinical discretion and professional autonomy can be understood in terms of the centrality physicians place on their exclusive right to regulate patient treatment, diagnosis and decisions via their possession of medical professional knowledge (Doolin 2002). This knowledge is a primary source of power, so physicians hold significant power and have significant professional autonomy and discretion over their work within some limitations (Freidson 2001). This then becomes the main vehicle for the establishment of normative values that underpin the construction of their identity and the organisation of their work. Hence, 'physician identity' is developed and shared amongst professional members through occupational and professional socialization, as a consequence of common educational backgrounds, professional training and experiences (Evetts 2003; Finn *et al.* 2010). However, as a physician's career progresses task based work roles evolve and this facilitates changes in nested identities within their organisational setting (Pratt *et al.* 2006). Physicians may be anxious or threatened by new ways of working, insofar as this can necessitate a change in the equilibrium of power and hierarchy emanating from their knowledge (Doolin 2002). They therefore need to negotiate these local changes in relation to their pre-existing identities, aligning their decisions and actions with their new work roles and relations with other physicians and their managers.

Our study proposes that it is necessary to accept the likelihood that some physicians may be at the forefront of the drive towards a more managerial reinterpretations of their identity – their multiple

identities form a 'holistic gestalt' where the boundaries around nested and cross-cutting identities are more flexible and the 'hybrid physician' emerges (Ashforth and Johnson 2001, p. 46). Others may be slower to alter more traditional conceptualisations of their identity (Spyridonidis and Calnan 2011). In understanding how professionals embrace or resist new organisational hybrid roles (in our case physician-manager) most existing empirical studies lack convincing theoretical explanation. We believe, to shed light on this process it is necessary to examine identity theory, a task we turn on in the next section.

Salience

To better understand the dynamics between identities that are cross-cutting (physician) and nested (e.g. clinical unit manager) we mobilize the concept of 'identity salience'. This has been used to determine how central an identity is to an individual's values and beliefs and whether it will be invoked in a given state of affairs (Ashforth 2001; Stets and Burke 2000). Identity salience is determined by the identity's subjective importance and situational relevance (Ashforth 2001). A subjectively important identity is one that is highly central to an individual's sense of self as well as relevant to values, beliefs and interests defined by personal preferences and psychological traits - the gestalt of idiosyncratic attributes such as traits, abilities and interests (Ashforth *et al.* 2008). A situationally relevant identity is one based on social interaction and formal social roles within an organisational setting, i.e. department, division, organisation. It follows that individuals vary in the level of magnitude they ascribe to a particular nested identity and the role it affords; some identities will become more salient than others. Hence, we suggest some physicians in our study will give salience to the nested identity 'manager', whilst others perceive being a 'manager' and the tasks attached to this role as less central to, or even eroding, their cross-cutting physician identity, hence as a threat to their overall sense of self. Consequently each individual's hierarchy of nested identities and salience afforded this 'basket of selves' (Ashford and Johnson 2001) will differ – a process we explore in our empirical data below.

Empirical focus of the study

As mentioned earlier, nine “Collaboration for Leadership in Applied Health Research and Care” (CLAHRC) programmes were established to address the problem of embedding best practice and innovation within the healthcare system. Each CLAHRC was provided with £10m funding for five years to develop improvement partnerships that aimed to radically transform the way innovative healthcare interventions were introduced and sustained. One of the CLAHRCs (from now on referred to as ‘CLAHRC’) is the empirical focus of this paper. The CLAHRC represents an organisational model of service improvement which is dependent on the emergence and participation of hybrid physician-managers, and is thus an ideal exemplar by which to study identity processes in enacting hybrid roles.

The CLAHRC is led by a senior team responsible for setting its strategic vision. The senior team consists of academics with a world-class reputation in clinical and health services research, and senior local NHS managers. The CLAHRC introduced an approach which made it different from the other eight. Firstly, it decided to adopt a project-focused approach, whereby a series of improvement projects were provided with funding and support for 18 months to build translational capacity and implement evidence-based research. If successful the improvement ideas would be embedded into mainstream healthcare practice. In total 36 projects were funded in four annual rounds between 2009-2013.

Secondly, the CLAHRC aimed to create new hybrid roles in the form of new physician-managers who would lead applied research and run project teams. These newly appointed physician-managers would work within their clinical units to enable knowledge translation using a set of Quality Improvement tools (e.g. ‘plan-do-study-act’ or PDSA cycles, statistical process control and process mapping) and performance management methods, some of which were designed by the CLAHRC management team. The physicians’ new role consisted of a new title, new forms of governance by, and reporting to, the CLAHRC management team, with a strong emphasis on performance management.

