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Emotion as an identity construct of hybrid Doctor-Managers

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ABSTRACT

The aim of this paper is to use a social identity approach to obtain a better understanding of what underlies the engagement strategies that Doctor-Managers (DMs) use when interacting with their clinical colleagues. This paper draws on social identity theory to examine the processes by which DMs construct and attach meaning to their hybrid professional identity. Interviews were conducted with 18 DMs. The findings show DMs emotions influence how they shape the DM role within the organisation. This research highlights that a better organisation of the DM role is needed in terms of position descriptions and in terms of essential and desired skill set requirements for the dual role.

Key words: Doctor-managers, emotions, professional identity, healthcare management

INTRODUCTION

The purpose of this paper is to explore the influence of emotion on the construction and meaning of the professional identity of doctor-managers (DMs) in Australian hospitals. A DM is a doctor working in both a clinical role and managerial role (Braithwaite, 2004; L. Fitzgerald & Dufour, 1998; L. Fitzgerald & Ferlie, 2000; Fulop & Day, 2010). The role of the DM was introduced to counter the divide within healthcare organisations between those with managerial functions and those with clinical functions with the aim to increase organisational efficiency by having clinicians on-board with organisational objectives (Glouberman & Mintzberg, 2001).

The demand for organisational efficiency and cost reduction means that now more than ever medical clinicians are required to measure and account for their clinical practice decisions. It is suggested that when doctors are given a management function, they are more likely to engage with the objectives of the organisation and are more likely to implement changes to clinical practice that result in efficiencies (Dedman, Nowak, & Klass, 2011; L. Fitzgerald & Ferlie, 2000; Swanwick & McKimm, 2011). However, engaging clinicians with health reform policy is difficult. Therefore, there is a need

for hybrid clinician-manager roles such as the DMs to engage and assist with the alignment of clinical and organisational objectives.

This paper uses data from a qualitative research exploring the role of DMs in Australian hospitals. This paper will assist in gaining further insights into the role of the DM within Australian hospitals by applying a social identity approach (SIA) to understand the influence of a DM's emotions, such as internal conflict, on the construction of their professional identity.

LITERATURE REVIEW

Professional identity construction

Despite a growing interest in identity formation there is little known about how identities are formed among medical doctors, let alone DMs. Because of their unique skill sets professionals are granted higher levels of prestige and autonomy than non-professionals. Given the increasing importance of professionals and the centrality of identity in how professionals make sense of and enact with their environment teasing out the professional identity of DMs is timely. To do this we first have to understand identity formation of professionals.

Professionals have multiple role identities that they organise in a hierarchy according to the salience of the individual (Stryker, 2004). The particular roles that an individual professional considers most salient are dependent on the significant social and personal investment to themselves. The subjective importance of a DM's professional role and the prestige they associate with that role are important considerations when exploring the construction of their professional identity. DMs identity construction can be understood through three lenses. 1: career and role transitions (Hall, 1995); 2: socialisation (Pratt, Rockmann, & Kaufmann, 2006); and, 3: identity work (Alvesson, Ashcraft, & Thomas, 2008). These three lenses are discussed below.

1) Career and role transitions

Hall (1995) argues that individuals throughout their careers must move or transition into new roles. These transitions facilitate changes which Hall (1995) calls sub-identities. These sub identities touch on the aspects of identity, however, they do not change the content of the identity that was created

initially. In other words, role transitions may help shape a professional's identity, it does not lead to identity conversion (Pratt et al., 2006). In fact, previous research confirms that when under pressure, the DM returns to a default clinical position (Kippist, 2012).