Thirdly, the CLAHRC stressed the need for inter-disciplinary working, where physician-managers would work closely with the CLAHRC senior members and other academics to build long term collaborations and take shared responsibility for knowledge translation.

The introduction of the CLAHRC thus created a new hybrid role – the CLAHRC manager – involving the formal enactment of managerial tasks that physicians had not encountered before. New rules for accountability resulted directly from the need to work collaboratively to design, develop and evaluate knowledge translation practices. In a sense, CLAHRC brought into being a ‘new kind’ of physician-manager, working within a new organisational form; a specific related discourse, practice and new ways of talking and thinking about knowledge translation in healthcare.

Methods

The research reported here is part of a larger study that aimed to explore the organisational development of the CLAHRC and its impact on the local health economy. The data were collected over a period of 4 years, allowing the research team to follow the development of the CLAHRC programme over an extended period of time.

We used multiple sources of evidence, the goal being to converge different viewpoints to arrive at an overall shared perspective between research team members. Our main source of data is from interviews with physician-managers (n= 62) involved in CLAHRC projects. Physician-managers were interviewed twice, at the beginning of their project and at the end over an 18 months’ time period (a total of n=124 interviews). The paper also draws on interviews with CLAHRC senior members conducted as part of the larger study. In total we conducted 210 interviews.

Each informant was contacted and provided with a written overview of the research of the study. A face-to-face interview lasting no more than one hour was scheduled. Before the interview each

informant was emailed an information sheet, which was reviewed in person prior to the start. All informants signed a consent form acknowledging their willingness to participate and indicating their willingness to be digitally recorded and anonymously quoted. All interviews were digitally recorded and transcribed. Each interview began with broad questions to establish the nature of their involvement with the CLAHRC. Following this a semi-structured interview was conducted using open-ended questions to elicit information on the informant's relationship with the CLAHRC programme, their understanding of its aims and objectives, how they described their own professional role within the programme, and their understanding of what it meant to be an effective professional in the CLAHRC. When informants were re-interviewed our emphasis was on capturing how they made sense of their developing role and how possible shifts in the centrality and distinctiveness of themes identified in the first round of interviews may have occurred.

Face-to-face interviews were complemented by observation of CLAHRC meetings and workshops, where field notes were taken, and evaluation of documentary material such as meeting minutes and internal reports. We observed 194 hours of strategic meetings, workshops and development events. Meetings were identified as strategic through interviews and informal discussion with the CLAHRC senior members, and the content of such meetings. We did not participate in these meetings. They were of particular importance because they enabled us to explore the language the CLAHRC senior members used to introduce their work, engage with new members, and sustain their relationships with both new and existing members.

Further background data came from documents, both internal (including emails, minutes of meetings, annual reports and other internal reports) and external, such as national policy documents. These provided useful information on the aims, objectives, vision and mission of the CLAHRC initiative.

Data analysis

The data analysis progressed in three overlapping stages of analysis, during which the level of analytical generalization was raised step by step (Mantere 2008). In the first stage, after transcribing each interview verbatim, transcripts were read closely to identify instances of informants' talk relating to identity. We were particularly interested in statements about their role within CLAHRC and how this made sense to them. This required capturing informants' sensemaking and associated practices and behaviours across time and organisational levels. In addition, it required repeated iterative correspondence between reporting and data analysis, which enabled a better understanding of different 'stages' in identity development, and a better grasp of the emerging codes. For example, during the early stages of our analysis we identified codes such as 'seeking information,' 'raising an issue', 'agreement, and 'disagreement', 'constructing understanding', 'negotiating technical/practical details'. These preliminary codes gave way to final codes and concepts linked to physicians' perceptions of their work as clinicians and managers, and physicians' statements about '*what is my role within CLAHRC*' and physicians' statements '*why I am involved in this*' (see figure 1, first column). This first stage was highly intensive, involving three months of part-time work after each phase of interviewing. At this stage we realized that professional identity was emerging as a key theme during the interview data analysis. Conversely, we decided to use the concept of identity work (Pratt *et al.* 2006) in order to consider how identity was recreated and used by physician-managers in the CLAHRC.

In the second stage, we examined the data to inductively generate rough categories in line with the open coding system recommended by (Strauss and Corbin 1998). Constant comparison of codes was utilised, so that similarities and differences in views were identified while related key codes were collapsed into broader explanatory categories (Gioia *et al.* 2012). Using these categories we produced an account of what it meant to be a hybrid physician working with the CLAHRC. We further compared categories to examine variations in views within and between our informants. This was

necessary to allow us to develop a better understanding of how the emerging themes and related codes connected to each other and what important information they revealed.

As our coding progressed, we were able to consolidate rough categories, continue the interrogation of text and development of major categories, which became more theoretical and more abstract but related to each other (axial coding) (Locke 1996). Emphasis in this stage of the analysis was on conversations (complemented with the observations of their practices when possible) among physicians, identifying instances of talk relating to hybridization, such as talking about 'taking on additional responsibilities', 'wearing two hats', and 'trying to carve out a new quality improvement role'. Our intention was to capture how they made sense of themselves, how and with whom they interacted, and what was their perceived work identity at the professional and organisational level. For example, in the first stage of analysis we observed how physicians redefined their professional identity in relation to the CLAHRC. Through our discussions we grouped physicians' emergent identities based on similarities and differences between their expressed views. During these discussions, it became clear to us that physicians did think about managerial roles in the way that Ashforth and Johnson (2001) have speculated about identity salience, i.e. multiple identities can be simultaneously central to an individual's values and beliefs. However we also identified variation in the hybrid identities adopted by physicians. In order to move to an interpretive and explanatory mode, we used the category 'different levels of identity salience shifts' to capture these elements (see figure 1, second column).

The third level of analysis involved interrogating the relationships between and within categories to develop theoretical explanations for questions emerging from the data. During this process our emphasis was on how explanatory categories could capture the overarching dimensions relevant to the process of negotiating a hybrid role. Three aggregate categories emerged: 1) Redefining

professional identity in relation to the new organisation, 2) Identity salience shifts between nested identities and 3) Formation of holistic gestalt (see figure 1, third column).

Insert figure 1 here

We continue with the presentation of our findings, followed by a discussion of how the hybrid physicians engaged in a specific type of identity construction. We follow this discussion by proposing a more general theoretical model of role hybridization among powerful professionals. We then conclude with a discussion of the practical and theoretical implications for the study of hybrid roles.

Findings

Redefining physician identity

Almost all the physicians indicated that for them their identity developed through increasing involvement in management activities following the formation of the CLAHRC. Participation in the CLAHRC was typically preceded by substantial sensemaking and identity claims on their part. Overall, our data suggest that physicians who participated in the CLAHRC were increasingly accepting responsibility for leading their healthcare improvement initiative and the possible redefinition of their nested identities associated with this. For example, the following informant describes engaging in identity work – i.e. becoming more ‘managerial’ – in order to create, change, protect and switch between multiple work-related identities. They also elucidate that their cross-cutting physician role is the priority for them.

‘I’ve become more managerial in my last few years now I’ve got used to it I enjoy it more but it’s all about time management to ensure that you are able to do your clinical job just as well....I think it’s very important for doctors actually to have a voice in management’. [Project 6-Physician 2 OR P6P2]

Further, our informants engaged in identity work in order to shift between the identities by which they define themselves. We were able to ask one of the informants during this interview about these identity shifts – he described this as ‘wearing different hats’. The following quote conveys how, by working out how to ‘wear different hats’, this physician tried to temporarily adopt new nested identities. In this sense, they were trying to assimilate different selves into their overall sense of being. As demonstrated in the quote below this trying on or skipping between identities was not easy and took time and practice to get right:

‘you have to be clear about the different roles you have at various times, in order to be consistent with yourself, and if you skip from one to the other without knowing you're changing the hat, you get internally very discomforted and you become, actually quite paralysing or anxiety provoking, as I myself have discovered before I became more skilled at that doffing caps myself.’ [P2P2]

Our data analysis suggested that physicians had different reasons for engagement in a wider set of management activities in the CLAHRC, implying that engagement had to fit in and benefit their cross-cutting identity. Table 1 describes the variety of reasons invoked for involvement in CLAHRC activities, ranging from financial incentives to status related reasons.

Insert table 1 here

Three major categories of physician emerged from the analysis of interviews, each of which was linked to the physician-manager’s approach perception of their role in the CLAHRC and how they negotiated this. The first (which we describe as ‘innovators’) emphasised the positive elements of their CLAHRC role. These embraced new techniques to facilitate Quality Improvement that were

being put in place by CLAHRC senior team. The second category ('sceptics') refers to those physicians who never fully engaged with the CLAHRC. The third category ('late majority') refers to those physicians who were initially resistant to their new role – even when in receipt of CLAHRC funding for their project – but gradually over the duration of the CLAHRC they came around. In the next section we discuss these categories and how in the case of the late majority, they re-evaluated their identity in relation to the evolution of the CLAHRC programme.

The innovators

Physicians we term 'innovators' emphasized the positive sides of the CLAHRC programme from its outset. They believed that by embracing CLAHRC's managerial tasks designed to promote knowledge translation they could enhance the quality and safety of their own team's clinical practices. However, only a quarter of those interviewed espoused this positive view.