2) Socialisation

Pratt et al., (2006) examines how groups' and organisations' interactions help shape members identity. Similar to role transition, the process of socialisation shapes a professional's identity by focussing on the desired identity content as favoured by the group and/or organisation. In the medical context the socialisation of doctors is a long and anchored process from the time they enter university, or earlier, through their speciality training and career. As J. A. Fitzgerald (2002) outlines, whilst professional identity is not static, the medical professional identity has been extremely slow to shift over the past 5 decades, much slower than other health professions such as nurses and allied health professions. Medical socialisation has focussed on what organisations do when they train medical professionals and less on identity construction of the medical professional themselves (Pratt et al., 2006). With the rise of the DM role, managers must consider that organisational socialisation of that new hybrid role is challenged by an entrenched medical professional identity. To take a DM from their perceived positon of authority, autonomy and professional dominance in the healthcare organisation to a role that requires organisational accountability with differing power relations requires a significant cognitive and emotional shift.

3) Identity work

The construction of one's identity is a dynamic process that is continually negotiated and co-constructed within a social and relational environment (Wong & Trollope-Kumar, 2014). This paper uses Tajfel (1982) social identity approach (SIA) to understanding how DMs construct their identity as it refers to an individual's self-concept in relation to their membership of social groups. SIA encompasses social categorisation theory (SCT) and social identity theory (SIT). SCT refers to aspects of identity that stem from how individuals categorise important memberships to which they belong (Ashforth, Harrison, & Corley, 2008). For example, DMs categorise themselves as a doctor,

rather than a doctor and a manager when they occupy their dual role. SIT refers to an individual's perception of themselves as a member of a group (Alvesson et al., 2008). For example, DMs see themselves as a doctor who has autonomy and authority over their work, rather than a doctor and a manager who has responsibility and accountability to senior management for their managerial role.

Using a SIA to understand the construction and meaning of the DM role highlights the paradox within the role; DMs have an independent sense of their professional identity and at the same time they use strategies to categorise the social memberships to which they belong within the healthcare organisation. For example, clinicians often see managers as part of the out-group based on their perception of managerial status, legitimisation and threat to their clinical work (Kippist, 2012). Hence, having the opportunity to explain the DM's behavioural patterns from a SIA has the potential to add insight to the political and relational aspects of managing in healthcare organisations. There is much opportunity to add to the emerging literature on identity construction. For example, the Professional Identity literature is devoid of acknowledging the issue of emotion as a contextual element for the construction of identity. It is our premise that emotions may play a role in how one's professional identity is constructed, understood and enacted. We believe that understanding the role of emotions in the DM will shed more light on how this new hybrid identity is constructed and enacted.

Emotions and professional identity

As stated, there has been significant interest over recent years into the construction of clinical professional identity (Hallier & Forbes, 2004; Ibarra, 1999; Pratt et al., 2006). Some have highlighted the link between experienced emotions and the construction and enactment of the DM's professional identity (Cascon-Pereira & Hallier, 2012; Kippist, 2012; Kippist & Fitzgerald, 2010).

Stryker (2004) suggests that it is worth considering how affect, sentiment and emotion influence ones choice of role. For the purpose of this paper we define the following terms: "affect" as an individual's expression of emotion; "sentiment" as a feeling or emotion that emerges from an interaction and "emotion" as a strong feeling that emerges from an interaction (Stryker, 2004). While affect serves to communicate to others about oneself, sentiment and emotions send signals to others as

well as to oneself about the strength of their commitment and the salience of their identity (Stryker, 2004). By drawing on affect, emotions and sentiment we aim to provide a deeper understanding of how DMs engage with their multiple role demands as well as how they work to position their multiple identities.

Pratt et al., (2008) suggest that, in the construction of professional identity of Residents (doctors who are in training to become specialists), it is important to understand the role of work identity integrity, the consistency between who you are and what you do. Their findings point to how work and identity reinforce each other. For example, when residents performed the work related to their "speciality" they felt like the specialist doctor they were in training to be. The specialist work they did reinforced their perception of themselves as a specialist doctor. Although there is no mention of the emotions felt by the residents, there is an underlying assumption that the doctors in training had positive feelings (emotions) when they were acting (working) as specialists.