'So, you know, there is a clinical drive to improve quality there, there's no doubt about that. That's, probably why I started the journey with the CLAHRC, to be honest with you. And I mean the other thing is that there is a bit for me around becoming a better professional, you know, we, as clinicians, use evidence based medicine, so-called evidence based medicine, when we want it and when it suits our purposes.' [P3P1]

The identity of an innovator as a 'CLAHRC manager' was aligned with his or her cross-cutting identity as a 'physician'. The concept of identity salience is key to understanding the identity work (Pratt et al., 2006) these innovators engaged in 'to achieve feelings of a coherent and strong self, necessary for coping with work tasks and social relations as well as existential issues' (Alvesson 2000, p. 991). By aligning their interests, they were able to accord salience to their CLAHRC role. The use of the term '*service improvement*' by a physician in the following quote can be seen as part of an explicit agenda in capturing physicians' responsibility for service improvement:

'I think CLAHRC's very good because they used methods which by and large are not used for service development and should be. So I think that's a really good thing and I think CLAHRC should be selling itself more as this is the way we should do service improvement'. [P7P1]

From the previous quote, it became clear to us that these physicians did not think about taking on a CLAHRC manager role in the way that the literature has traditionally understood that concept, i.e. professionals being seen as the victims of performance management, which they oppose in order to defend their physician role and professional values and beliefs (Thomas and Davies 2005). These physicians saw their new nested identity as a service improvement manager as a potential avenue to enhance their cross-cutting physician identity, and their organisational status and legitimacy, by systematically taking on more responsibility for a range of tasks to improve healthcare.

[Informant talking about her clinical lead] 'She brings together two sides of the same thing which have, unfortunately, till now have been very disparate (and) 'ivory tower', to coin a phrase, the managerial side of things and the frontline'. [P4P4]

The innovators constructed their preferred self-conceptions according to their professional interests mediating between clinical and managerial responsibilities particularly at the project level.

Noordegraaf (2007) has speculated that professionals can readily adapt to organisational and bureaucratic realities and become part of large-scale organisational systems. In the case of our innovators, such characteristics were visible.

The sceptics

Our second category, the sceptics, represented about a quarter of physicians. This category comprises those who never fully engaged with the CLAHRC. These sought to construct a role that was as close as possible to the existing one. In this way they could keep their old identity, but with

limited engagement with the CLAHRC. While the prospect of financial support – in the form of funding for projects – meant that sceptics did not wish to completely withdraw from engagement with the CLAHRC, they wished to balance their own clinical interests with a conditional acceptance of CLAHRC's performance management and mentoring approach.

'We obviously, for research purposes, we need a stable baseline and stable measures over time. But I don't think we comply with all the CLAHRC monitoring requirements. I suppose the question, is whether there is a fit between the CLAHRC Programme methodology and the actual requirements and needs of the clinical practice. So there's a lot of, you know, merging of roles and ideas and stuff and is my job to define a role for myself here'. [P16P1]

Sceptics therefore used some of CLAHRC's quality improvement tools but emphasized their separateness from CLAHRC. They saw themselves and CLAHRC as fulfilling separate roles. The identity work of these physicians reveals a desire to maintain control and autonomy over their work, centring on the formation of their own rules of governance.

'But there were a few, sort of, things they [CLAHRC] didn't understand about our project that we understood so well. There are add-ons that you have to do that, you know, like I said, that seem hugely beneficial to the project. I think we can probably say, slightly cynically, that we do those add-ons and neglect some of the CLAHRC stuff'. [P11P2]

In contrast to the innovators, where CLAHRC was praised by physicians, many sceptic physicians mentioned that the loss of their historical autonomy in setting priorities and targets was the key constraint to engagement in the CLAHRC. In the following quote the interviewee expresses how CLAHRC sought to reconfigure authoritative control through principles of external regulation:

'I don't have a lot of people telling me what to do. I don't have, you know, other people don't impose targets. You know, I'm asked to say what the key performance indicators are. I set the objectives and so compared to most senior posts in the NHS I've got a lot of autonomy. I don't have to go to lots of directors meetings. I'm not on the Board. I don't have to feed the beast as much as other people. This is a professional job you know!' [P7P6]

This group of physicians emphasized that they could not understand the CLAHRC tools and could not find enough time to engage with them. The next quote demonstrates how a physician engaged in identity work and draws attention to the differentiation between CLAHRC and his beliefs as a way of ordering and making sense of his world.

'I don't know what they do, and I think some of the tasks and things that they ask us to do are not thought through enough, so I end up saying, we're not going to do that because, I think we're wasting time on it, or it's not part of my agenda'.
[P3P9]

They also felt that the new job description included tasks which should belong to other team members who were better equipped to deal with performance management practices.

'Yes, it'll be data analysis and performance management. And I don't know how involved in that I'll be, I don't want to be involved in it. I mean, data analysis and performance management is a skill, and I haven't got it, and I wouldn't want to spend the time to develop those skills, it is not part of my role as a clinician' [12P4].

In the following example a physician distances herself from the CLAHRC work that she felt was inappropriate.

'I've no criticism of [named a senior physician within the CLAHRC], he's done much research, service implementation and he's keen on infrastructure and

keen on processes and quite charismatic. But it is the rest of the CLAHRC people. As soon as you challenge them on any point [relating to the CLAHRC 'model'], they crumble. It's the background, there's no understanding of our world, I just don't think they fit with us' [P8P1]

The late majority

Approximately half the physician interviewed were categorised in this way. The 'late majority' were physicians who accepted funding from CLAHRC but resisted the need to produce data for performance management. They were disengaged from the CLAHRC during the early stages of the programme but gradually over its five year duration they became more engaged, particularly after CLAHRC introduced a strategy of emphasising the importance of clinical leadership (see below). During the early days of the programme they emphasized that their physician role had been devalued and their clinical competence was not being appreciated. They emphasized the negative sides of a physician-manager identity within the CLAHRC. They accorded less salience to the underlying management role, even as they assumed a hybrid role. Many of these physicians sought to defend their work from the influence of what was perceived as external interference, even though CLAHRC was offering physicians and their teams support to build translational capacity, such as help with data analysis and advice on publication in scientific journals, defining measures of quality, and assessing cost and clinical effectiveness.

'We didn't appreciate when we'd been told about the support. To start with we took it maybe like... more like an interference in how we are going to do the project'. [P1P2]

We also observed that many physicians in this category, compared to the innovator category, were younger and more junior in their physician role. Our analysis indicated that they felt their managerial identity was less salient than their physician one and this meant a potential loss of distinctiveness in

terms of who they were, what they did and what they aspired to. This represented a perceived threat to their physician identity. Identity threat is conceptualized here as experiences appraised by individuals as indicative of potential harm to the value, meanings, or enactment of an identity (Petriglieri 2011). For these physicians engagement with the CLAHRC accorded less salience to their identity. This resulted in them adopting practices of resistance, such as being unwilling to discuss their research interests openly with the CLAHRC or reporting data for performance management. The late majority felt that the CLAHRC had put into place a hierarchical structure through which it could impose authoritative control, taking a functional, managerialist approach to research and service improvement. In the next quote the informant speaks very negatively about been told by CLAHRC how to organise their work:

'It's probably not the best of things [work as a CLAHRC manager]. Surely, it's always better to do research in what you want to do, rather than have been told that's what you're going to do'. [P11P3]

Engagement in CLAHRC quality improvement and performance management was interpreted as a constraint to their professional discretion and autonomy, imposed by the new organisational structure. Maintaining their cross-cutting identity was key, so they prioritized their clinical discretion, ensuring it was maintained in a manner compatible with being a physician. More fundamentally, it entailed reconfiguring organisational practices in a manner that retained the essence of physician identity. An example of this is when physicians were mindful of the boundaries between themselves and the CLAHRC to the extent that when they referred to CLAHRC they talked about 'them' and when they referred to the project they talked about 'us'.

'What we're doing is what they [CLAHRC] want us to do, which is the whole CLAHRC mission, to work in partnership with academics and develop leaders to facilitate the uptake of evidence based research and put it on the bedside. I think we completely agree with this, there is so much good quality evidence and

research out there, but it stays in nice beautiful papers. It doesn't get translated, um, to the bedside as they [CLAHRC] say.' [(P10P1)]

However this transition from being completely disengaged from the CLAHRC to gradually engage over the five years duration of the programme was not a straightforward process. We describe this in the next section.

Crafting a new identity - the role of saliency

As the CLAHRC programme unfolded beyond its early stages, the CLAHRC senior members realized that some senior physicians at the project level exhibited high levels of resistance to engage in what were perceived as a rigid and overly bureaucratic performance management regime.

'It's been a constant battle to try to convince the physicians in those teams to engage with the methodology and try it and support their team to try it as well' [CLAHRC senior member-3]

Essentially they realised that telling physicians what to do was not working – they did not see this as part of their identity or role. Although they were happy to take any funding offered, they remained unconvinced about the efficacy of CLAHRC itself. To address this limitation the CLAHRC senior members realized physicians should be allowed to make decisions regarding the strategic direction of their clinical projects. For this reason, CLAHRC created clinical leadership roles for physicians. This appeared to be a strategically astute way to address the issue of a lack of saliency afforded by the previous CLAHRC physician-manager role. By re-framing the role in terms of leadership this appeared to create a higher level of saliency for physicians. Senior CLAHRC members were active in promoting the saliency of this new 'leadership' roles for physicians, who began to actively embrace the idea.