Haines and Saba (2012) suggest that professionals have multiple role identities which they internally organise in a hierarchy according to their considered salience. The roles that a professional considers most salient hold significant social and personal investment to themselves. The subjective importance a professional holds toward a role and the prestige they associate with that role are important considerations in understanding the link between emotion and professional identity construction. How DMs navigate and enact their dual role will be influenced by the significance and meaning each role identity has for them.

However, Pratt et al., (2008) suggest that when there is a mismatch between identity and work, resident doctors used several customisation strategies to help make sense of the work they were doing. These strategies include "*splinting*" where the resident draws on his/her prior identity (as a medical student) to protect their tenuous identity as a resident; "*patching*" where the resident draws on one identity (as a resident or medical student) to reinforce their lack of understanding of their current self and "*enriching*" where the resident is engaged with their new role and has a deeper understanding of the roles meaning and how to enact the role. As a result of these customisation strategies Pratt et al.,

(2008) suggest that professional identity is not static, more a means of drawing on known identities that serve as temporary measure of making sense of work when an individual aligns who they are to what they do.

Such customisation strategies used by medical residents highlights that emotions may influence the construction of professional identity. When residents use splinting or patching strategies there is an assumption that they experience a discord between their now self and their possible future selves. Such an experience of emotional dissonance causes the residents to employ their known (safe) identity and ways of behaving to decrease feelings of internal tensions.

Casco-Pereira and Hallier (2012) used a social identity approach to explore the professional identity of DMs. They suggest that there is a central role for emotions in the construction, meaning and enactment of a DM professional identity. They found that both emotions and cognition influence readiness for the DM role and how that role is enacted. DMs expressed both negative and positive emotions about occupying their dual role. Some expressed feelings of anxiety, sadness and insecurity when they experienced dissonance between espoused management characteristics and their clinical identity. While others expressed positive emotions of security, ability and power as they gained experience in their management role (Cascon-Pereira & Hallier, 2012).

Cascon-Pereira & Hallier (2012) suggest that the value of recognising emotions as part of the professional identity construct is that they may serve as an indicator of the importance individuals place on adopting or rejecting a particular identity. For example, when a DM feels angry or frustrated about sitting in a management meeting when he/she feels they should be doing their clinical work, may serve as an indicator that their management role is less important to them than their clinical role. Also emotions may act as pointers of how aligned professional values and beliefs are when one role transitions into another role.

Pratt et al (2008) and Cascon Pereira & Hallier (2012) suggest that when individuals hold multiple identities they draw on different parts of their identities to meet the needs of their changing environments and relationships. In this paper, we extend Cascon Pereira & Hallier's (2012) work that

suggest that the emotional and political relational patterns that occur in organisations may be a result of the link between emotions, identity construction and meaning to specific professional behaviour. The findings provide insights about how DMs construct, place meaning and behave when they occupy their dual role. These findings demonstrate that DMs emotions influence how they shape the DM role within the organisation. This paper provides an insight into how emotions and cognition influences the professional identity of DMs, which may lead to patterns of behaviours that engage or not engage with the objectives of the organisation.

METHOD

This research adopted a qualitative methodology to understand engagement strategies used by DMs in their leadership role, that influence organisational objectives being met and to make recommendations for practice. The primary method of data collection involved semi structured interviews with 18 DMs (doctors working in combined management and clinical roles). The DMs were all Heads of Departments, from a range of medical and surgical specialities. Their role as a DM included duties such as maintaining budgets, staffing, quality control, performance management and rosters. Their management experienced ranged from 6 months to 10 years and they worked in their management role between 1 – 3 days per week and they worked in their clinical role 3 – 5 days per week. Twelve of the DMs interviewed had no management education and 5 had attended a Management Development courses run through the Area Health Service or via their Speciality College. No DM had any tertiary qualifications in management.