I think probably one of the biggest issues has been the leadership issue. I think as a manager I can wear many hats, but I was not, in my opinion, strategically in charge of my project team [...] but now I can make the changes that I think are worthwhile, that's a great, great thing, and you know, obviously quite a few people think that, and that's why they've got the money to do what they've got, is because, you know, clinical leadership it's a great idea. [P14P2]

It was clear that senior CLAHRC members worked with the innovators to proselytize its goals and secure support from the late majority. There were several informal discussions between senior members and physicians around the nature and importance of the clinical leadership and how instrumental this could be for the effective delivery of good quality care. Most of the senior physicians we re-interviewed – especially the late majority – supported the proposal for clinical leaders in the CLAHRC who could champion improvements in service provision. The importance and status of the title – i.e. becoming a clinical leader – gave this new identity salience. The identity of the physician in the following quote is presented as being subject to change, evolving from being ‘a CLAHRC manager’ to providing ‘clinical leadership’, implying a sense of belonging to a community that is distinct from the CLAHRC and demonstrating her desire to maintain a salient cross-cutting identity. However, she also implies hazy boundaries between her clinical and managerial roles in the CLAHRC, suggesting the need to maintain salience for her clinical leadership role, a cue that is possibly conditioned by the physician’s subjective interpretation of what a clinical leader should be doing.

‘Well, my role has changed since the last time we met. I am the clinical leader for the project, but it's a bit confusing. My role in CLAHRC is still quite fuzzy actually. I am trying to make sense of it myself and I suppose partly what I'm here to do is to try and make sense of what it is we're trying to do internally’.
[(P5P2 second interview)]

The previous quote also demonstrates some degree of flexibility within the new role, which we believe was another reason that enabled physicians to give more salience to their CLAHRC role. In essence, physicians were free to give away any part in the new role they saw as robbing them of saliency.

'My role has become as I say more fluid, and more open to interpretation really, I have a number of hats here and I try to, sort of negotiate separate various roles' [P17P1]

According to the previous quote, although the CLAHRC senior members defined the roles physicians should execute in their projects, the individual physician identity reveals the ultimate decision as to whether or not to enact this role. Overall she managed to do this by delegating 'Quality Improvement work' functions concerned with monitoring and feedback that she did not accord an appropriate level of salience to other project members. This behaviour was shared by many of our informants.

The other side of it is that, you know, from a line management perspective sometimes you have to allow people, you have to delegate authority to enable people to develop, so they have to go away and take responsibility for a decision they've made and then unpick it afterwards. Um, you know, and again from a, being a clinical leader and managing a ward, you know, getting that balance right is really important [P16P2]

I am responsible for leading the project and, also, delegating things that need to be done, things like audit and monitoring of adherence to the CLAHRC outcome measures. Ultimately, there are different members of the team that have more time available to them. [P18P2]

These two statements illustrate the creative ways in which physicians were gradually delegating less salient management activities to other project member in order to maintain salience for their own new nested identity. This appeared to be a mechanism that enabled physicians to assume a hybrid role, prioritize essential work practices and rectify potential conflict in a manner that retained the essence of who they were. By doing so, they were able to negotiate their new identity in ways that were satisfactory to themselves, to the CLAHRC and to other project members.

Central to understanding the identity work that these physicians engaged in is the notion of identity salience shifts (Ashforth and Johnson 2001). In particular, working as clinical leaders and having the flexibility to enact their role emerged as a vital step to the way the CLAHRC programme as a whole evolved, by emphasizing the development of physicians' capacity to engage with and manage the programme. In this regard, the previous quotes point to the way that the informant builds a new nested identity by setting priorities for their professional development across different roles. Statements made by our informants indicate that they perceived themselves as holding a hybrid role, although with perhaps a variety of different meanings, highlighted in the following quote:

'I think I was frustrated because I felt I had a clear identity on this hybrid role of doing both clinical and managerial work but there was no flexibility on how to enact this role. So that was my frustration. I'm in a better place now because there is little bit more space now to do some things differently' [P14P3].

Acquiring a hybrid role and a new identity within the CLAHRC was not seen as an identity threat any more. They were able to reappraise the experience of being a clinical leader in the CLAHRC. They associated the meanings of 'professional autonomy' and 'clinical experts' with their new identity as clinical leaders. An ability for CLAHRC senior members and this group of physicians to negotiate a

new role was crucial in the evolution of the programme, enabling it to progress into a new stage in which the emphasis became more focused on clinical leadership development rather than simply managing physicians' performance.

Discussion

Our paper shows how healthcare professionals enact hybrid roles. We employ the concepts of identity and identity salience shifts to gain a richer and more grounded understanding of the phenomenon of hybridity in the public sector, focusing on the development of a new hybrid role as physician and manager during a period of organisational change within the English NHS. In the context of our case study, we showed that in the enactment of such a role the importance of salience was crucial. The negotiations between the CLAHRC senior members and physicians were the medium by which CLARHC aims and objectives were implemented and subsequently evolved. In particular, CLAHRC senior members redefined hybrid roles in relation to physicians' sensemaking, in order to construct a role that appealed to physicians.

According to research (e.g. Finn *et al.* 2010; Pratt *et al.* 2006; Doolin 2001), occupational identity is negotiable, changing within specific social contexts and via social interaction with others, affecting professionals' attitudes as well as enabling and limiting their behaviours (Ashforth *et al.*, 2008). Our analysis confirms this negotiation process – although we found the physicians in our study reacted in very different ways to their new proposed role as CLAHRC managers. Some physicians (those we called the innovators) responded by according high levels of salience to the new managerial role, easily nesting this new identity within their existing professional identity. Others (the sceptics) found it much harder to accept the role of manager and saw this new role-based identity as a threat to their overarching cross-cutting identity as a physician – that being a manager might take away their professional autonomy and prestige. However, we observed that those physicians who initially resisted this new role (the late majority) eventually came around, once they were able to delegate

what they perceived as less prestigious aspects of the management role to others and once the CLAHRC management began to redefine the role more around one of clinical leadership. Our analysis therefore highlights the multiple ways that physicians began to socially construct meanings about their roles in the CLAHRC and how those meanings structured their behaviour and subsequently their nested identities.

These findings contribute to the literature on identity in several ways. First, we argue that the concept of identity salience shifts can be used as an analytical device to better understand how professionals' multiple interpretations of their identity co-evolve, clash and are often rationalized during organisational change initiatives. During this process routines, tasks, and structures are redefined by individuals in order to serve their established sense of self. Secondly, we add to the literature by treating the physician identity as a holistic construct, which emphasizes the idea that identity is manifested as both nested and cross-cutting. In doing so, we show that the boundaries around nested and cross-cutting identities have a degree of flexibility. However, contained within this flexibility are complex processes that involve physicians managing multiple, nested identities, and simultaneously resolving any perceived threat between these identities and their overarching sense of being a physician.

Another finding is that the successful construction of identity salience required effort by individual physicians and others in their social environment, such as the CLAHRC senior members. Identity salience was determined by the construction of a rule-based system around physicians' status and role within their organisational settings. For example, we found that physicians' cross-cutting identity, before their involvement with the CLAHRC, appeared to have a lasting effect on their identification as CLAHRC managers. The reconstruction or not of their identity was dependent upon the perceived threat to their professional power and autonomy and contributed to their sensemaking of 'being a CLAHRC manager' and what that management role should consist of. Both the CLAHRC senior members and the physicians we categorized as innovators worked collectively

with those who were unsure of the new role (the late majority) to facilitate identity salience shifts. This identity work served to change the identity of the late majority by reducing any perceived threat.

We found a variation in the form and manner by which physicians reconciled their preferred self-conceptions with the work that they were performing. In essence, physicians' attempts to become better professionals were wrapped up in becoming 'a more complete physician', albeit in different ways (Pratt *et al.* 2006). In our data, the length of time physicians had been in the role appeared to be linked to perceived identity threat. Becoming a 'CLAHRC manager' was seen by more experienced physicians as non-threatening. In contrast, for the late majority becoming a CLAHRC manager represented a more temporary, but in some ways more complex, identity change that involved attempts to resist change and redefine what the role meant. Taking on a role as a CLAHRC manager was perceived as threatening for these physicians (many of whom we observed were junior), at least during the early stages of the CLAHRC, because they believed that their status had been devalued, their clinical competence as experts was not appreciated and they were not able maintain a sense of professional distinctiveness in the CLAHRC. However, our analysis demonstrates that this threat was resolved once CLAHRC senior members introduced a strategy of emphasising the importance of clinical leadership. This wider more prestigious role allowed more junior physicians to use more discretion in making sense of their role and identities as they saw fit.

These accounts are also useful because they elucidate how the content of physicians' identity changed, allowing us to theorize about the formation and enactment of a hybrid role. Our analysis demonstrates that cross-cutting identity of being a physician takes precedence over other nested identities. We showed that for longer-standing physicians their cross-cutting identities were very dominant and stable and that this stability of knowing who they were allowed them to more easily assimilate a new nested identity and take on a managerial role. However, this was not a straightforward transition and our informants' responses varied. Recent work has shown that is important to understand how members actively use work-related information to construct their own

identities (Pratt *et al.* 2006). We further extend this argument by proposing that during the transition of physicians into these new organisational roles the level of identity threat at a cross-cutting level may be uncomfortable for some, preventing them from constructing and maintaining a sense of distinctiveness.