The interviews were conducted between October 1, 2009 and March 30, 2010, in several large hospitals within an Area Health Service in Sydney, Australia. Interviews lasted approximately one hour. The interview questions were broadly framed around the research participants' experiences and perceptions of the DM role. The interview data was supplemented with observation and field notes about the research participant's behaviour in the interviews, the research participant's interactions with other members of their department and from the researcher observations when attending department meetings. The data was coded and analysed for thematic content using the constant

comparative method of iterative inquiry to identify similarities and differences in the respondent's views (Boeije, 2000).

FINDINGS AND DISCUSSION

In this section we explore how emotions influence how DMs define themselves professionally.

One participant who is a doctor with managerial duties drew on his medical authority and autonomy to define himself. He stated:

They [management] can't bully me, but I can bully them. They [management] may be threatened, but I am not. (DM 2)

DM2 demonstrates his feelings of superiority over those who occupy a management role and he appears to use such a sentiment of authority to engage in aggressive behaviour toward others. Medical professional dominance occurs through the use of selective resources to restrict and exclude other professions from gaining legitimacy in the field of healthcare (Freidson, 1970; Illich, 1976). Members of the medical profession are understood to be distinct from other occupations in healthcare organisations through their professional autonomy, authority and sovereignty (J. A. Fitzgerald, 2002).

DM2's use of controlling language is a way of maintaining dominance within the organisation. His quote highlights what Stryker (2004) refers to as how emotions are signals to self and others about the strength of network commitments and the relative salience of their identity. DM2 disassociates his role as a DM from the identity of a manager and as part of the management network of the organisation. His use of "me" and "them" shows how he separates or categorises himself as different from management. This further supports Pratt et al's (2008) notion of identity patching, where individuals draw on their initial identity when they feel threatened in their alternate role.

Another DM demonstrates the salience he attributes to his DM role when he excuses himself from chairing a Department meeting to answer a page about a clinical issue. He stated: *Excuse me while I go and do some real work. (DM1).* DM1 demonstrates that the meaning of his professional identity is through the salience of his clinical role. This suggests that he holds the sentiment that being a

manager holds less importance than being a doctor through his reference to the words "real work" when referring to his clinical role. Pratt et al (2008) suggest that, when individuals have stronger feelings toward one identity over the other, they splinter themselves and draw on what they perceive as their stronger identity.

The DM role requires the incumbent to do both managerial and clinical work. However, the expectation is that one role would not be seen as more important or in this case as more "real" than the other. Hallier & Forbes (2004) suggest that management will trigger a need for DMs to see themselves as a member of management or re-order the salience of their membership of the clinical group to which they belong. DM1 appears to have placed more relevance on his clinical role even at the time that he is enacting his managerial role.

While DM 10 expresses a feeling of pride in occupying a dual role. He states:

It [being a DM] is like running a small business, as you are a businessman. I built it [his department] up as a 100-person unit; I built every single bit of it. (DM10).

DM10's statement suggests he is engaged with the experience of being a manager. He uses his feeling of pride to express the positive experience of achieving a goal (Timostsuk & Ugaste, 2012). DM10's response further supports Pratt et al's. (2008) notion of enriching, where individuals who engage with their new role have a better understanding of what the role means which influences their behaviour and hence their identity as they enact their role. Nonetheless, his use of business language to describe his personal achievements does not necessarily draw on an overarching management philosophy, that further suggests being part of a management team in the organisation holds little salience to him and his colleagues (Glouberman & Mintzberg, 2001).

DM8 expresses a negative feeling from what he perceives to be expectations of others when occupying a dual role. He states:

It [the DM role] is a little bit daunting. I think there is a great expectation from people about this role, from clinicians and management. (DM8)

DM8's response suggests that he feels somewhat intimidated because of how others perceive him in his DM role and his feelings influence the meanings he subscribes to occupying the role. Stryker (2004) suggests that where emotions are "out of the ordinary" they can act as a signal to an individual that there is something important to which they need to pay attention. DM8's response may be explained by his experience of a negative emotion as he accounts meaning to his dual role and this may influence the construction and behaviour of his multiple identities as he highlights his accountability to both managers and clinicians.