Our analysis also suggests that the power of physicians to make salience shifts and identity choices may be relevant in explaining the formation of an aligned sense of self. Physicians are powerful and autonomous professionals, able to 'try on' different identities to see if they fit their work roles or change their work roles to fit themselves (Ashforth and Saks 1996; Ibarra 1999; Ferlie Mcgovern and Fitzgerald 2012). In the CLAHRC, the reconstruction of a new nested identity started from a position of a secure and salient cross-cutting identity that was unlikely to be completely overridden or eroded. Consequently physicians were able to enrich their longer-standing cross-cutting identity and bring together distinctly different roles. However, this was not the case for all; for some physicians any level of change was a difficult transition.

The empirical contribution of this research is that we confirm that the physician-manager role comprises cross-cutting and nested identities, which are arranged hierarchically in order of salience. We argue that salience offers an alternative perspective through which to understand the reconfiguration of professional-management hybrid roles in healthcare. It has been argued that professional identity is in a constant state of flux, changing within specific social contexts and models of governance via social interaction with others and affects professionals' attitudes as well as enables and limits their behaviours (Noordegraaf 2007). We extend this argument by arguing that this constant state of flux is deeply embedded in the salience accorded by physicians when they negotiate potentially conflicting roles. By mobilizing the concepts of cross-cutting and nested identities we offer a more complex picture of professional identity construction, whereby moments of being (cross-cutting identity) as well as periods of becoming (nested identities) guide physicians' actions.

Conclusions

This research has implication for the successful management of high profile public policy programmes such as those relating to the improvement of healthcare. By creating organisational roles that make sense to professionals, senior managers can persuade different and powerful groups to act collectively and so enable policy implementation. Our study shows how physician-managers in the English NHS assume and 'negotiate' potentially conflicting roles.

Since the creation of the first wave of CLAHRCs – including our case study here – the government has funded more, meaning this organisational form is destined to become established in the UK over the coming years. As such, the findings of this study have implications for policy and practice by providing new information about why some physicians-managers are more effective than others in negotiating managerial roles and engaging with so-called 'wicked' problems like knowledge translation, staff performance management and team leadership (Ferlie *et al.* 2011). In particular, this study provides insights into how physicians-managers modify and enact their roles within an evolving organisational landscape, offering senior management lessons for supporting physicians-managers who need to successfully embrace new hybrid managerial roles.

Finally, we suggest there is a need for empirical studies which examine the role of identity salience shifts in different empirical contexts, including different professional groups, as a mechanism for the maintenance of self-distinctiveness and the exercise of agency in this process. More research into identity salience shifts during occupational identity reconstruction would test the generalizability of analytical themes that emerged from this study.

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Tables and figures

Table 1: Key reasons physicians invoked for involvement in the CLAHRC

Themes	Example quotes from interviews	Benefits to their cross-cutting identity
Financial incentives	<p>‘we were trying to see if there was some pot of money somewhere in the Trust’ [P3P2]</p> <p>‘Why did we go to CLAHRC? Um, because</p>	Attracting funding to support their clinical

	<p>we recognised that for this project we would need a certain level of financial support to enable us to do the work ‘ [P7P2]</p> <p>‘I was motivated because I thought there was a better chance of us getting money than going anywhere else’ [P11P2]</p>	research
Status	<p>‘Improve the process of patients as well, and, also, be able to translate, um, what we learnt from the pneumonia project, because I have,my background is cardiology, to translate some of that learning into the cardiology field, about the process improvement. So, that’s really, ah, what, what it’s about for me.’[P6P2]</p> <p>The way I see it is that the CLAHRC have, not that we're accountable to them but that they have provided some of the facilitations of training and some of the skills that can have an influential on career progression [P9P1].</p> <p>Some of us are there just because it’s good for our CVs[P13P1]</p>	Strategic career move to enhance their professional power
Personal learning	<p>‘I think it will help me personally, because I’ve not done research before, to see how things are implemented and to see how to do things properly rather than to see how things are done, um, by clinicians.’ [P4P1]</p> <p>‘I think there are lots of things to gain from here. The quality improvement methodology, is very alien for me and would enable me to stay at the forefront of improving patient care’ [P5P2]</p> <p>‘Well, self-development incentives. In the beginning I think financial incentives were used, Patient care incentives, you know, let’s have quality care for our patients, let’s make sure we’re the best that we can be. And finally increase our capacity to sustain healthcare improvements in practice.’[P7P6]</p>	Moral incentives to become a better professional

Figure 1: The following figure depicts the analysis process and the progression from simple coding to more aggregate theoretical categories