The above findings suggest several potential explanations for how emotion might add to our understanding of how DMs construct and give meaning to their hybrid professional identity. Some DMs have negative sentiments towards management to maintain clinical dominance. These negative feelings contribute to the meaning of the role and results in the DM disassociating themselves from the management community of the organisation. Maintaining clinical dominance within health care organisations may mean that organisations will not achieve the expected organisational engagement of individuals occupying the DM role that was intended to meet.

The meanings DMs attribute to their dual role may be influenced by the increased salience they place on their clinical role over their managerial role. When the DM role is not seen as important by the incumbent they are less likely to the value their management role and this may impede their ability to engage their clinical colleagues with organisational goals and objectives.

In contrast to Cascon- Pereira and Hallier's (2011) suggestion that an individual's awareness of a negative emotion brings with it a negative experience. We suggest that there may be times when negative feelings or emotions act as a marker for alerting an individual to be more aware of the relational aspects required of their role. In doing so, DMs may be more likely to bring a clinical view to management and a management view to clinicians.

CONCLUSION

We set out to explore the role of emotions in how DMs construct and give meaning to their hybrid professional identity. Our initial findings suggest that emotions, displayed through sentiment and

affect, may play a part in the construction and meaning of the DM role and can have a significant effect on how they perceive and behave in their dual role.

Negative sentiments or feelings about management lead DMs to differentiate themselves from being part of the management community as well as influenced their behaviour with other members of the organisation (Pratt et al 2008). When DMs experienced feelings of superiority toward non clinical managers it appeared to allow a sense of cognitive separation from the management community in which they belong. This separation process can be further explained through SCT where negative emotions lead individuals to categorise themselves between the (clinical) in-group and the (management) out-group within the health care organisation (Stryker 2004). This way of thinking also influences the interactions DMs have with non-clinical managers. It appears that feelings of superiority give the DMs the authority to interact in an aggressive manner toward the non-clinical managers which leads to conflict between other members of the organisation (Kippist 2012).

While affect provided some indication of the emotional satisfaction of the occupying a dual role and how the DM is motivated and identifies with the role (Stryker 2004). When DMs expressed behaviour that the DM role is less important or holds less value than their clinical role they may send signals to clinicians and others that the dual role is not an important role within the organisation. This can have implications for succession planning within the clinical community for future DMs (Kippist & Fitzgerald, 2010). Conversely, when DMs expressed positive feelings and behaviours toward their identity as a manager there was a display of ownership of the responsibilities of the role. When DMs engage with their dual role they are more likely to create a better alignment between clinical and managerial goals that focus on improving quality of care, reducing the differences between the clinical perspective and the managerial perspective of organisational objectives (Baker & Denis 2011).

Cascon-Pereira & Hallier (2012) suggest that the influences of emotions are linked to how DMs construct and give meaning to their dual professional identity. Such an understanding provides a way of informing the political and relational patterns that occur in organisations. Our initial findings

support this notion and suggest that the DM role is more complex than creating a hybrid position to increase the managerial profile of the organisation. There needs to be greater understanding that the emotions that DMs feel and or express influence how they think about their dual role as well as the social interactions in which they engage.

This research is a basis for future research on DM's professional identity using emotions and a SIA. Our theoretical perspective of using SIA and emotion to the concept of professional identity has increased understanding that the construction and meaning of a DM's professional identity may be influenced by the emotions they experience when they occupy a dual role.

This paper has combined SIA and emotions as a framework to explore the professional identity of DMs working in the Australian health care context. We have demonstrated that the construction, meaning and behaviour of those who occupy a DM role are broader than a cognitive process. The emotions that DMs bring with them as part of their medical socialisation influence their behaviour as a manager and as a clinician.

The results of our research suggest that emotions influence the salience DMs place on their dual role and can lead to them to categorise themselves into a clinical in- group and a management out-group as well as affect their interactions with others. However, future research on the role emotions play in the construction and meaning of a DMs professional identity may extend the literature on professional identity in hybrid roles within health care.

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